Funding and Characteristics of State Mental Health Agencies, 2007

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

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Contents

Acknowledgments . . . iii

Executive Summary . . . 1

1. Overview . . . 7
   - 1.1 Impacts on SMHAs' Areas of Focus . . . 8
   - 1.2 Outline of This Report . . . 9

II. Study Approach and Limitations . . . 11
   - 2.1 Study Approach . . . 11
   - 2.2 SMHA Profiling System . . . 11
   - 2.3 SMHA-Controlled Revenue and Expenditure Study . . . 12
   - 2.4 The Uniform Reporting System . . . 12
   - 2.5 Limitations . . . 12

III. Organization and Structure of SMHAs . . . 15
   - 3.1. Location of SMHAs Within State Government . . . 15
     - 3.1.1 Mental Health Boards/Commissions . . . 15
   - 3.2 Other Disability Service Responsibilities of SMHAs . . . 17
     - 3.2.1 Substance Abuse Services Colocated With Mental Health Services . . . 17
   - 3.3 Reorganization of SMHAs . . . 18
   - 3.4 SMHA Mental Health Responsibilities . . . 19
     - 3.4.1 Children/Adolescent Mental Health Services . . . 19
     - 3.4.2 State Psychiatric Hospitals . . . 19
     - 3.4.3 Forensic Mental Health Services . . . 19
     - 3.4.4 Alzheimer's Disease and Organic Brain Syndrome . . . 20
     - 3.4.5 Traumatic Brain Injury Services . . . 20
   - 3.5 Eligibility for SMHA Mental Health Services . . . 20
     - 3.5.1 Adult Mental Health Eligibility . . . 20
     - 3.5.2 Child and Adolescent Eligibility . . . 20
   - 3.6 Number of Mental Health Organizations Operated and/or Funded by SMHAs . . . 23
     - 3.6.1 SMHA Relationship to Local Providers . . . 23
     - 3.6.2 Privatization of SMHA-Operated Programs . . . 23

3.6.3 SMHA Class Action Lawsuits 23

IV. Characteristics of Persons Served by SMHAs, FY 2007 25

4.1 Persons Served by Age and Gender 25

4.1.1 Children and Adolescents. 26

4.1.2 Adults. 26

4.1.3 Older Adults. 26

4.2 Persons Served by Race and Gender 27

4.2.1 Children and Adolescents. 27

4.2.2 Adults. 27

4.2.3 Older Adults. 27

4.3 Adults (SMI) and Children (SED) Served by SMHAs 28

4.3.1 Children (SED). 28

4.3.2 Adults (SMI). 29

4.3.3 Older Adults (SMI) 29

4.4 Living Situation of Mental Health Consumers Served 29

4.4.1 Children 29

4.4.2 Adults. 30

4.4.3 Employment Status 30

4.4.4 Employment Status by Diagnosis. 30

4.5 Adults and Children With Co-Occurring Mental Health/Substance Abuse Disorders 31

4.5.1 Persons Served in Community and State Hospitals 31

4.6 Persons Served Through Medicaid and Other Funding Sources 31

V. SMHAs' Responsibilities for Community Mental Health Services 33

5.1 Role of County/City Government 34

5.2 Community Mental Health Providers 34

5.2.1 Community Providers Given Control Over Utilization or Budgets of State Psychiatric Hospitals 35

5.2.2 Community Providers Perform Gatekeeping Entry Into State Psychiatric Hospitals 35

5.3 Types of Community Mental Health Services Offered 35

5.4 Consumer-Operated Services. 36

5.4.1 Types of Consumer-Operated Services 37

5.4.2 States Reimbursing Peer Specialists for Providing Mental Health Services Through Medicaid 37

5.4.3 Office of Consumer Affairs 37
5.4.4 Managed Care Practices 37
5.4.5 SMHA Use of Managed Care 37
5.4.6 Services Provided Under Managed Care Plans 39
5.4.7 Medicaid Options Adopted by the State Medicaid Plan for Covering Mental Health Services 39

VI. SMHA Psychiatric Inpatient Systems, Acute Care Issues, and Forensic Services. 41

6.1 State Psychiatric Hospitals 41
6.2 State Psychiatric Hospital Reorganization. 43
6.3 Closing State Psychiatric Hospitals 44
6.3.1 Construction of State Psychiatric Hospitals 44
6.3.2 How SMHAs Use State Psychiatric Hospitals 46
6.3.3 Use of Non-SMHA General Hospitals and Other Local Hospitals 46
6.4 Psychiatric Acute Care Shortages 46
6.5 Forensic Mental Health Services 49
6.5.1 Organization of State Forensic Mental Health Services 50
6.5.2 Not Guilty by Reason of Insanity and Guilty but Mentally Ill Statutes 51
6.5.3 Scope of Forensic Mental Health Services 51
6.5.4 Sex Offenders. 51
6.5.5 Provision of Mental Health Services to Persons in Prison or Jails 52

VII. New Freedom Commission Activities. 55

7.1 Goal 1: Americans Understand That Mental Health Is Essential to Overall Health 55
7.1.1 Public Information Initiatives. 55
7.1.2 Stigma 55
7.1.3 Suicide Prevention 56
7.2 Goal 2: Mental Health Care Is Consumer- and Family-Driven. 57
7.2.1 Insurance Coverage and Parity for Mental Health Services 57
7.2.2 Recognition and Treatment of Persons With Mental Illnesses by Primary Care Providers 57
7.2.3 Individualized Treatment Plans 58
7.2.4 Recovery Orientation 58

7.2.5 Consumer Involvement in Mental Health Systems 58
7.2.6 Psychiatric Advanced Directives 58
7.2.7 Types of Advanced Directives Supported 59
7.2.8 Comprehensive Mental Health Plans 59
7.2.9 Fragmentation 59
7.2.10 Child Custody Relinquishment 60
7.2.11 Services to Veterans and Military Members 60
7.2.12 Housing 61
7.2.13 Criminal Justice and Mental Illnesses 61
7.2.14 Mental Health Courts 62
7.2.15 Prebooking Diversion Programs for Adults 63
7.2.16 Postbooking, Preadjudication Diversion Programs for Adults 63
7.2.17 Youth Diversion Programs 63
7.2.18 Reentry Programs 63
7.3 Goal 3: Disparities in Mental Health Services Are Eliminated 63
7.3.1 Cultural Competence 63
7.3.2 Workforce Initiatives 64
7.3.3 Workforce Improvement 64
7.3.4 Prescription Privileges and the Use of Licensed Health Care Providers 64
7.3.5 Staffing in State Psychiatric Hospitals 65
7.3.6 Rural/Frontier Services 65
7.4 Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice 66
7.4.1 Screening for Mental Health Problems 66
7.4.2 Older Adult Mental Health Services 67
7.5 Goal 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated 67
7.5.1 Moving Research and Evaluations Into Practice 68
7.5.2 Research and Evaluations by SMHAs 68
7.5.3 Types of SMHA-Conducted Research/Evaluation 69
7.5.4 Evidence-Based Services 70
7.5.5 Assertive Community Treatment (ACT) 71
7.5.6 Supported Employment 72
7.5.7 Medication Algorithms 73

7.5.8 Family Psychoeducation 73
7.5.9 Integrated Dual Diagnosis Treatment (Mental Illness and Substance Abuse) 74
7.5.10 Illness Self-Management 74
7.5.11 Supported Housing 74
7.5.12 Consumer-Operated Services 75
7.5.13 Multisystemic Therapy 75
7.5.14 Therapeutic Foster Care 76
7.5.15 Functional Family Therapy 76
7.5.16 School-Based Interventions 76
7.5.17 Older Adult Evidence-Based Practices 76
7.5.18 Training for Evidence-Based Practices 77
7.5.19 Barriers to Implementing Evidence-Based Practices 78
7.5.20 SMHA Initiatives to Support the Adoption of Evidence-Based Practices 78
7.5.21 Emerging Evidence-Based Practices 78
7.5.22 Clinical Practice Guidelines 79
7.6 Goal 6: Technology Is Used to Access Mental Health Care and Information 81
7.6.1 Telemedicine 81
7.6.2 Electronic Health Records 81
7.6.3 Implementation of EHR Components 83
7.6.4 Sharing EHR Information 83
7.6.5 Reported Benefits of Using EHRs 84
7.6.6 Electronic Pharmacy/Medication Ordering System 84
7.6.7 Medication Administration Recording 84
7.6.8 Electronic Personal Health Records 84

VIII. SMHA Financing of Mental Health Services 87
8.1 Mental Health Expenditures Controlled by State Mental Health Agencies 87
8.2 Change in SMHA-Controlled Expenditures Over Time 87
8.3 Shift From State Psychiatric Hospital-Based Services to Community-Based Mental Health 90
8.3.1 Variations in SMHA Expenditures 90
8.4 SMHA-Controlled Expenditures by Type of Mental Health Service 91

8.5 SMHA-Controlled Mental Health Spending and Total State Government Expenditures 93
8.6 State Tax Dollars Remain the Major Source of Funding of SMHAs. 94
8.7 SMHA Revenue Trends Over Time. 97

IX. The SMHA and its Relationship With Other State Government Agencies 111

9.1 Analysis of Medicaid-Paid Claims Files. 111
9.2 Linking SMHA Data With Other State Agency Data 112
9.3 Participation in Special Projects That Strengthen Collaborative Relationships With Other State Agencies 112

Glossary 115

References 117

List of Tables

Table 1: SMHA Organization, Structure, and Relationship to Substance Abuse and Mental Retardation/Developmental Disabilities Agencies 16
Table 2: SMHA Mental Health–Related Responsibilities 21
Table 3: Eligibility Criteria to Receive Mental Health Services From SMHA-Operated/SMHA-Funded Providers. 22
Table 4: Number of Mental Health Organizations Operated or Funded by SMHAs, 2007 24
Table 5: Examples of SMHA Initiatives to Integrate Private and Public Mental Health Providers 24
Table 6: Primary Methods Used by SMHAs to Fund Community Mental Health Services, 2007 35
Table 7: Methods of Gatekeeping That Control Entry to and Discharge From State Psychiatric Hospitals 35
Table 8: Community-Based Services Targeted Toward Specific Population Groups . . 36
Table 9: Types of Consumer-Operated Services Funded by the SMHA 37
Table 10: Services Provided by Self-Identified Consumers 38
Table 11: Services Provided via Managed Care Plans. 39
Table 12: Number of Resident Patients, Total Admissions, Net Releases, and Deaths: State and County Psychiatric Hospitals, 1950–2005 43
Table 13: State Psychiatric Hospitals 45
Table 14: Number of States Using State Psychiatric Hospitals by Age and Service . . 46

Table 15: Number of 24-Hour Hospital and Treatment Beds 47
Table 16: 24-Hour Hospital and Residential Treatment Beds per 100,000 Population 47
Table 17: Forensic Status of State Psychiatric Hospital Residents 52
Table 18: Responsibilities for Sex Offender Services. 52
Table 19: How SMHAs Promote Consumer Choice (Number of SMHAs Reporting) 58
Table 20: SMHAs Has initiative Under Way to Work With Other State Government Agencies to Coordinate, Reduce, or Eliminate Barriers Between Delivery Systems and Funding Streams (Number of SMHAs Reporting) 59
Table 21: Barriers That Impede the SMHAs' Ability to Address Consumer Housing Needs. 62
Table 22: SMHA Cultural Competence Activities Needs 64
Table 23: Number of SMHAs Implementing/Planning to Implement Adult EBPs 71
Table 24: Number of SMHAs Implementing/Planning to Implement Child/ Adolescent EBPs 72
Table 25: Funding Sources for ACT 73
Table 26: Type of Information the SMHA Makes Available via the Internet 81
Table 27: EHR Modules Implemented in State Psychiatric Hospitals and Community Mental Health Providers 84
Table 28: Sharing EHR Information. 84
Table 29: Average Annual Change in State Government Expenditures: FY 1997 to FY 2005 94
Table 30: SMHA Mental Health Actual Dollar and per Capita Expenditures by State, FY 2005. 99
Table 31: SMHA Mental Health Actual Dollar and per Capita Expenditures by State, FY 2005. 100
Table 32: SMHA Mental Health per Capita Expenditures for State Mental Hospitals, Community-Based Programs, and State Mental Health Support Activities by Type of Service Setting and by State, FY 2005 (in Millions). 101
Table 33: SMHA-Controlled Mental Health Expenditures by Type of Program, FY 2005 (in Millions) 102
Table 34: SMHA Mental Health-Controlled per Capita Expenditures for State Mental Hospital Inpatient Services, Community Services Research, Training, and Administration: FY 2005 103

Table 35: SMHA Mental Health-Controlled Expenditures per Inpatient Day, All Civil (Voluntary and Involuntary) Patients in State Psychiatric Hospitals by Age and State, FY 2005 (in Millions) 104
Table 36: SMHA Mental Health-Controlled Expenditures per Inpatient Day, All Forensic Patients in State Psychiatric Hospitals Receiving Mental Health Services, by State, FY 2005 (in Millions) 105
Table 37: SMHA-Controlled Mental Health Revenues, by Revenue Source and by State, FY 2005 (in Millions) 106
Table 38: SMHA-Controlled Mental Health Revenues to Community Programs, by Revenue Source and by State, FY 2005 (in Millions) 107
Table 39: SMHA-Controlled Mental Health Medicaid Revenues as a Percentage of Total State Medicaid Spending, by State, FY 2005 108
Table 40: FY 2001 to FY 2005 SMHA-Controlled Mental Health Expenditures (in Millions) 109
Table 41: FY 2001 to FY 2005 Percent Change in SMHA-Controlled Mental Health Expenditures 110
Table 42: Other State Agencies SMHAs Link Data With 113

List of Figures

Figure 1: SMHA Responsibilities for Substance Abuse and MR/DD Services 17
Figure 2: Number of States With Mental Health and Substance Abuse Colocated in One Agency: 1981 to 2007 18
Figure 3: Percentage of Consumers Served by Age 25
Figure 4: Utilization Rates of Persons Served by Age and Gender (Rate per 1,000) . . 26
Figure 5: Utilization Rates of Children (0–17) by Race and Gender (Rate per 1,000) 27
Figure 6: Utilization Rates of Adults (18–64) by Race and Gender (Rate per 1,000) 28
Figure 7: Utilization Rates of Older Adults (65 and Over) by Race and Gender (Rate per 1,000) 29
Figure 8: Employment Status of Adult Mental Health Consumers, 2007 30
Figure 9: Persons Served in Community, State Hospitals, and Other Inpatient Beds 31
Figure 10: Persons Served by Medicaid and Other Funding Sources 31
Figure 11: Persons Served by Medicaid and Other Funding Sources by Race 32

Figure 12: Primary Methods SMHAs Use to Fund Community Mental Health Services 34
Figure 13: Medicaid-Managed Care Waivers Used for Mental Health 38
Figure 14: Number of State Psychiatric Hospitals 42
Figure 15: State Psychiatric Hospital Residents per 100,000 Population 42
Figure 16: State Psychiatric Hospital Reorganization Activities, 2007 44
Figure 17: SMHAs Experiencing a Shortage of Psychiatric Inpatient Beds, 2007. . . . 48
Figure 18: SMHA-Controlled Forensic and Sex Offender Mental Health Expenditures, FY 1983– FY 2005 49
Figure 19: SMHA Responsibility for Forensic Mental Health Services, 2007 50
Figure 20: SMHA Has Stigma and Discrimination Initiatives 56
Figure 21: States With Mental Health Court and/or Jail Diversion Programs 62
Figure 22: SMHA Shortages of Mental Health Staff by Discipline, 2007. 65
Figure 23: SMHA Early Detection of Mental Health Problem Initiatives. 67
Figure 24: Organizational Location of Research and Evaluation 69
Figure 25: Number of EBPs Being Implemented by States 70
Figure 26: SMHA Uses or Promotes Telemedicine for Mental Health 82
Figure 27: Implementation of EHRs. 82
Figure 28: EHR Status in State Psychiatric Hospitals 83
Figure 29: Total FY 2005 SMHA-Controlled per Capital Mental Health Expenditures (in Billions) 88
Figure 30: Trend in SMHA-Controlled Mental Health Spending, FY 1981 to FY 2005 88
Figure 31: Average Annual Change in SMHA-Controlled Mental Health Expenditures, 1981 to 2005, by Decade and Type of Program. 89
Figure 32: SMHA Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY 1981 to FY 2005 90
Figure 33: FY 2005 SMHA-Controlled Per Capita Expenditures for Mental Health Services 91
Figure 34: SMHA-Controlled Mental Health Expenditures by Type of Service: FY 1981 92
Figure 35: SMHA-Controlled Mental Health Expenditures by Type of Service: FY 2005 92
Figure 36: SMHA-Controlled Expenditures by Type of Mental Health Service: FY 1981 to FY 2005 (Expenditures in Billions) 93

Figure 37: Total SMHA-Controlled Mental Health Expenditures as a Percent of Total State Government Expenditures: FY 1981 to FY 2005 94
Figure 38: SMHA-Controlled Expenditures as a Percent of Total State Government Expenditures: FY 2005 95
Figure 39: SMHA-Controlled Revenues for Mental Health, FY 2005 96
Figure 40: SMHA-Controlled Revenues for Mental Health Services: FY 1981 to FY 2005 (in Billions). 96
Figure 41: Percent of SMHA-Controlled Community Mental Health Revenues by Major Sources: FY 1981 to FY 2005 98
Figure 42: Percent Increase in SMHA-Controlled Revenues From Major Funding Sources: FY 1981 to FY 2005 98

Executive Summary

State Mental Health Agencies (SMHAs) are the state government agencies responsible for assuring the provision of mental health services to persons with mental illnesses and emotional disturbances. SMHAs annually administer nearly $30 billion to provide mental health services to over 6 million individuals. SMHAs vary widely regarding how they are organized within state government, the specific array of disability services they deliver, the way they organize and deliver mental health services, and their eligibility and funding requirements. This report provides a comprehensive review of the various ways SMHAs are organized and structured, their major policy initiatives to better meet the mental health needs of the residents of their state, the mental health services they provide or fund, and how they finance these services.

SMHA Organizational Location in State Government

Most SMHAs are now organized as a division or agency within a larger state government department. Most SMHAs (29) are now a division within a department of human services that is also responsible for Medicaid, social services, children's services, and older adult services. Fewer SMHAs (13) are organized as Cabinet-level departments that report directly to the Governor's office or to a mental health oversight board.

Non-Mental Health Disability Responsibilities of SMHAs

Beyond mental health services, most SMHAs are also responsible for other disability services. In the most common organizational arrangement (28 states), the SMHA is responsible for both mental health and substance abuse services. A frequent rationale for this organizational structure is that persons with serious mental illnesses (SMI) often have co-occurring substance abuse problems. Colocating the service responsibilities facilitates better coordination of co-occurring service needs. However, a substantial number of SMHAs—particularly agencies in the larger states (California, New York, Illinois, and Ohio)—are responsible only for provision of mental health services.

SMHA Eligibility Criteria

Although all SMHAs provide mental health services to adults with SMI and usually also serve children with serious emotional disturbances (SED), states differ in how they operationally define SMI and SED. States also differ regarding eligibility criteria for determining who qualifies for SMHA services. Some states (19) restrict the use of state dollars to serve only persons who meet the state's definition of SMI. Other states provide or fund services to

adults and children who have mental health needs but do not meet the state definition of SMI.

Types of Mental Health Services Provided by SMHAs

SMHAs vary widely in the responsibilities they assume for different types of mental disorders and service populations. While all SMHAs serve adults with mental health issues, there are three states where all children's mental health services are provided by a separate state agency. This agency is usually integrated into a department of children and their families that provides mental health, child substance abuse, developmental disability, child welfare, and juvenile justice services.

In most states (47), the SMHA is responsible for providing forensic mental health services to persons sent by the courts because of their criminal justice system involvement. In 20 states, services for brain impairment (traumatic brain injury) are part of SMHA responsibilities or a responsibility the SMHA shares with other state agencies. Alzheimer's disease and dementia are responsibilities the SMHA shares with other state agencies in 17 states.

Persons Served by SMHAs

In 2007, SMHAs provided mental health services to over 6 million persons, just over 2 percent of the population of the United States. Over 96 percent of the persons who received SMHA services received community-based services (usually outpatient or other less-than-24-hour services provided in their own communities), while 3 percent received services in state psychiatric hospitals, and 7 percent received inpatient services from general hospitals or private psychiatric hospitals. Consumers may be served in more than one setting during the year.

Persons with mental illness served by SMHAs were mostly White (62 percent) or African American (20 percent). However, the utilization rates for most minorities (African Americans, Native Americans, and Hispanics) were higher than the rates* for Whites or Asian Americans. Equal numbers of males and females were served by SMHAs, although this differed slightly by age (more boys were served than girls among children, but slightly more females than males among adults).

Persons served by SMHAs tended to be unemployed (only 21 percent of adult SMHA consumers were employed) and poor—57 percent had Medicaid** that paid a portion of their mental health services. The majority of adults in the SMHA system (80 percent) lived in private residences, but 3 percent were homeless or living in shelters, and 2 percent were living in jails or other correctional settings when their living situation was last assessed.

SMHA Provision of Community Mental Health Services

Every SMHA develops and implements a plan for a comprehensive mental health service system as a requirement to receive Federal Community Mental Health Services Block Grant funds. The community mental health systems in states provide a variety of ambulatory services such as individual outpatient counseling, group therapy,

* Utilization rates refer to the number of persons of a particular age, gender, or race/ethnicity divided by that group's population in a state.

** Medicaid is a state-Federal program that pays for health care for low-income individuals and those with disabilities.

medications management, day treatment, case management, peer support services, vocational and educational supports, housing supports, and training and skill development to foster recovery from mental illness. Increasingly, SMHAs are implementing evidence-based practices (EBPs) designed to ensure consumers receive services that mental health research has proven to be effective.

All SMHAs reported they are implementing and supporting at least one of the EBPs identified by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA). The most frequently implemented EBPs are supported employment, assertive community treatment (ACT), and integrated treatment for co-occurring mental illness and substance abuse.

SMHAs vary in how they organize and finance the delivery of these community-based mental health services. Although most SMHAs contract with private not-for-profit community mental health centers and other community providers, many of the larger states work through county or city government mental health agencies. Several smaller population states provide SMHA services using state employees working in mental health centers operated by the SMHA.

SMHA Provision of Inpatient Psychiatric Services

Although all SMHAs operate psychiatric inpatient beds designed to provide safe and effective services to individuals with the most severe psychiatric illnesses, states vary widely regarding how many psychiatric beds they have and the patient populations the inpatient services are designed to serve. Increasingly, state psychiatric hospital beds are being used for short-term "acute" clients and to serve forensic clients.

States have significantly downsized their state psychiatric hospitals over time (with the number of state psychiatric beds having declined by 90 percent from 1950 to 2005). Data on the number of psychiatric inpatient beds in America over the last 35 years show that not only have the number of state psychiatric hospital beds declined, but the numbers of psychiatric inpatient beds in private psychiatric hospitals, in general hospitals, and in the Department of Veterans Affairs have also declined.

The impact of closing all these psychiatric inpatient beds is that 39 of 49 reporting states (80 percent) are now experiencing a shortage of psychiatric beds. SMHAs are responding to these shortages with a variety of strategies including developing community-based crisis services and increased use of EBPs.

SMHA Policy Initiatives

This decade, two major Federal government reports have examined the mental health systems in America and proposed a series of goals and actions to improve mental health services. The President's New Freedom Commission on Mental Health (PNFC) (US DHHS, 2003) formulated six major goals to transform mental health services. The Institute of Medicine (IOM) reviewed the mental health and substance use services through the lens of their "Crossing the Quality Chasm" framework and developed an action agenda to improve services (IOM, 2006).

SMHAs have embraced these goals and objectives and are actively working to meet the goals established by the PNFC and the IOM:

- Most SMHAs are now supporting initiatives to better inform the public about mental illness and reduce its stigma. Most SMHAs are also now working to promote suicide awareness and reduce the incidence of suicide in their state. These initiatives often link the SMHA with state and/or local health departments.
- SMHAs are working with state and local health departments and other community health providers to recognize and meet the physical health needs of persons with mental illnesses. A CMHS-funded study by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI), (Lutterman, Ganju, Schacht, Shaw, Monihan, et al., 2003) found that persons with mental illness served in the SMHA system often die prematurely (up to 25 years of lost life)—often from a variety of physical health conditions such as coronary artery disease, diabetes, obesity, and other treatable health conditions. SMHAs have embraced the concept of recovery from mental illness—that consumers can heal and live meaningful lives in a community of their own choosing. SMHAs have engaged in numerous initiatives to promote consumer choice of services and to ensure consumers have individualized treatment plans reflecting their needs and desires.
- Most SMHAs have initiatives to assure that the mental health services they provide incorporate the cultural and linguistic background of mental health consumers.
- Most states reported initiatives to promote the early detection of mental illness. Most states (40) have early screening programs for children, and 19 states reported such early detection initiatives for adults.
- Most SMHAs reported working with academia to translate research results into practice. Every state reported implementing at least one EBP, and most states are supporting several different EBPs.
- SMHAs are using technology to enable consumers and families to access mental health care and information. Nearly all (94 percent) of the reporting 50 states are either implementing or considering the adoption of an electronic health record (EHR) in their state psychiatric hospitals and/or community mental health system. Most SMHAs (90 percent or 44 states) are now engaged in activities to promote the use of telemedicine to provide mental health services.

Financing of SMHA Mental Health Services

In state fiscal year (FY) 2005, the SMHAs controlled and directed the expenditures of $30 billion to provide mental health services. Over 70 percent of SMHA expenditures were devoted to community-based services, with 27 percent devoted to state psychiatric hospital inpatient services.

State government sources contributed $18.8 billion (63 percent of SMHA funding), with state general and special revenues making up $13.9 billion of SMHA funding.

Medicaid, a joint state-Federal health insurance program, was the second largest funder (42 percent) and paid $12.5 billion (Federal and state shares combined) for SMHA mental health services. Over the last 25 years, Medicaid has been the fastest growing source of funds for the SMHA mental health system, growing at an average rate of 12 percent per year.

Other State Government Provision of Mental Health Services

Although the SMHA is legally responsible for planning, organizing, and providing mental health services to individuals with mental illnesses, it is not the only state entity that provides such services. Increasingly, other state government agencies, particularly Medicaid, and other state agencies such as the departments of corrections, vocational rehabilitation, child welfare, juvenile justice, and housing play critical roles in providing or financing the provision of mental health services. Each of these agencies has its own data collection and reporting systems that make counting the provision of mental health services provided by these systems exceedingly difficult. However, a pilot study funded by CMHS/SAMHSA and conducted by the NRI (Phelan, Lutterman, Berhane, Frank, Rivard, et al., in press) found that in several states, the total state government agency spending on mental health is over twice that of the amount identified by the SMHAs alone.

I. Overview

This section presents an overview of State Mental Health Agencies (SMHAs) and briefly highlights some landmark reports that have impacted the SMHAs' areas of focus. SMHAs are the single state government entity identified by the Governor of each state as the central authority related to mental health services. SMHAs provide the backbone of the organization, delivery, and financing of mental health services to adults with serious mental illiness (SMI) and children and adolescents with serious emotional disturbance (SED). In delivering these services, SMHAs develop systems and services to help persons with mental illness recover from their illness and lead fulfilling lives in the community. To assist consumers in the recovery process, SMHAs provide acute and long-term mental health treatment, plus a variety of community-based support services including supportive employment, housing, and education. In doing so, SMHAs organize and coordinate larger state systems that also provide mental health services and supports to persons with mental illnesses. However, SMHAs are increasingly constrained in their ability to manage the public mental health system by a variety of historical trends in organization and financing.

Over the last 25 years, most new funds to SMHA systems have come from Medicaid, a reimbursement system that pays for services along an insurance model, unlike traditional state general revenue funds that went to the SMHAs, which then controlled the expenditures for services. From 1981 to 2005, the share of SMHA funding from state general revenue sources declined from 75 percent to 47 percent, while Medicaid grew from 13.5 percent to 42 percent. As a result of this shift, Medicaid has become an important new funder of SMHA mental health services. While Medicaid has provided critical new resources to finance mental health services, the funds come with a new set of payment rules and requirements established by the Medicaid program and thus may reduce the SMHA's autonomy and control over the public mental health system.

In addition to having direct control over only parts of their financing, SMHAs vary widely in their involvement in the licensing and monitoring of public and private mental health providers that make up the specialty mental health systems in states. In 2007, 21 SMHAs were responsible for licensing private mental health providers; in the remaining states, this task was the responsibility of a separate state licensing or health department.

SMHAs have evolved greatly over the last century, from government entities that devoted nearly all their human and fiscal

resources to the provision of inpatient care in large state psychiatric hospitals to the present where they support community-based provider agencies that receive SMHA funds, and where the SMHA organizes systems and monitors the quality of the care. As persons with mental illness were moved out of state psychiatric hospitals, SMHAs began to broaden their focus from primarily providing inpatient services in large state hospitals to providing community-based mental health treatment and coordinating or providing essential support services to help persons with mental illness live in the community. SMHAs today are providing housing and housing supports, employment and education supports, and other supports beyond the traditional mental health treatments that were the focus in the past.

SMHAs vary widely in where they are organizationally located in state government and in the service and disability responsibilities they are assigned. Every SMHA shares some common elements. SMHAs:

- Operate inpatient psychiatric beds that provide critical services to individuals who are at risk of harm to themselves and or/ others.
- Oversee and fund community-based mental health services to meet the needs of individuals within their states. In some states, community mental health services are delivered directly by the SMHA, with state employees delivering these services. The more common method for providing community mental health services is an arrangement where the SMHA provides funds and leadership to local mental health agencies or authorities that then deliver services using a mixture of providers—often private, not-for-profit specialty mental health centers.
- Are responsible for planning the development of an array of comprehensive mental health services and submitting an annual community Block Grant plan to the Federal government.
- Are working with other state and Federal government agencies to ensure the provision of essential mental health, health, and support services to persons with mental illnesses.
- In most states, play a key public health role in informing the residents of their state about the risks of mental illness, reducing stigma, preventing suicide, and encouraging needed treatments.
- Serve a public safety function in providing and coordinating services to individuals determined by the courts to be dangerous to themselves or others. In most states, the SMHA is also responsible for providing mental health treatments to persons identified by the criminal justice system as requiring mental health forensic services (such as persons found incompetent to stand trial, persons found not guilty by reason of insanity, persons found guilty but mentally ill, and persons found eligible for commitment to psychiatric facilities as sexual offenders or violent sexual predators).

1.1 Impacts on SMHAs' Areas of Focus

In the last decade, several landmark reports have been produced highlighting new and expanded areas of focus for SMHAs. A Surgeon General's report on mental illness (US DHHS, 1999) highlighted the latest

knowledge about state-of-the-art treatments to persons with mental illnesses. The report also revealed that many people with SMI and children with SED were not receiving any mental health services, and that even those people who received services often were not receiving the best evidence-based services. A critical message to the states and advocates of the Surgeon General's report was that mental health treatments *do work*, and persons with mental illnesses *can recover* and live productive and rewarding lives in their communities. The report was used in many states to focus attention on improving the availability of evidence-based practices (EBPs) and on public health functions of SMHAs (suicide prevention, addressing unmet needs, improving the cultural competence of services, and addressing stigma related to mental illnesses).

The President's New Freedom Commission (PNFC) report on mental health (US DHHS, 2003) laid out six major goals for a transformed mental health system (see Section VII, New Freedom Commission Activities). These goals have been embraced and endorsed by the SMHAs through their membership organization, the National Association of State Mental Health Program Directors (NASMHPD). The Federal government has provided leadership to work with the states to implement the transformation goals of the PNFC. CMHS has provided a set of Mental Health Transformation State Incentive Grants (MHT SIG) to nine states to help them implement the goals of the PNFC.

CMHS's *Transforming Mental Health Care in America, the Federal Action Agenda: First Steps* (2005) identified a series of leadership steps being undertaken by SAMHSA and partner Federal agencies, including Education, Medicaid, Labor, and others. The major focus of the Federal Action Agenda is empowering and working with SMHAs to transform the delivery of mental health services.

With the release of the Surgeon General's Report, the PNFC, and the *Federal Action Agenda*, a new and broader mission for SMHAs has become apparent. SMHAs are being asked to exert leadership in public mental health services in several areas:

- Building mental health service systems that promote and support recovery and resilience of mental health consumers
- Providing culturally competent services
- Working beyond the traditional specialty mental health system to reduce the fragmentation in service delivery and eliminate barriers to consumers receiving mental health services
- Bringing the physical and mental health needs of consumers together to ensure both sets of needs are being met
- Focusing on accountability and outcomes from mental health services
- Focusing on public safety related to mental illness, including mental health courts, involuntary outpatient commitment statutes, and commitment and treatment for sexual offenders

1.2 Outline of This Report

Section II reviews the methodology used for collecting the data for this report and the limitation of the data.

Section III discusses the organization and structure of SMHAs, including their location within state government, their disability service responsibilities, their reorganization,

their eligibility determination for mental health services, and the number of mental health organizations they fund and/or operate.

Section IV provides a discussion of the characteristics of persons served by the SMHAs in fiscal year 2007.

Section V presents the SMHAs' responsibilities for community mental health services.

Section VI reviews other SMHA policy initiatives with a focus on state psychiatric hospitals.

Section VII addresses SMHAs' initiatives related to the six goals of the PNFC.

Section VIII reviews the funding sources and expenditures of SMHAs.

Section IX discusses the SMHAs' activities working with other state agencies.

The Appendix (on CD and SAMHSA website, www.samhsa.gov) provides individual SMHA profiles that show how each SMHA is organized within the state government, the SMHA responsibilities and roles, the number and characteristics of the persons served, and the financing of the services.

II. Study Approach and Limitations

This section provides a description of the study approach and limitations of the information sources.

2.1 Study Approach

This report utilizes the 2007 cycle of the SMHA Profiling System (SPS) (NRI, 2008) and *The FY 2005 State Mental Health Revenue and Expenditure Study Results* (NRI, 2007) as primary sources of data. These primary sources are supplemented with data from the Uniform Reporting System (URS) (CMHS, 2008) to describe the clients served by the SMHAs.

2.2 SMHA Profiling System

The SPS is a database containing information describing the organization, funding, operation, services, policies, statutes, and clients of SMHAs. The database describes each SMHA's organization and structure, service systems, eligible populations, emerging policy issues, number of clients served, fiscal resources, client issues, information management structures, and the research and evaluation it conducts. Questions are grouped into 12 components by topical area to facilitate SMHA review and completion of the profiles. Questions within each component address the specific needs of SMHA managers and others interested in public mental health systems, and they support decision-making, policy analysis, research, and evaluation.

Guided by an expert panel, the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI), revised SPS's 12 components (New Freedom Commission; Organization and Structure; Policy; Client; Services; Forensic; Workforce; Financial; Managed Behavioral Healthcare; Research and Evaluation; Information Management; and National Outcome Measures) for the 2007 information update cycle. The revised components were then sent to all SMHA commissioners/directors and their agencies' designated SPS contact persons for completion during 2007. States were offered several methods of data submission: They were given the option to input the requested information through the NRI-developed SPS online data entry system, or complete the questions on the forms and fax, mail, or e-mail the completed forms to NRI. Individual state responses to the profiles are available on NRI's website at www.nri-inc.org, where users can access state responses by keyword, state, and special topical reports.

2.3 SMHA-Controlled Revenue and Expenditure Study

The *Revenue and Expenditure Study* describes the major expenditures and funding of the SMHAs. Every year, NRI works with the SMHAs to document the expenditures for mental health services controlled by the SMHAs and the major funding sources for these expenditures. The methodology for this effort is predicated on compiling actual (rather than estimated) revenues and expenditures under the direct control of the SMHA. The depiction of actual figures is considered necessary for reporting valid and reliable data. Without reference to specific financial reports indicating actual expenditures, it is difficult, if not impossible, to both verify figures and have an accessible database for followup and/or analysis.

A set of Excel spreadsheets containing four tables with built-in data edits serves as the data collection instrument for the *Revenue and Expenditure Study*. The tables depict the mental health expenditures and revenues under the control of the SMHA. The funds include all state general funds to the SMHA, the Federal Mental Health Block Grant, local funds (when required) to match state dollars, other funds the SMHA controls, and the total expenditures and revenues of the community mental health system. For the purposes of this report, the fiscal year (FY) 2005 cycle of the *Revenue and Expenditure Study* data received from the 50 states and the District of Columbia is used to discuss the expenditures and funding sources of SMHAs.

2.4 The Uniform Reporting System

CMHS's Uniform Reporting System (URS) (CMHS, 2008) is a Federal reporting system used by SMHAs to compile and report annual data from each state as part of the SAMHSA/CMHS Federal Community Mental Health Block Grant. The URS is part of the Mental Health Block Grant Implementation Report, approved by the Office of Management and Budget (OMB), which SMHAs are required to submit to CMHS every December 1. The URS is part of an effort to use data in decision support and planning in public mental health systems and to support program accountability.

The URS, composed of 21 tables developed by the Federal government in consultation with SMHAs, compiles annual state-by-state and national aggregate information, including numbers and sociodemographic characteristics of persons served by the states, the outcomes of care, use of selected EBPs, client assessment of care, and insurance status. The tables are used by SAMHSA to calculate the 10 mental health National Outcome Measures (NOMs) for state and national reporting. For the purposes of this report, 2007 data submitted by the 50 states, the District of Columbia, and 7 U.S. territories are used to describe clients served by the SMHAs.

2.5 Limitations

While there was a high response rate for each of the SPS components, the level of completion of each component varied across states. Some states did not provide answers to all questions asked; therefore, some information presented in this report is based on responses from less than the total number of reporting states.

The SPS components on Information Management and NOMs were completed by all 50 states and the District of Columbia; the Organization and Finance components

were completed by 50 states (including the District of Columbia); the Managed Care component was completed by 48 states; the Policy, Services, New Freedom Commission, and Forensic components were completed by 47 states each; the Client and Workforce components were completed by 45 states.

While this report focuses on SMHA-controlled expenditures, it should not be assumed that the revenues and expenditures reported here include all expenditures for mental health services within a state government. State governments expend considerable resources to provide mental health services through other state government agencies not included in this report.

The major state government expenditure not fully depicted in this report is Medicaid, one of the fastest growing expenditures of state governments in the last 20 years. Mental health services constitute a significant part of this Medicaid growth. Medicaid's billing and reporting systems do not differentiate mental health from any other physical health services reimbursed by Medicaid. While some SMHAs and state Medicaid agencies have conducted thorough analyses of Medicaid-paid claims files to determine total Medicaid expenditures for mental health, many of these expenditures are outside the control of the SMHA or the community mental health system the SMHA funds. The Medicaid expenditures included in this report are limited to the portion of Medicaid expenditures controlled or administered by the SMHAs. Studies by CMHS on Medicaid suggest that total Medicaid expenditures for mental health may be double that controlled by SMHAs.

An additional limitation of the revenue and expenditure data is the reporting period. While the SPS information and URS data used in this report come from the 2007 cycle, data for revenues and expenditures are based on actual expenditures data from state FY 2005.

III. Organization and Structure of SMHAs

The organizational location and structure of SMHAs, their specific mental health responsibilities, and the extent to which they are responsible for disability services beyond mental health vary widely among states. When considering SMHA systems, it is important to understand the role and unique responsibilities of the SMHA in each state.

Over the last 25 years, many SMHAs have been reorganized as a division or agency within a larger umbrella agency. This reorganization has occurred as Governors and state legislatures moved mental health services together with substance abuse services and put the mental health agency under the same umbrella as one of its major funding sources—Medicaid. See Table 1 for a state-by-state listing of the SMHAs' organization and structure and their relationship to substance abuse and developmental disabilities/mental retardation agencies.

3.1. Location of SMHAs Within State Government

As noted above, state mental health agencies are most often administratively located within a larger umbrella agency. In 2007, 29 SMHAs were located within state departments of human services, 7 were in health departments, and 2 were in some other state department, often one combining health and human services. In 13 states, the SMHAs were independent departments of mental health.

In 12 states, the SMHA's director is a member of the Governor's Cabinet. In 8 states, the SMHA's director is directly accountable to the governor; in 38 SMHAs, the director is accountable to another administrator such as the Cabinet secretary of the umbrella agency; and in 5 SMHAs, the director is accountable to other leadership such as the mayor.

3.1.1 Mental Health Boards/Commissions

In seven states, the SMHA's director reports to a mental health board or commission (Connecticut, Missouri, Oklahoma, South Carolina, Utah, Vermont, and Wisconsin). A mental health board or commission is charged with overseeing the activities of the SMHA in 18 states. These mental health boards are usually appointed by the Governor (13 states), or jointly appointed by the Governor and legislature (3 states); in 4 states, the board members are approved by the legislature.

Table 1: SMHA Organization, Structure, and Relationship to Substance Abuse and Mental Retardation/Developmental Disabilities Agencies

State	SMHA Organization and Structure			SMHA Relationship to AOD and MR/DD* Agency	
	SMHA Located in State Department	Levels Between Commissioner and Governor	SMHA Director Reports to MH Board/Council	Alcohol and Drug Abuse	MR/DD*
AL	Independent Agency	0	No	Part of SMHA	Part of SMHA
AK	Human Services	2	No	Same umbrella	Same umbrella
AZ	Health Department	1	No	Part of SMHA	Other agency
AR	Human Services	2	No	Part of SMHA	Same umbrella
CA	Independent Agency	1	No	Other agency	Other agency
CO	Human Services	2	No	Part of SMHA	Same umbrella
CT	Independent Agency	0	Yes	Part of SMHA	Other agency
DE	Human Services	1	No	Part of SMHA	Same umbrella
DC	Independent Agency	0	No	Other agency	Other agency
FL	Human Services	3	No	Same umbrella	Other agency
GA	Human Services	1	No	Part of SMHA	Part of SMHA
HI	Health Department	1	No	No response	Same umbrella
ID	Human Services	2	No	Same umbrella	Same umbrella
IL	Human Services	3	No	Same umbrella	Same umbrella
IN	Human Services	1	No	Part of SMHA	Same umbrella
IA	Human Services	1	No	Other agency	Part of SMHA
KS	Human Services	2	No	Part of SMHA	Part of SMHA
KY	Human Services	2	No	Part of SMHA	Part of SMHA
LA	Health Department	1	No	Same umbrella	Same umbrella
ME	Human Services	2	No	Same umbrella	Same umbrella
MD	Health Department	2	No	Same umbrella	Same umbrella
MA	Independent	1	No	Same umbrella	Same umbrella
MI	Other Department	1	No	Same umbrella	Part of SMHA
MN	Human Services	2	No	Same umbrella	Same umbrella
MS	Independent			Part of SMHA	Part of SMHA
MO	Independent	1	Yes	Part of SMHA	Part of SMHA
MT	Human Services	2	No	Same umbrella	Same umbrella
NE	Human Services	1		Part of SMHA	No response
NV	Human Services	1	No	Part of SMHA	Part of SMHA
NH	Human Services	3	No	Same umbrella	Same umbrella
NJ	Human Services	1	No	Same umbrella	Same umbrella
NM	Human Services	0	No	Part of SMHA	Other agency
NY	Independent	0	No	Other agency	Other agency
NC	Human Services	1	No	Part of SMHA	Part of SMHA
ND	Human Services	1	No	Part of SMHA	Same umbrella
OH	Independent	0	No	Other agency	Other agency
OK	Independent	1	Yes	Part of SMHA	Other agency
OR	Human Services	1	No	Part of SMHA	Same umbrella
PA	Human Services	1	No	Other agency	Same umbrella
RI	Human Services	1	No	Part of SMHA	Part of SMHA
SC	Independent	1	Yes	Other agency	Other agency
SD	Human Services	1	No	Same umbrella	Same umbrella
TN	Independent	0	No	Part of SMHA	Other agency
TX	Health Department	2	No	Part of SMHA	Same umbrella
UT	Human Services	2	Yes	Part of SMHA	Same umbrella
VT	Health Department	2	Yes	Same umbrella	Other agency
VA	Independent	1		Part of SMHA	Part of SMHA
WA	Human Services	1	No	Same umbrella	Same umbrella
WV	Other Department.	1	No	Part of SMHA	Part of SMHA
WI	Human Services	1	Yes	Part of SMHA	Same umbrella
WY	Health Department	1	No	Same umbrella	Same umbrella
	Independent = 13 **Human services = 29** **Health department = 7** **Other structure = 2**	**0 (Direct Gov) = 7** **One level = 27** **Two levels = 13** **Three + levels = 3** **No response = 1**	**Yes = 7** **No = 41** **No response = 3**	**Part of SMHA = 26** **Same umbrella = 17** **Other agency = 7** **No response = 1**	**Part of SMHA = 13** **Same umbrella = 25** **Other agency = 12** **No response = 1**

*MR/DD = Mental retardation/developmental disabilities

3.2 Other Disability Service Responsibilities of SMHAs

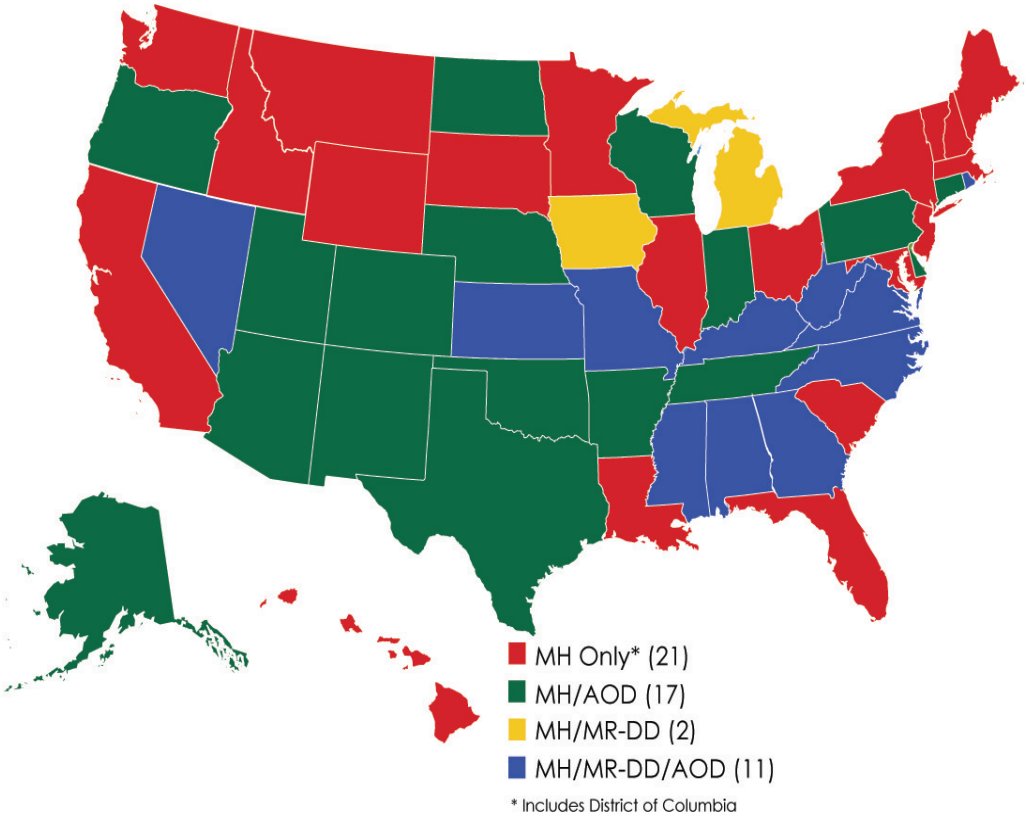
Many SMHAs are responsible for other disabilities in addition to mental health, with the two most common being substance abuse services and mental retardation/ developmental disabilities (MR/DD). Over the last 20 years, many SMHAs have had responsibilities for MR/DD services moved out, and several have had substance abuse services combined.

3.2.1 Substance Abuse Services Colocated With Mental Health Services

In 28 states, the SMHA is also responsible for the provision of substance abuse treatment services (including alcohol and other drug abuse), and the two agencies are located within the same state umbrella agency in 17 additional states (see Figure 1). In six states, interagency agreements exist between the SMHA and substance abuse agencies to coordinate care (Florida, Illinois, Massachusetts, New Jersey, New York, Ohio).

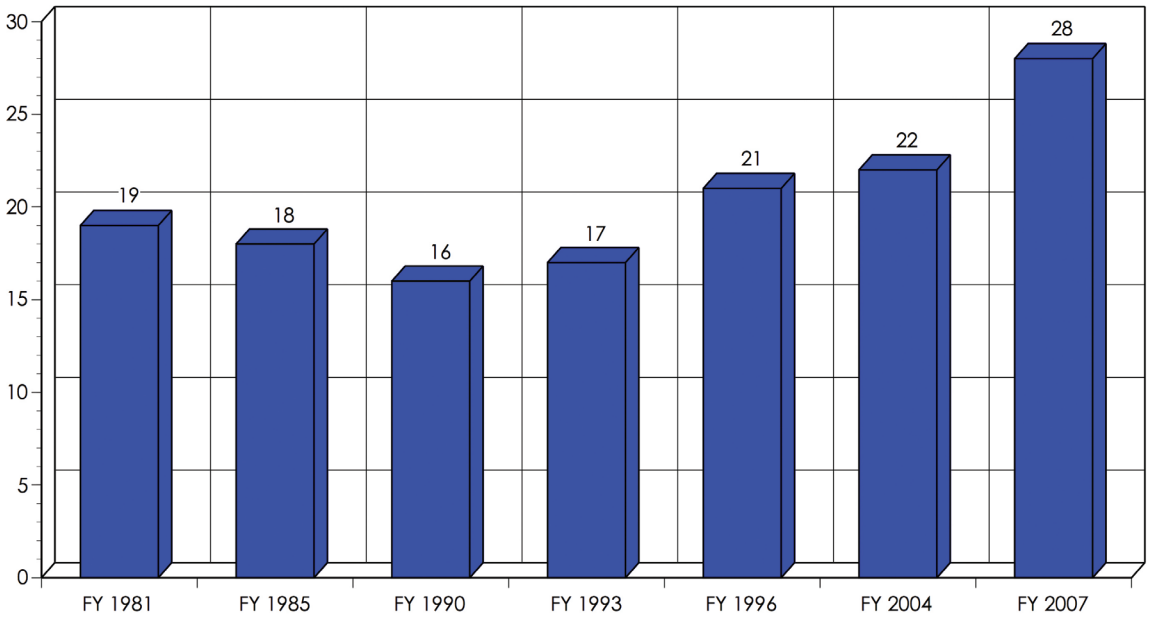
In 13 states, the SMHA is also responsible for the provision of MR/DD, and the MR/ DD agency is located within the same umbrella agency as the SMHA in 25 states. In 11 states, all 3 disability services are organized together within the SMHA (see Figure 2).

Figure 1: SMHA Responsibilities for Substance Abuse and MR/DD Services



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure1.html

Figure 2: Number of States With Mental Health and Substance Abuse Colocated in One Agency: 1981 to 2007



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure2.html

3.3 Reorganization of SMHAs

Within the last 2 years, nine SMHAs have been organizationally relocated within state government (Colorado, Florida, Kansas, New Jersey, New Mexico, Rhode Island, Tennessee, Texas, Washington). In six states (Colorado, Nevada, Tennessee, Vermont, Florida, Kentucky), the reorganization involved shifting additional disability services into or out of the SMHA. For example, in Nevada, substance abuse services were moved into the SMHA, and in Florida, the Agency for Persons with Disabilities was created, and services for persons with mental retardation were moved out of the SMHA. Twenty years ago, substance abuse was colocated with mental health in 19 states. During the 1980s and early 1990s, the trend was to split mental health and substance abuse into separate agencies. However, in the later 1990s and this decade, this trend has reversed and more states have reorganized to place mental health and substance abuse in the same agency, while separating mental retardation services into a separate state agency.

When substance abuse and mental health services are combined into a single state agency, the most common rationale is to better coordinate co-occurring mental health/substance abuse services and to move the system towards a behavioral health focus that better addresses both the mental health and substance abuse needs of a state's consumers. For example, Tennessee's reorganization to place substance abuse

together with mental illnesses was justified as follows:

> *Integrating alcohol and drug abuse services within [Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD)] will streamline government and its resources by ensuring that clinical services are coordinated, communication is improved, and incentives effectively aligned for populations in need for which there is tremendous overlap. This transfer will also facilitate the opportunity to expand access to integrated treatment options that focus on the whole person especially for persons with co-occurring disorders (TDMHDD, 2007).*

3.4 SMHA Mental Health Responsibilities

SMHAs vary widely in the specific array of mental health services they are responsible for. Some are responsible for mental health services across the life span—children, adults, and older adults. In some states, responsibilities for specific types of mental health services, such as forensics, brain injuries, or Alzheimer's disease, are carved out to a different state agency and are not part of the SMHA's mission.

3.4.1 Children/Adolescent Mental Health Services

In most states (30), the SMHA is responsible for both adult and child/adolescent mental health services; however, in 3 states (Connecticut, Delaware, and Rhode Island), the responsibility for providing mental health services to children/adolescents has been split out into a separate state agency, usually a department of children and families. The concept behind these children and families departments is to put the responsibility of children's mental health services into a single agency that is also responsible for child welfare, juvenile justice, and other related social and health services for children. In 16 states, the responsibility for mental health services for children and adolescents is shared between the SMHA and another state agency.

3.4.2 State Psychiatric Hospitals

In every state, there are state-owned-and-operated psychiatric inpatient beds that are used for persons in need of the most intensive level of mental health services. In most states (44), the operation of state psychiatric hospitals is part of the SMHA's responsibilities. In six states (Colorado, New Hampshire, New Mexico, Rhode Island, South Dakota, and Wyoming), a separate state government agency has this responsibility. In these states, the SMHA works with the state psychiatric hospitals and the other state agency to coordinate care between the state psychiatric hospital(s) and the SMHA's community mental health system. These states describe having special initiatives to help coordinate the movement of consumers out of the psychiatric facilities back into community mental health services.

3.4.3 Forensic Mental Health Services

Forensic mental health services are provided to persons found in need of mental health services by a court through the criminal justice system. Forensic services range from evaluations of competency to stand trial to providing mental health services to persons found by courts to be not competent to stand trial, not guilty by reason of insanity, and/or guilty but mentally ill. In most states (34), the provision of forensic mental health services is the responsibility of the SMHA; in 13 states, this responsibility is shared with another agency; and in 2 states, the responsibility lies with the state department of corrections and is not part of the SMHA's service mission.

3.4.4 Alzheimer's Disease and Organic Brain Syndrome

In 17 states, responsibility for providing services to persons with Alzheimer's and organic brain syndrome (OBS) is shared with another state government agency (often the state health department), and in 32 states, the SMHA has no responsibility for such services. However, even in states where the SMHA does not have responsibility for providing Alzheimer's and OBS services, data from state psychiatric hospitals often show that patients with these diagnoses are being served in the state hospitals. This is often because the patients may have co-occurring mental health diagnoses or because there are no alternative placements.

3.4.5 Traumatic Brain Injury Services

In four states, the SMHA is responsible for providing services to individuals with traumatic brain injuries (TBI). In 20 states, the responsibility for providing such services is shared between the SMHA and another state government agency, and in 24 states, the SMHA has no responsibility for these services. Table 2 provides each SMHA's responsibilities for mental health–related disability.

3.5 Eligibility for SMHA Mental Health Services

SMHAs vary in their eligibility criteria regarding those who can receive mental health services from SMHA-operated or SMHA-funded providers (see Table 3).

3.5.1 Adult Mental Health Eligibility

Most states have some form of eligibility criteria for adults receiving public mental health services. In 19 states, mental health services using state general or special funds are limited to adults with SMI, while in 21 states there are eligibility criteria for both adults with SMI and adults with any mental illness. For services funded with nonstate sources such as Medicaid, fewer states (13) restrict eligibility to only adults with SMI, while 25 states have eligibility criteria for both adults with SMI and adults with any mental illness.

States use a mixture of specific diagnoses, functional status, and other criteria to establish eligibility for adults receiving SMHA-funded or SMHA-operated mental health services. In 44 states, specific diagnoses are part of the eligibility criteria. In 40 states, an adult's functional status is part of the eligibility criteria, and in 11 states some other additional criteria are used to establish eligibility (such as duration of illness, history of prior hospitalization, income, and risk).

3.5.2 Child and Adolescent Eligibility

In 17 states, mental health services using state general or special funds are limited to children with SED, while in 22 states there are eligibility criteria for both children with SED and children with any emotional disturbance. For services funded with nonstate sources such as Medicaid, fewer states (12) restrict eligibility to only children with SED, while 26 states have eligibility criteria for both children with SED and children with any emotional disturbance.

States use a mixture of specific diagnoses, functional status, and other criteria to establish eligibility for children's mental health services. In 39 states, specific diagnoses are part of the eligibility criteria. In 37 states, the child's/adolescent's functional status is part of the eligibility criteria, and in 8 states some other additional

Table 2: SMHA Mental Health–Related Responsibilities

State	Children's Mental Health in SMHA	Alzheimer's Disease/ Organic Brain Syndrome	Traumatic Brain Injury	State Psychiatric Hospitals	Forensics
AK	Part of SMHA	No responsibility	Part of SMHA	Part of SMHA	Part of SMHA
AL	Part of SMHA	Responsibility shared	No responsibility	Part of SMHA	Part of SMHA
AR	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
AZ	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Responsibility shared
CA	Part of SMHA	No responsibility	Part of SMHA	Part of SMHA	Part of SMHA
CO	Responsibility shared	No responsibility	Responsibility shared	Responsibility shared	Responsibility shared
CT	No responsibility	No responsibility	Responsibility shared	Part of SMHA	Part of SMHA
DC	Responsibility shared	No responsibility	No responsibility	Part of SMHA	Part of SMHA
DE	No responsibility	No responsibility	Responsibility shared	Part of SMHA	Responsibility shared
FL	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
GA	Responsibility shared	No responsibility	No responsibility	Part of SMHA	Part of SMHA
HI	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
IA	Part of SMHA	No responsibility	Responsibility shared	Part of SMHA	No responsibility
ID	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Responsibility shared
IL	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
IN	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Responsibility shared
KS	Part of SMHA	Responsibility shared	Responsibility shared	Part of SMHA	Responsibility shared
KY	Part of SMHA	Responsibility shared	Responsibility shared	Part of SMHA	Part of SMHA
LA	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
MA	Responsibility shared	No responsibility	No responsibility	Part of SMHA	Part of SMHA
MD	Part of SMHA	Responsibility shared	Responsibility shared	Part of SMHA	Part of SMHA
ME	Part of SMHA	No responsibility	No response	Part of SMHA	Part of SMHA
MI	Part of SMHA	Responsibility shared	Responsibility shared	Part of SMHA	Responsibility shared
MN	Part of SMHA	No responsibility	Responsibility shared	Part of SMHA	Part of SMHA
MO	Responsibility shared	Responsibility shared	Responsibility shared	Part of SMHA	Part of SMHA
MS	No response	No response	No response	No response	No response
MT	Responsibility shared	Responsibility shared	No responsibility	Part of SMHA	Responsibility shared
NC	Part of SMHA	Responsibility shared	Part of SMHA	Part of SMHA	Part of SMHA
ND	Responsibility shared	No responsibility	Responsibility shared	Responsibility shared	Responsibility shared
NE	Responsibility shared	No response	No response	Part of SMHA	No response
NH	Responsibility shared	No responsibility	No responsibility	Responsibility shared	Responsibility shared
NJ	Responsibility shared	Responsibility shared	Responsibility shared	Part of SMHA	Part of SMHA
NM	Responsibility shared	Responsibility shared	Responsibility shared	Responsibility shared	Responsibility shared
NV	Responsibility shared	No responsibility	Responsibility shared	Part of SMHA	Part of SMHA
NY	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
OH	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
OK	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
OR	Part of SMHA	Responsibility shared	Responsibility shared	Part of SMHA	Part of SMHA
PA	Part of SMHA	No responsibility	Part of SMHA	Part of SMHA	Part of SMHA
RI	No responsibility	Responsibility shared	Responsibility shared	No response	Part of SMHA
SC	Responsibility shared	Responsibility shared	Responsibility shared	Part of SMHA	Part of SMHA
SD	Part of SMHA	Responsibility shared	No responsibility	No responsibility	No responsibility
TN	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
TX	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
UT	Responsibility shared	No responsibility	Responsibility shared	Part of SMHA	Part of SMHA
VA	Part of SMHA	Responsibility shared	No responsibility	Part of SMHA	Part of SMHA
VT	Responsibility shared	Responsibility shared	Responsibility shared	Part of SMHA	Responsibility shared
WA	Responsibility shared	No responsibility	No responsibility	Part of SMHA	Part of SMHA
WI	Part of SMHA	No responsibility	No responsibility	Part of SMHA	Part of SMHA
WV	Part of SMHA	Responsibility shared	Responsibility shared	Part of SMHA	Part of SMHA
WY	Part of SMHA	No responsibility	No responsibility	Responsibility shared	Responsibility shared
	Part of the SMHA = 31 **Responsibility shared = 16** **No responsibility = 3** **No response = 1**	**Part of the SMHA = 0** **Responsibility shared = 17** **No responsibility = 32** **No response = 2**	**Part of the SMHA = 4** **Responsibility shared = 20** **No responsibility = 24** **No response = 3**	**Part of the SMHA = 43** **Responsibility shared = 5** **No responsibility = 1** **No response = 2**	**Part of the SMHA = 34** **Responsibility shared = 13** **No responsibility = 2** **No response = 2**

Table 3: Eligibility Criteria to Receive Mental Health Services From SMHA-Operated/SMHA-Funded Providers

State	Adults			Children		
	Eligibility Criteria for Serving Adults Using State General Fund/ Special Fund Dollars	Eligibility Criteria for Serving Adults Using Other Funds (Including Medicaid)	What Factors Are Part of the SMHA's Determination of SMI?*	Eligibility Criteria for Serving Children Using State General Fund/Special Fund Dollars	Eligibility Criteria for Serving Children Using Other Funds (Including Medicaid)	What Factors Are Part of the SMHA's Determination of SED?*
AK	Adults with SMI	Adults with SMI	D and F	Children with SED	Children with SED	D and F
AL	Adults with SMI	Adults with SMI	D	Children with SED	Children with SED	D
AR	No eligibility criteria	No eligibility criteria	D and F	No eligibility criteria	No eligibility criteria	D and F
AZ	Both	Both	D and F	Both	Both	D
CA	Both	No response	D	Both	No response	No response
CO	Both	Both	D and F	Both	Both	F
CT	Adults with SMI	No response	D and F	Both	No response	D and F
DC	No response	No response	No response	Non-SED Children	No response	D, F, and O
DE	Both	Both	D, F, and O	Both	Both	D and F
FL	Non-SMI adults	No response	D	No response	No response	No response
GA	Adults with SMI	Adults with SMI	D and F	Children with SED	Children with SED	D and F
HI	Adults with SMI	Adults with SMI	D and F	Children with SED	Children with SED	D and F
IA	No eligibility criteria	No eligibility criteria	D	No eligibility criteria	No eligibility criteria	D
ID	Adults with SMI	Both	D and F	Children with SED	Both	D and F
IL	Both	Both	D, F, and O	Both	Both	D, F, and O
IN	Adults with SMI	Both	F and O	Children with SED	Both	F and O
KS	Both	Non-SMI adults	D, F, and O	Both	Non-SED Children	F and O
KY	Both	Adults with SMI	D, F, and O	Both	Children with SED	D and F
LA	Adults with SMI	Adults with SMI	D and F	Children with SED	Children with SED	D and F
MA	Adults with SMI	Both	D and F	Children with SED	Both	D and F
MD	Both	Both	D and F	Both	Both	D and F
ME	Both	Both	D and F	Both	Both	D and F
MI	Adults with SMI	Adults with SMI	D and F	Children with SED	Children with SED	D and F
MN	Adults with SMI	Both	D and F	Children with SED	Both	D and F
MO	Adults with SMI	Non-SMI adults	D	Children with SED	Non-SED Children	D
MS	No response	No response	No response	No response	No response	No response
MT	Adults with SMI	Both	D and F	Children with SED	Both	D and F
NC	Adults with SMI	Both	D and F	Children with SED	Both	D and F
ND	Both	Both	F	Both	Both	D and F
NE	No response	No response	No response	No response	No response	No response
NH	Adults with SMI	Adults with SMI	D and F	Children with SED	Both	D and F
NJ	Both	No response	D and F	No response	No response	No response
NM	Both	Both	D and F	Both	Both	D and F
NV	Adults with SMI	Adults with SMI	D and F	Children with SED	Children with SED	D and F
NY	Both	Both	D and F	Both	Both	D and F
OH	Both	Both	D, F, and O	Both	Both	No response
OK	Both	Both	D and F	Both	Both	D and F
OR	Adults with SMI	Both	D and F	Both	Both	D and F
PA	Both	Both	D and F	Both	Both	D and F
RI	Non-SMI adults	Non-SMI adults	D and F	No response	No response	No response
SC	No response	Both	No response	No response	Both	D
SD	Adults with SMI	Both	D and F	Children with SED	Both	D and F
TN	No eligibility criteria	No eligibility criteria	D and F	No eligibility criteria	No eligibility criteria	D and F
TX	Adults with SMI	Adults with SMI	D, F, and O	Children with SED	Children with SED	D, F, and O
UT	Both	Both	D	Both	Both	D
VA	No eligibility criteria	Adults with SMI	D, F, and O	No eligibility criteria	Children with SED	D, F, and O
VT	Both	Both	D, F, and O	Both	Both	D, F, and O
WA	Both	Adults with SMI	D and F	Both	Children with SED	D and F
WI	Both	Both	F	Both	Both	F
WV	Both	Both	D and O	Both	Both	D, F, and O
WY	No eligibility criteria	Adults with SMI	D and F	No eligibility criteria	Children with SED	No criteria
Both**	21	25		22	26	
SMI	19	13		17	12	
Non-SMI	2	3		1	2	
No criteria	5	3		5	3	
No response	4	7		6	8	

*(D= Specific diagnoses, F = Functional status, O = Other factors)
** Both for adults = SMI and non-SMI; Both for children = SED and non-SED

criteria are used to establish eligibility (duration of illness; history of prior hospitalization, income, and risk are other criteria states use).

3.6 Number of Mental Health Organizations Operated and/or Funded by SMHAs

In 2007, SMHAs funded and/or operated 11,681 mental health organizations (see Table 4). SMHAs work with a mix of types of mental health providers ranging from state psychiatric hospitals staffed by the state and operated by the SMHA, to a variety of county-based or city-based providers and a mixture of for-profit and not-for-profit community organizations. Most of the organizations making up the SMHA system are not operated by the SMHA, but instead receive funds from the SMHA. In a few states, the SMHA operates community mental health organizations that are state-owned (with state employees delivering the mental health services). During 2007, there were 338 community mental health organizations operated by SMHAs in 16 states.

3.6.1 SMHA Relationship to Local Providers

In addition to funding and operating mental health organizations, in 21 states, the SMHA is responsible for licensing or certifying private mental health providers. In 18 of these states, the SMHA receives reports on the services provided by the private mental health providers. Thirty-eight SMHAs reported the initiatives the SMHAs were undertaking to integrate public and private providers over the next year. Examples of these initiatives are shown in Table 5.

3.6.2 Privatization of SMHA-Operated Programs

In recent years, several states have explored privatizing some of their state-owned-and-operated mental health programs. Two states (Florida and Kansas) reported that within the last year they had privatized one of their state-operated psychiatric hospitals. In Florida, the Treasure Coast Forensic Treatment Facility was entirely privatized, and in Kansas, the Rainbow Mental Health Facility children's program was privatized. Three states (Kansas, North Carolina, and South Dakota) reported they had privatized one or more of their state-operated community mental health programs.

3.6.3 SMHA Class Action Lawsuits

Class action lawsuits regarding mental health services are an additional important driver of policy. In 2007, 27.1 percent of SMHAs (13 of 48) reported they were involved in a class action lawsuit. Several of these suits are years old (with the District of Columbia having a suit that started in 1974, and Arizona and West Virginia having suits from 1981). Often the consent decrees and/or court-ordered settlements will impact the services and priorities of SMHAs.

Table 4: Number of Mental Health Organizations Operated or Funded by SMHAs, 2007

	State Psychiatric Hospitals	Community Mental Health Providers	Private Psychiatric Hospitals	General Hospitals With Separate Psych Units	Nursing Homes and Other ICF-MI* and SNF** Providers	Total Mental Health Providers
State-operated	210	338		4	17	569
State-funded	15	10,641	98	273	85	11,112
Total	225	10,979	98	277	102	11,681

*ICF-MI = Intermediate-care facility, mentally ill
**SNF = Skilled nursing facility

Table 5: Examples of SMHA Initiatives to Integrate Private and Public Mental Health Providers

State	Initiative
AL	As part of acute care planning process, private providers are developing partnerships by mental health centers related to local inpatient and other crisis intervention capacity.
CT	(1) Continued/expanded purchase of acute care beds in general hospitals; (2) Alternative to Hospitalization (ATH) program to divert people in emergency departments of general hospitals to addiction services when appropriate.
GA	The SMHA has contracted with private psychiatric hospitals for adult "spillover" capacity. RFPs have been released for private hospitals to serve both children/adolescents and adult consumers.
ID	Private ACT Teams. Use private hospitals to supplement public hospitals. Contract for peer support specialist on ACT teams.
IL	Do have purchase of service (beds) contracts with private community hospitals to supplement state-operated bed need and utilization. (1) Evaluating protocols to standardize medical clearance screenings. (2) Investigating alternative service delivery options within emergency departments (consumer/peer services) as well as alternative site programs to defer crisis nonemergency cases. Investigating (1) expansion of capacity for crisis residential services; (2) adding capacity of subacute substance abuse programs; (3) alternative site peer-run programs like the Living Room model.
KY	Several community providers are developing agreements with local private hospitals with psychiatric beds to better serve rural populations with limited access to the state hospitals.
NJ	Initiating a central admissions intake to better manage alternative mental health and community-based resources while expediting appropriate admissions to the state psychiatric hospitals; initiating greater cooperation with specialty population providers such as Division of Developmental Disabilities, MICA (Mental Illness and Chemical Abuse Addiction), and Corrections.

IV. Characteristics of Persons Served by SMHAs, FY 2007

This section summarizes the characteristics of the more than 6 million people served by SMHAs. Consumer data are presented by age, gender, race/ethnicity, diagnosis, employment status, Medicaid status, and living situation. Information is also provided about the utilization rates of persons served in community settings and state psychiatric hospitals.

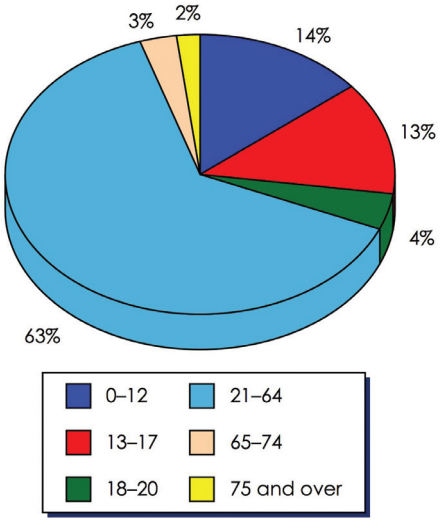
In 2007, 6,121,641 persons (just over 2 percent of the U.S. population) were served by the 50 states, the District of Columbia, and 7 territories.

The total number of persons served by each state ranged from a low of 9,756 in Delaware to a high of 658,314 in California. Slightly under half (48 percent) of persons served were male (with a utilization rate of 19.7 per 1,000 population), and 51 percent were female (with a utilization rate of 20.3 per 1,000 population). Of all the SMHAs reporting data, New Jersey had the highest utilization rate (4,027 per 100,000), while Massachusetts had the lowest rate (424 per 100,000).

4.1 Persons Served by Age and Gender

Adults aged 21–64 made up the majority (63 percent) of the total number of persons served. Children (0–12) represented 14 percent, while young adults (18–20) were 4 percent of the persons served. Older adults aged 65–74 and 75 and over made up only 3 percent, and 2 percent, respectively, of the total. See Figure 3 for the percentage distribution of persons served by age group.

Figure 3: Percentage of Consumers Served by Age



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure3.html

4.1.1 Children and Adolescents

Children (0–12 years) and adolescents (13–17) had an average utilization rate of 27.3 per 1,000. Although adolescents (13–17) accounted for only 13 percent of the total number of persons served, they had the highest utilization rate (37.7 per 1,000) of all age groups. Male adolescent consumers (13–17) had higher rates (40.5 per 1,000) compared to females (34.3 per 1,000). Children (0–12) had a utilization rate of 16.9, with higher male utilization rate (21.0 per 1,000) than females (12.4 per 1,000).

4.1.2 Adults

Adults (18–64) had an average utilization rate of 21.9 per 1,000. Young adults (18–20) had an average utilization rate of 21.8 per 1,000, with no significant difference between male and female consumers. Adults (21–64) had higher utilization rates for female consumers (24.2 per 1,000) compared to male consumers (19.5 per 1,000).

4.1.3 Older Adults

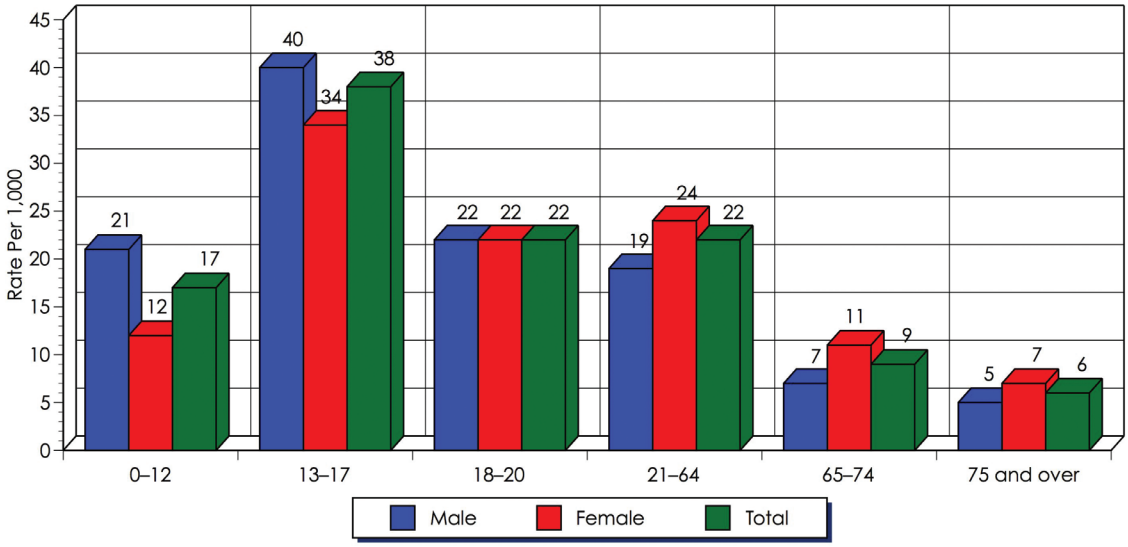
Older adults (65 and above) had an average utilization rate of 7.5 per 1,000. Older adults in the 65–74 age range had an average utilization rate of 8.9 per 1,000, with slightly higher rates for females (10.7 per 1,000) than males (6.8 per 1,000). Older adults aged 75 and over had an average utilization rate of 6.1, with nearly equal rates among male (4.8 per 1,000) and female (6.9 per 1,000) consumers. Figure 4 shows that adolescents (13–17) were served at the highest rates for both males and females. Rates for male consumers were lower than female rates in older age groups compared to children's rates, where females were served at higher rates than males.

4.2 Persons Served by Race and Gender

4.2.1 Children and Adolescents

Children and adolescents (aged 0–17) accounted for 28 percent of the total number

Figure 4: Utilization Rates of Persons Served by Age and Gender (Rate per 1,000)



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of consumers served. African American children had the highest utilization rate (39.6 per 1,000). African American adolescents (13–17) had a higher average utilization rate (54.5 per 1,000), of which male children had a higher utilization rate (63.3 per 1,000) than females (45.4 per 1,000). American Indian/Alaska Native adolescents (13–17) also had higher utilization rates (50.2 per 1,000), where males had a slightly higher utilization rate (52.6 per 1,000) than females (47.6 per 1,000). The lowest utilization rate in children was reported by Asian Americans, with an average utilization rate of 6.3 per 1,000 population. Figure 5 shows the average utilization rates of children by race and gender. As depicted, male consumers had higher utilization rates across all ethnic groups.

4.2.2 Adults

Adults (18–64) made up 68 percent of the total number of consumers served by the SMHAs. Similar to the children's rates, African American adults had the highest utilization rate (31.1 per 1,000). Adults in the 21–64 age group had a higher utilization rate (34.3 per 1,000), with male African American adults having a slightly higher utilization rate (34.8 per 1,000) than females (33.9 per 1,000). Adult Native Hawaiians/ Pacific Islanders (aged 18–64) also had higher utilization rates (29.5 per 1,000), with no significant differences in the utilization rates by gender (males 29.2 per 1,000; females 29.8 per 1,000). Adult Asian Americans had the lowest utilization rate (6.5 per 1,000 population). Figure 6 shows the average utilization rates of adults by race and gender.

4.2.3 Older Adults

Older adults (65 and above) represented only 5 percent of the consumers served by SMHAs. Native Hawaiian/Pacific Islanders had the highest utilization rates (16.8 per

Figure 5: Utilization Rates of Children (0–17) by Race and Gender (Rate per 1,000)

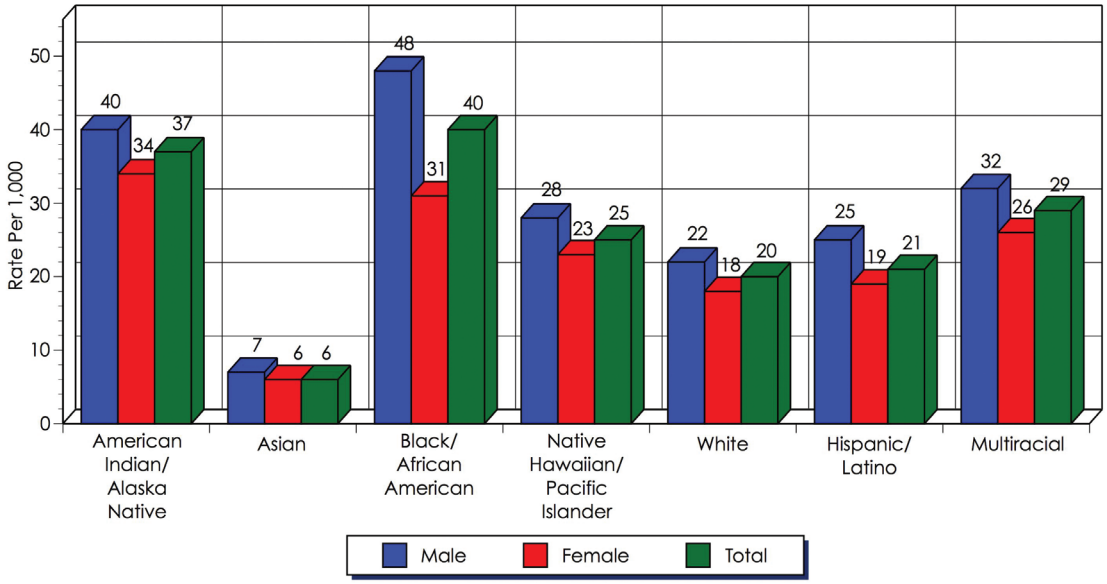

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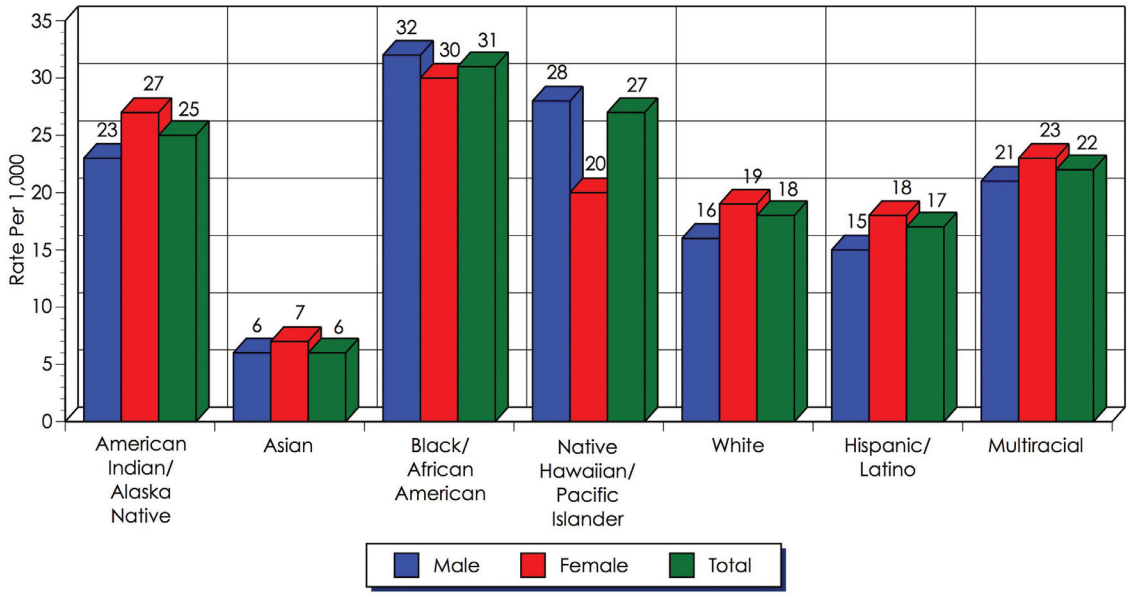
Figure 6: Utilization Rates of Adults (18–64) by Race and Gender (Rate per 1,000)



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1,000 population). Consumers in the 65–74 age group had a higher utilization rate (18.8 per 1,000), with females having higher rates (20.6 per 1,000) than male consumers (16.4 per 1,000). Consumers who were 75 and over did not have any significant difference by gender, where females had a utilization rate of 14.7 per 1,000, and males had a utilization rate of 15.0 per 1,000. Asian Americans had the lowest utilization rate, with an average of 4.7 per 1,000 population. Figure 7 shows the average utilization rates of older adults by race and gender.

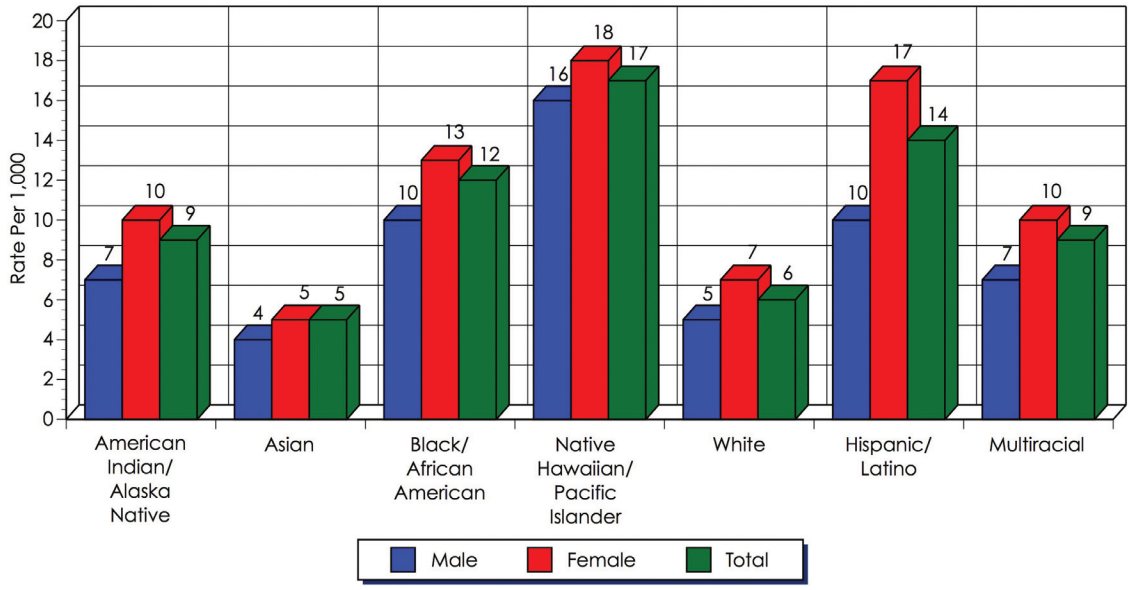
4.3 Adults (SMI) and Children (SED) Served by SMHAs

Fifty-seven states reported demographic characteristics (age, gender, and race) of adults and children with SMI/SED served by the state mental health authority. The data are reported by age groups, gender, and race/ethnicity. In 2007, 65.8 percent of adults and 65.2 percent of all the children served by SMHAs had a diagnosis of SMI/SED. States varied significantly in the percentage of SMI/SED population served for both adults (SMI) and children (SED). Seven states served only the consumers that met their definition of a SMI/SED diagnosis (both adults and children).

4.3.1 Children (SED)

African American adolescents (13–17) had the highest utilization rate among all age groups (38.1 per 1,000), with higher utilization rates for males than females (males 45.2 per 1,000; females 30.8 per 1,000). Adolescents (13–17) had high utilization rates for the Native Hawaiian/Pacific Islander population (25.9 per 1,000), with higher utilization rates for males (27.11 per 1,000) than females (24.7 per 1,000). Lowest utilization rates were reported by Asian Americans: 2.0 per 1,000 for children (0–13) and 6.4 per 1,000 for adolescents (13–17).

Figure 7: Utilization Rates of Older Adults (65 and Over) by Race and Gender (Rate per 1,000)



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4.3.2 Adults (SMI)

African American young adults (18–20) had the highest utilization rate among adult consumers (24.3 per 1,000), with no significant difference between rates of males and females. Adults (21–64) had high utilization rates for Native Hawaiian/Pacific Islanders (23.6 per 1,000), with no significant difference between male and female consumers. Lowest utilization rates were reported by Asian Americans: 5.1 and 4.1 per 1,000 for adults aged 21–64 and 18–20, respectively.

4.3.3 Older Adults (SMI)

Older adults (65–74) who were Native Hawaiians/Pacific Islanders reported the highest utilization rate among the older adult population (16.9 per 1,000), with higher utilization rates for males compared to females (males 23.3 per 1,000; females 13.6 per 1,000). Older adults (75 and over) also showed higher rates for the Native Hawaiian/Pacific Islander population (11.6 per 1,000), with utilization rates for males slightly higher than females (males 12.7 per 1,000; females 10.9 per 1,000). The lowest utilization rate was reported by Asian Americans (4.3 per 1,000 for the age group 65–74 and 2.9 per 1,000 for ages 75 and over).

4.4 Living Situation of Mental Health Consumers Served

Most consumers (both children and adults) were living in private residences.

4.4.1 Children

Fifty-four states and territories reported the living situation of child consumers. The majority of the children lived in private residences (84 percent), with the remainder living in a variety of settings, including foster homes (6 percent), residential care (2 percent), children's residential treatment (1.1 percent), institutional settings (1.4 percent), and jail/correctional facilities (2 percent). A

very small percentage (0.4 percent) of the children served by the SMHAs were homeless or living in a shelter.

4.4.2 Adults

Fifty-five SMHAs reported the living situation of adult consumers. Similar to child consumers, the majority of the adult consumers lived in private residences (79 percent). The rest of the adult consumers were living in variety of settings, including residential care (5 percent), institutional settings (4 percent), jail/correctional facilities (2 percent), and foster homes (0.8 percent). About 4 percent of adult mental health consumers were homeless or living in shelters. Adults in the 18–64 age group represented the highest percentage of homeless consumers (4 percent).

Overall, more male consumers (4 percent) were homeless or living in a shelter than female consumers (2 percent). Of the racial groups, more African American consumers (5 percent) were homeless or living in a shelter, while Hispanics/Latinos and Asian Americans had the lowest percentage of homeless consumers (2 percent each).

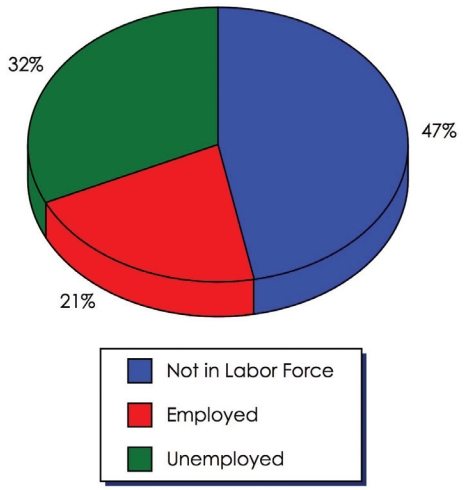
4.4.3 Employment Status

Fifty-five states and territories reported employment status of consumers served. Twenty-one percent of adult consumers were employed (as a percentage of those with known employment status). Consumers in the 21–64 age group had the highest employment percentage (22 percent) followed by the 18–20 age group (15 percent).

Almost half of the SMHAs adult consumers (47 percent) were not in the labor force (i.e., not actively looking for employment). Seventy-one percent of older adults (65 and over) were not in the labor force, while 46 percent of young adults (18–20) and 44 percent of adults (21–64) were not in the labor force.

Figure 8 depicts the employment status of consumers served in the community as a percentage of those employed, unemployed, and not in the labor force.

Figure 8: Employment Status of Adult Mental Health Consumers, 2007



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4.4.4 Employment Status by Diagnosis

Thirty-nine states reported the employment status of consumers by diagnosis. Consumers with deferred diagnosis/no diagnosis had the highest rate of employment (35 percent). Consumers with a diagnosis of schizophrenia had the lowest employment rates (11 percent), followed closely by consumers with a diagnosis of psychotic disorder (13 percent). Consumers with a diagnosis of bipolar disorder had a comparatively higher employment rate (21 percent), and consumers with "other" diagnoses had an employment rate of 24 percent.

4.5 Adults and Children With Co-Occurring Mental Health/ Substance Abuse Disorders

Twenty-four percent of adults served by the SMHAs had a co-occurring mental health and substance abuse disorder (43 states reporting). Only 6 percent of children served by the SMHAs had a co-occurring mental health and substance abuse disorder.

4.5.1 Persons Served in Community and State Hospitals

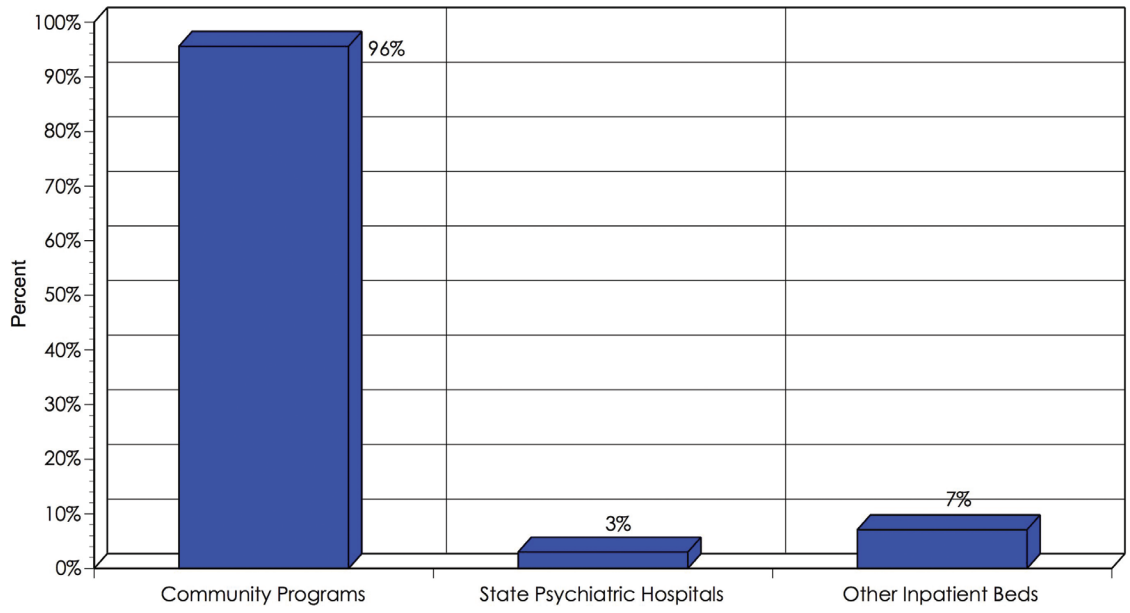
The vast majority of the SMHAs' consumers were served in community mental health programs (96 percent), and only 3 percent received services in state hospitals, while 7 percent of consumers received inpatient services from settings other than state hospitals (see Figure 9). Consumers may be served in more than one setting during the year.

Male consumers had a higher utilization rate (0.77 per 1,000) of services provided in state hospitals than females (0.43 per 1,000). There were no gender differences in the utilization rates of services being provided in community mental health programs.

4.6 Persons Served Through Medicaid and Other Funding Sources

Medicaid funds were used to pay for at least part of the services received by 57 percent of the total consumers served; non-

Figure 9: Persons Served in Community, State Hospitals, and Other Inpatient Beds



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Medicaid funding sources were used by 43 percent of consumers (see Figure 10).

Services provided to 59 percent of all female consumers and 56 percent of male consumers were paid for by Medicaid. Forty-four percent of male consumers and 41 percent of female consumers utilized non-Medicaid funds to pay for services they received.

With regard to funding sources of services received by race, African Americans and multiracial consumers had the highest utilization of Medicaid funds, with 64 percent each. White consumers, by comparison, had the lowest percentage, with only 55 percent utilizing Medicaid as a funding source (see Figure 11).

Figure 10: Persons Served by Medicaid and Other Funding Sources

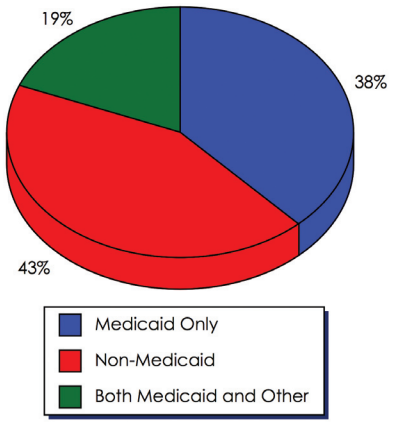

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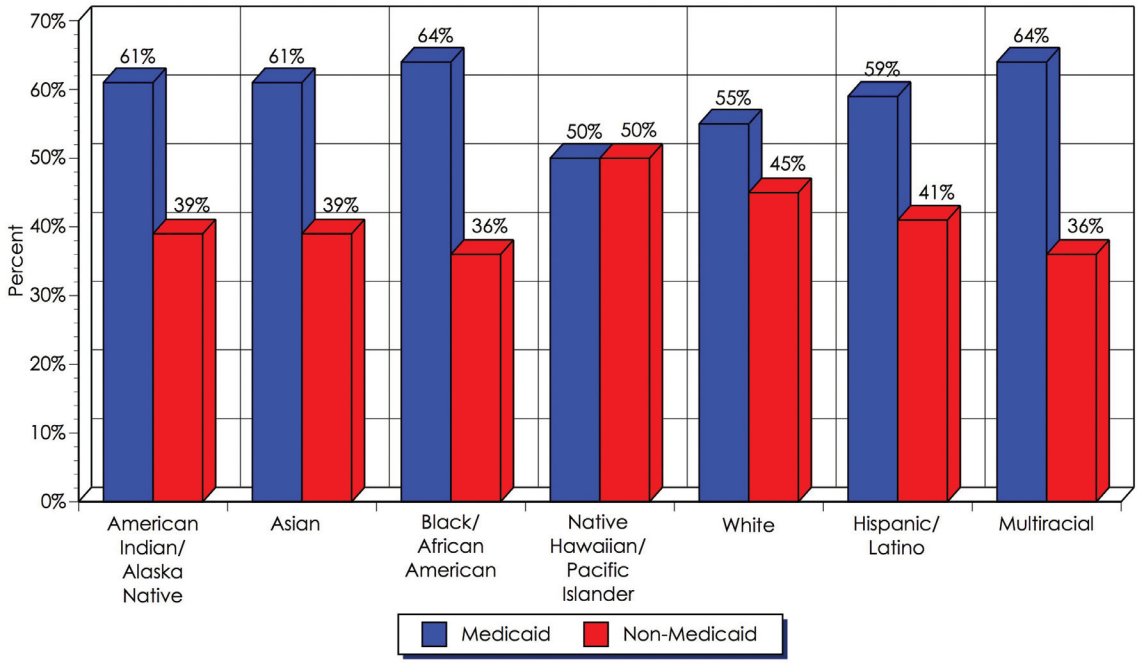
Figure 11: Persons Served by Medicaid and Other Funding Sources by Race



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V. SMHAs' Responsibilities for Community Mental Health Services

This section discusses the SMHAs' responsibilities for community mental health services. The discussion includes the role of county/city government in the delivery of community mental health services and the types of community mental health services offered.

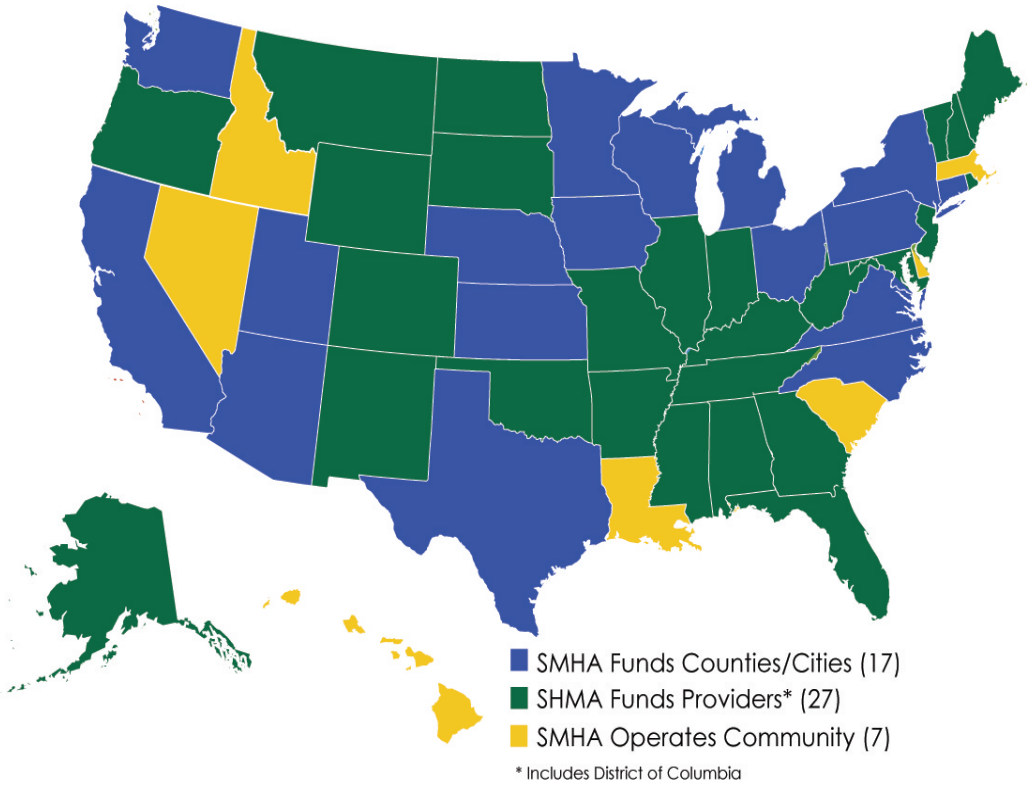
In 2007, 96 percent (5.5 million persons with 49 states, the District of Columbia, and 4 territories reporting) of mental health consumers served by SMHA systems received community mental health services. Some individuals who received community mental health services also received care in state psychiatric hospitals (3 percent) or other psychiatric inpatient settings (7 percent) during the year, but the vast majority were served only in community settings.

In 2005, SMHAs expended over 70 percent of their funds ($20.7 billion) for mental health services provided in communities. SMHAs used three primary methods to pay for or deliver community-based mental health services, with several states using combinations of these methods:

- SMHAs directly contract with local (usually not-for-profit) community-based mental health providers. This method is used in 36 states and is the primary method of funding community services in 27 states.
- SMHAs fund local government (city, county, or multicounty) mental health authorities, which in turn operate and contract for community mental health services. This method is used in 20 states and is the primary method used in 17 states.
- Mental health services are provided in communities by SMHAs using their own state employees in state-operated community mental health centers. This method is used in 12 states and is the primary method used in 7 states (See Figure 12).

In several states, a combination of these mechanisms is used, with the SMHA operating a few mental health clinics and funding county or private-not-for-profit mental health providers for most community mental health services. Large-population states tend to use local governments to organize the delivery of community mental health services (56 percent of the U.S. population lives in the 17 states that

Figure 12: Primary Methods SMHAs Use to Fund Community Mental Health Services



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure12.html

primarily use county/city governments to organize and deliver community mental health services), while smaller states often directly operate the community system with their own employees (see Table 6). Most large-population states use county and city governments to coordinate the delivery of community mental health services as a way of ensuring a match of mental health services to local needs.

5.1 Role of County/City Government

In the states that reported using county or city governments to provide mental health services, 14 states reported that counties or cities are used across the entire state, and in 3 states (Arkansas, Georgia, and Kansas), they are used in parts of the state. In 16 states, some counties have merged to form multicounty mental health authorities.

In 13 states, local governments contributed their own tax dollars to pay for community mental health services. In eight of these states, the local government contributions are required by the SMHA as a match for state funds. Ten states reported that local counties/cities collect dedicated taxes for mental health services.

5.2 Community Mental Health Providers

In 2007, SMHAs reported they operated and/or funded 10,979 community mental health providers. Of these community providers, the SMHAs operated 338 programs, and an additional 10,641

Table 6: Primary Methods Used by SMHAs to Fund Community Mental Health Services, 2007

Primary Mechanism Used by SMHAs To Fund Community Mental Health	Number of SMHAs	Average State Population (Using Method)	Percent of U.S. Population
SMHA directly contracts with local providers	27	4,133,742	37%
SMHA funds local government (county/city) mental health authorities	17	9,802,368	56%
SMHA operates community providers with state employees	7	3,021,025	7%

community mental health providers were funded by SMHAs (see Table 4). These community mental health providers served over 5.5 million consumers.

5.2.1 Community Providers Given Control Over Utilization or Budgets of State Psychiatric Hospitals

Over half the reporting states (24 of 47) are undertaking initiatives to restructure their community mental health system. In nine states, community mental health programs are being given control over the utilization or budgets of state psychiatric hospitals. In five states, community providers receive financial incentives for reducing state hospital utilization.

5.2.2 Community Providers Perform Gatekeeping Entry Into State Psychiatric Hospitals

In 38 states (81 percent of reporting states), community-based programs perform a gatekeeping function over entry to state psychiatric hospitals. The most common approaches to gatekeeping entry to state psychiatric hospitals are depicted in Table 7. Community providers are given this authority by state statute (20 states), SMHA regulations (11 states), or SMHA policy (21 states). In 18 states, the state has established mechanisms other than community mental health programs or the courts to control admissions to state psychiatric hospitals.

Table 7: Methods of Gatekeeping That Control Entry to and Discharge From State Psychiatric Hospitals

Methods	Voluntary Clients	Involuntary Clients
Preadmission screening	35	40
Hospital/community liaison activities	33	38
Predischarge planning	34	39

5.3 Types of Community Mental Health Services Offered

In 82 percent of the SMHAs (37 of 45 states), the SMHA required state-funded mental health service providers to offer a mandated set of mental health services. As shown in Table 8, case management and emergency services were the most commonly provided community-based services, which were offered by every reporting state for adult consumers.

For children and adolescents, case management, school-based services, outpatient services, and emergency services were the most frequently provided services. Psychosocial rehabilitation, consumer-run services, housing, and employment services

were much less commonly provided for children and adolescents, while specialized services such as in-home family services and family preservation/family psychoeducation services were much more common.

For persons who enter the SMHA system through the criminal justice system (forensics), the most commonly offered services are services to courts, case management, and outpatient services. For persons who are homeless and have a mental illness, many states target specific services to meet their needs and engage them into services. The most common services are case management, housing, and emergency services (see Table 8).

5.4 Consumer-Operated Services

As Table 8 shows, many SMHAs are using consumer-operated mental health services as part of their continuum of mental health services. SMHAs most frequently support consumer-operated services via direct funding from the SMHA (42 states), technical assistance (37 states), conference sponsorships (37 states), and providing office space (15 states).

SMHAs reported they provided a total of $62,003,065 (29 states reporting) for consumer-operated services. The median state spending for such services was $360,514, ranging from a high of $23,000,000 in Michigan to a low of $5,000 in South Dakota.

SMHAs reported they funded 327 consumer-operated programs (32 states), with a median of 5 consumer-operated programs in a state, and a range from a high of 50 programs in Michigan to a low of 1 program (in 6 states).

Table 8: Community-Based Services Targeted Toward Specific Population Groups

Community-Based Services	Children/ Adolescent	Adults	Elderly	MI Forensic	MI Homeless
Case management	41	44	34	27	36
Emergency	39	44	36	24	33
Dual diagnosis: MI/SA	32	42	23	19	26
Psychosocial rehabilitation	19	42	22	15	23
Outpatient	40	41	35	25	32
Housing	9	40	22	17	35
Acute care inpatient	32	38	26	20	20
Supportive employment	6	38	9	12	18
Consumer-run services	7	38	12	0	15
PACT/ACT	7	38	17	15	21
Employment/vocational rehabilitation	12	36	11	14	21
Residential	30	34	19	15	20
MI deaf and hearing-impaired services	24	32	20	10	10
Intensive case management	28	31	22	18	25
Dual diagnosis: MI/DD	25	27	15	12	10
Services to courts	23	27	14	29	17
Extended care inpatient	20	24	20	18	14
Partial day	23	24	15	8	12
Social clubs	3	19	9	5	10
Family preservation/family psychoed	35	17	8	3	3
In-home family services	40	13	10	2	2
School-based services	42	4	2	0	1
Other services	6	4	0	0	0

5.4.1 Types of Consumer-Operated Services

As Table 9 shows, SMHAs fund a variety of consumer-operated program activities. The most commonly funded activities are peer/mutual support, advocacy, leadership training, drop-in centers, and promoting positive public attitudes.

Table 9: Types of Consumer-Operated Services Funded by the SMHA

Services	Number of States
Peer/mutual support	46
Advocacy	40
Leadership skills training	35
Drop-in centers	32
Promoting positive public attitudes	32
Wellness/prevention services	28
Technical assistance	23
Policy development	22
Social services (e.g., independent living skills, training, job development)	17
Vocational rehabilitation/employment	16
Client-staffed businesses	13
Research activities	10
Nonresidential crisis interventions	8
Transitional/supported housing	8
Case management	7
Residential crisis facility	4
Other	7

In 28 states, the SMHA employs or requires contracted providers to employ self-identified consumers to provide peer services to consumers. Services provided by self-identified consumers are presented in Table 10.

5.4.2 States Reimbursing Peer Specialists for Providing Mental Health Services Through Medicaid

Peer specialists are a recent advance in using mental health consumers to provide peer services that Medicaid reimburses. Georgia was one of the leaders in establishing a training program to train and certify mental health consumers as peer specialists whose services are reimbursed by Medicaid. This model has been viewed as successful in many states, and 21 states report they now reimburse adult consumer peer specialists through Medicaid. Additionally, the District of Columbia and Michigan now also reimburse adolescent consumer peer specialists through Medicaid.

5.4.3 Office of Consumer Affairs

In 32 states, the SMHA has an office of consumer or recipient affairs. Most offices of consumer affairs are staffed with a current or former recipient of public mental health services responsible for ensuring that mental health consumers are represented throughout the SMHA system.

5.4.4 Managed Care Practices

The managed care practices of the SMHA include contracting with managed care organizations (MCOs), administrative service organizations (ASOs), and health management organizations (HMOs). This contracting happens regardless of whether a state has a Medicaid waiver for the provision of mental health or behavioral health services.

5.4.5 SMHA Use of Managed Care

Managed care is commonly used by states to provide behavioral health services. Most states (33) use managed care practice to provide mental health services. Of these, 27 are also providing substance abuse services via managed care. No behavioral health services are being provided via managed care in 16 states. In Idaho, substance abuse services and not mental health services are being provided via managed care. In 2007, SMHAs provided mental and behavioral health services to 2,161,523 individuals, or

Table 10: Services Provided by Self-Identified Consumers

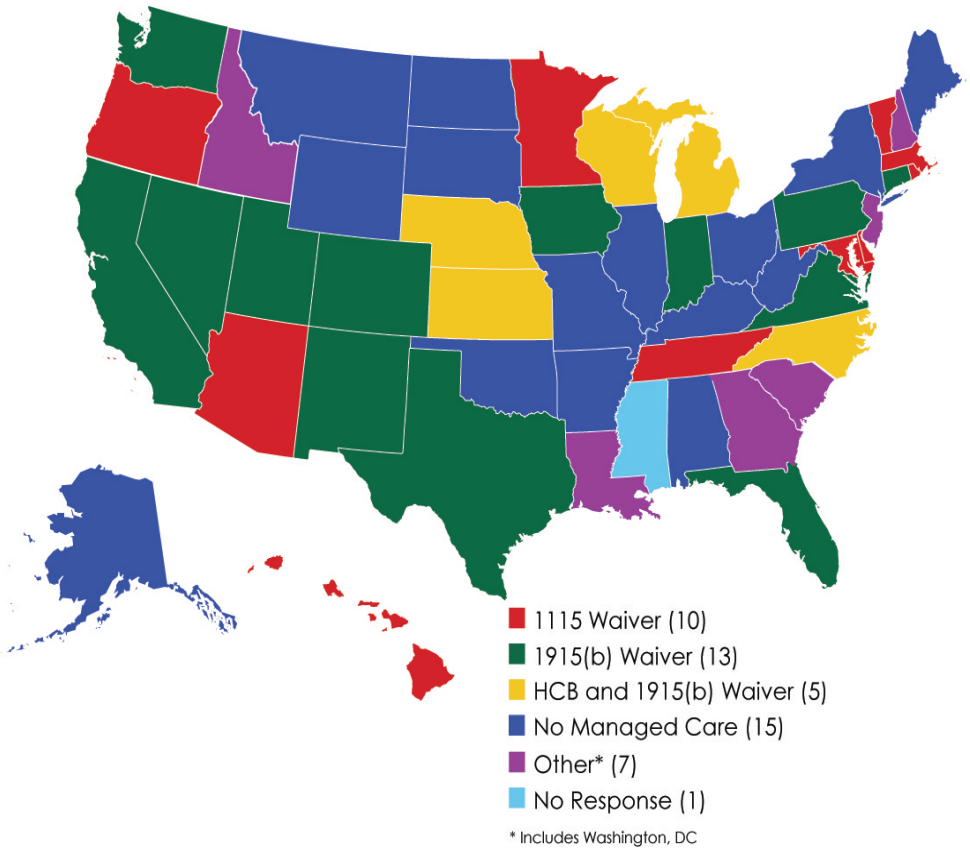
Services	Number of States
Consumers as providers in community mental health programs	26
State, regional, or local consumer-run organizations	22
Consumer-operated service programs	20
Support groups	18
Training and educational opportunities	15
Consumers as providers at state hospitals	14

10 percent of the 22,270,438 individuals covered by managed behavioral health plans.

Of the 33 states using managed care for mental health services, 18 have a Medicaid 1915(b) waiver, 10 have a Medicaid Research and Demonstration (1115) waiver, and 5 have a Medicaid Home and Community-Based waiver (see Figure 13 for types of waivers used in each State).

Medicaid 1915(b) waivers allow states to provide a continuum of services to older adults and individuals with disabilities, such as nontraditional home and community-based services. Medicaid 1115 waivers allow states to undertake new experimental and demonstration projects to test their efficacy. These projects often provide services that were not otherwise covered or provide innovative services. Medicaid Home and Community-Based waivers allow states to offer traditional medical services and nonmedical services. These services are

Figure 13: Medicaid-Managed Care Waivers Used for Mental Health



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sometimes provided by unpaid family members. There were 12 states with approved applications for 1115 waivers and 3 with prepared or pending applications. There were 17 states with approved applications for 1915(b) waivers and 2 with prepared or pending applications.

Some states are using state funds to implement managed care practices. These include:

- Colorado: Colorado Alcohol and Drug Abuse Division (the state substance abuse authority) uses a managed care delivery mechanism.
- Connecticut: Contracting with an ASO; also for the State Administered General Assistance (SAGA) for both mental health and substance abuse.
- The District of Columbia: Uses managed care practices with its local funds
- Georgia: State Plan Amendment
- Hawaii: SMHA acting as prepaid inpatient health plan
- Louisiana: The Office of Mental Health (OMH) serves as managed care agent for Medicaid-managed care services under the psychiatric rehabilitation option
- New Jersey: Children's mental health contracts with an ASO

5.4.6 Services Provided Under Managed Care Plans

The types and number of services provided by managed care plans vary by state and by waiver (see Figure 13 for types of waivers used in each state). The services most often cited by states with managed care waivers were the assessment and diagnosis of clients, emergency/crisis services, and treatment planning (see Table 11).

Most states (28) carve mental health benefits out of the basic benefit plan to specialty behavioral healthcare networks or managed behavioral health organizations. Some states (11) carve in mental health benefits, with general health benefits provided by primary healthcare providers or HMOs.

5.4.7 Medicaid Options Adopted by the State Medicaid Plan for Covering Mental Health Services

States are allowed to adopt a variety of Medicaid options for covering mental health services under their Medicaid plan. With the exception of Tennessee, all states, including the District of Columbia, have adopted the rehabilitation option. Most states have adopted the under age 21 inpatient (41 states), the over age 65 inpatient (35), targeted case management (31), and the clinic (30) options. Few states have adopted the

Table 11: Services Provided via Managed Care Plans

Services Provided Under Managed Care Plans	Number of States
Assessment and diagnosis	32
Outpatient therapy	30
Emergency/crisis	28
Treatment planning	28
Acute hospitalization	27
Day treatment/partial hospitalization	25
Psychosocial rehabilitation	23
Intensive in-home services	23
Prescription drugs for mental health	20
Services in residential treatment centers	19
Wraparound services (e.g., intensive case management, supported employment, respite services)	16
Crisis residential services	15
Peer support	14
Long-term hospitalization	11
Consumer-run services	7

personal care option (12). Other options that states have adopted include: Capitol Waiver; rehabilitation option for mental health group homes, and under 21, residential treatment; emergency mobile psychiatric and home-base services' EPSDT; 1115 waiver that includes clinic and rehabilitation options and no age limit for eligible populations; general acute inpatient care; counseling from licensed professionals (LPC, LMFT, advanced clinical social worker, psychologist, psychiatrist); crisis intervention services; and partial-day hospital (adult day treatment).

VI. SMHA Psychiatric Inpatient Systems, Acute Care Issues, and Forensic Services

All SMHAs operate state psychiatric inpatient beds, and many states are currently engaged in initiatives to reconfigure their state psychiatric inpatient system and how it relates to the needs for acute psychiatric treatment. Increasingly, state psychiatric hospitals are devoting resources to providing forensic mental health services.

6.1 State Psychiatric Hospitals

Every SMHA operates psychiatric inpatient beds that provide care and treatment to individuals with high levels of need and who are at risk to themselves or others because of their mental illnesses. These state psychiatric hospitals served approximately 175,583 persons during 2007 (3 percent of all mental health consumers served by SMHA systems during the course of 2007) and had expenditures of $8 billion (27 percent of total SMHA expenditures).

Forty-nine states and the District of Columbia operate a total of 232 state psychiatric hospitals—hospitals that are operated and staffed by the SMHA that provides specialized inpatient psychiatric care. Rhode Island is the only state that does not have a stand-alone state psychiatric hospital; however, Rhode Island does have a state-operated general hospital that has psychiatric inpatient beds. In over half the states (26), there are 3 or fewer state psychiatric hospitals. As the map below shows, the 13 states that have only 1 state psychiatric hospital tend to be in the mountain-frontier west and New England. The 11 states that have 6 or more state psychiatric hospitals are all larger-population states and are mostly in the east and southern regions of the country (See Figure 14 and Table 13).

At the end of 2006, there were 43,601 patients residing in these state psychiatric hospitals. States varied widely in the number of inpatients they had, ranging from 66 in Alaska to 6,327 in California. The median number of state psychiatric hospital residents was 655. On average, states had 14.5 state psychiatric residents per 100,000 population (the median was 13.7). The range was from a low of 3.5 in New Mexico to a high of 41.0 in North Dakota (see Figure 15).

Figure 14: Number of State Psychiatric Hospitals

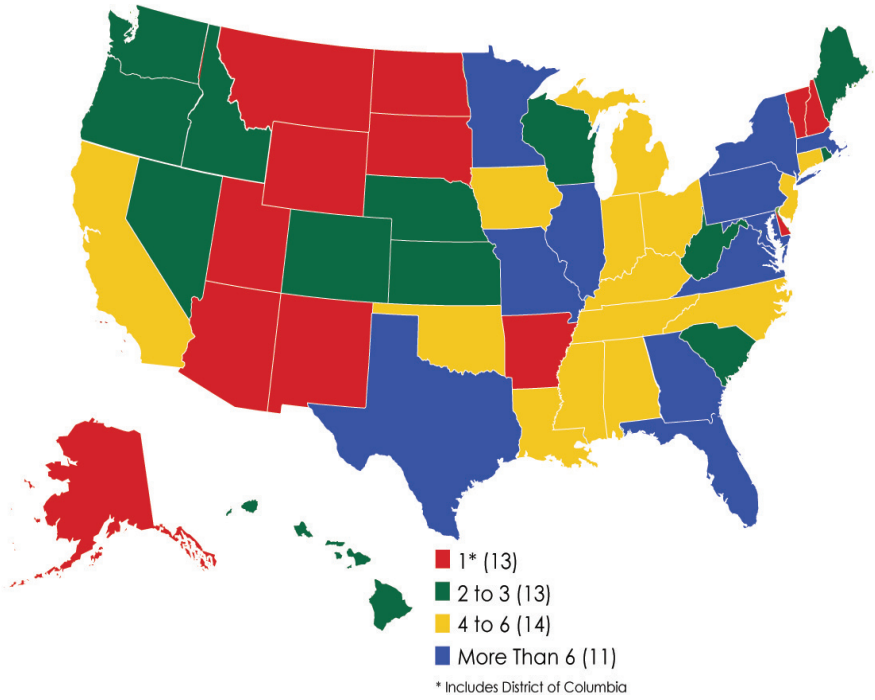

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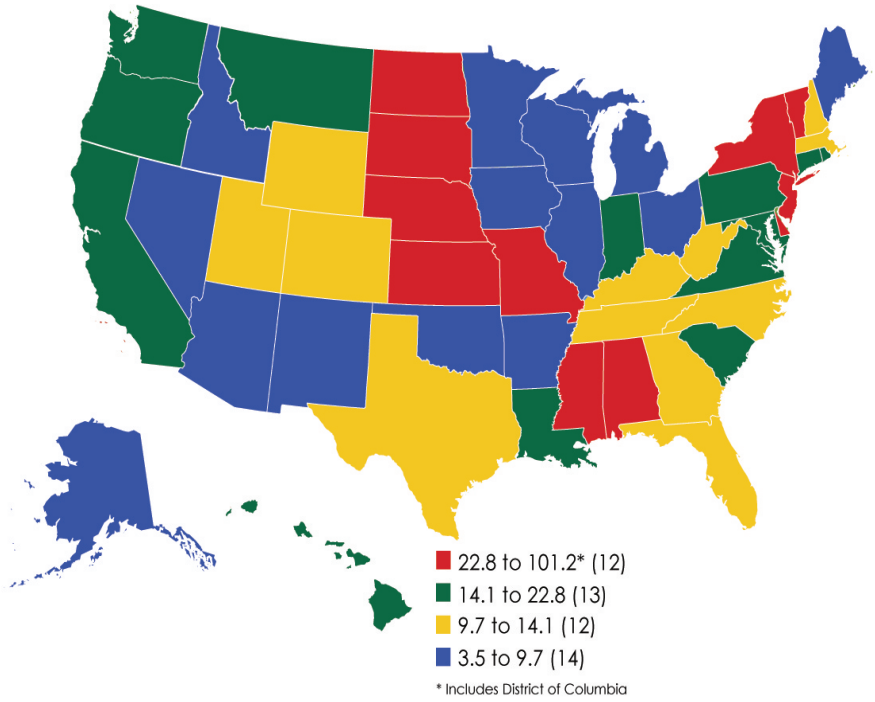
Figure 15: State Psychiatric Hospital Residents per 100,000 Population



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6.2 State Psychiatric Hospital Reorganization

Even prior to the 1963 Community Mental Health Centers Act, which established a goal of having a nationwide network of community mental health centers, states were under pressure to reduce the size of state psychiatric hospitals. One of the goals of the Federal Community Mental Health Services Block Grant is to help states minimize their use of state psychiatric inpatient beds. As a result of these policies, there were many fewer state hospitals in 2007 than before, and many fewer patients in them.

Over the past half century, the National Institute of Mental Health, CMHS, and the states have documented a historic shift in the size, nature, and usage of state psychiatric hospitals. According to CMHS, in 1950, there were 512,501 patients in state and county psychiatric hospitals. By 2005, that number had declined by 90 percent to only 49,947 patients (see Table 12). Over that time period, the number of state psychiatric hospitals had also declined by 37 percent (note that the CMHS count of the number of state psychiatric hospitals in 2005 is lower than the number of state psychiatric hospitals reported to the NRI SPS by SMHAs).

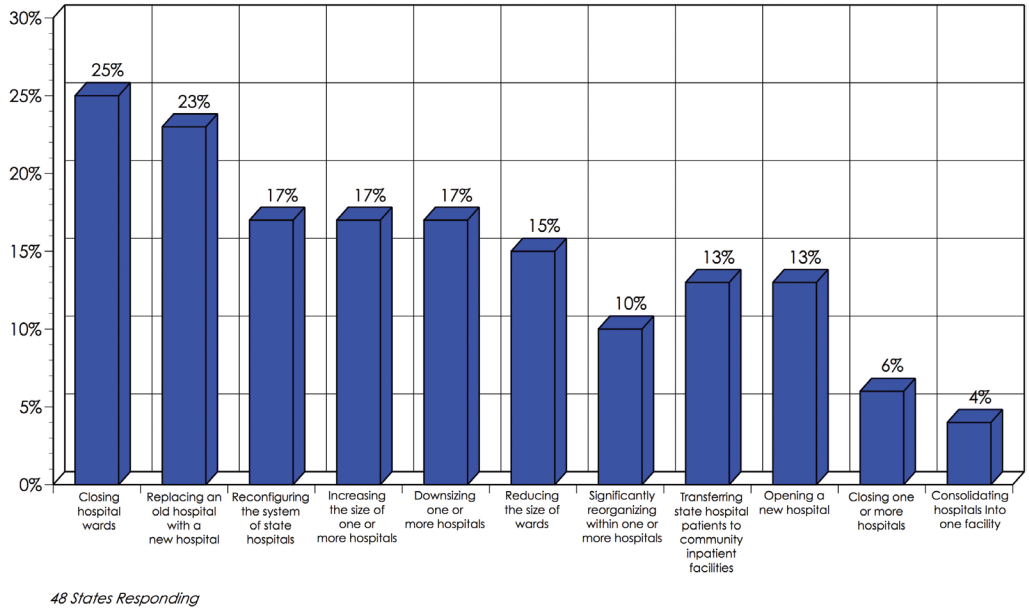
The number of deaths that occurred in state psychiatric hospitals shows a major decline from the 1950s through 1990, when CMHS ceased collecting that information. The state psychiatric hospitals of the 1950s and 1960s were much more focused on long-term care, with many patients remaining in the hospital for years. State psychiatric hospitals at the middle of the century had large numbers of older adults who had been at the hospitals for years and who may have had physical illnesses along with mental illnesses. At the current time, state psychiatric hospitals are much smaller but also have much shorter lengths of stay.

As a result of the major decrease in the number and size of state psychiatric hospitals, many states are reorganizing their state psychiatric hospital systems. In 2007, just over half of the states (54 percent) reported they were involved in some aspect of reorganization of their state psychiatric hospital system. As Figure 16 shows, the most frequently cited reorganization activities

Table 12: Number of Resident Patients, Total Admissions, Net Releases, and Deaths: State and County Psychiatric Hospitals, 1950–2005

Year	Number of Hospitals	Residents at End of Year	Admissions	Net Releases	Additions	Deaths
1950	322	512,501	152,286	99,659		41,280
1955	275	558,922	178,003	126,498		44,384
1960	280	535,540	234,791	192,818		49,748
1965	290	475,202	316,664	288,397		43,964
1970	315	337,619	384,511	386,937		30,804
1975	313	193,436	376,156	384,520	433,529	13,401
1980	276	132,164	NA	NA	370,344	6,800
1985	279	116,136	NA	NA	332,229	4,898
1990	281	92,059	NA	NA	277,813	2,321
1995	258	69,177	NA	NA	220,350	NA
2000	230	54,836	NA	NA	158,034	NA
2005	204	49,947	NA	NA	188,649	NA

Figure 16: State Psychiatric Hospital Reorganization Activities, 2007



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include closing hospital wards (25 percent) and replacing an old hospital with a new hospital (23 percent). An equal number of states (17 percent) were downsizing one or more state hospitals or were increasing the size of one or more state hospitals.

6.3 Closing State Psychiatric Hospitals

Over the last 55 years, there has been a reported net decrease of 118 state psychiatric hospitals (over this time, some states have opened new hospitals). In 2007, five states reported they had closed a total of seven state hospitals over the last 2 years, and three states reported they were currently planning to close a state psychiatric hospital. Five states reported they were working on plans to close an additional six state psychiatric hospital in the next 2 years. The data show that although many of the state hospital beds were closed during the 1950s to 1970s, the majority of state psychiatric hospitals have been closed since 1990.

6.3.1 Construction of State Psychiatric Hospitals

As Figure 16 on hospital reorganization demonstrates, states are no longer just closing state psychiatric hospitals. In 11 states, the SMHA is involved in replacing an old state psychiatric hospital with a new hospital. SMHAs often report that the cost savings from reduced maintenance and heating/cooling costs of a new modern building can help pay for the old building. Five states (California, the District of Columbia, Massachusetts, New Jersey, and Nevada) reported they are building or recently opened brand-new state psychiatric hospitals (not replacement hospitals). In California, the new psychiatric hospital represents a specialized program for sex offenders. In Nevada, the Rawson-Neal Psychiatric Hospital was built in the Las Vegas area in response to increased need resulting from the tremendous growth in population in that region of the state. North Carolina is building a new psychiatric central

Table 13: State Psychiatric Hospitals

State	Number of State Hospitals (2007)	Number of Residents (Last Day of Year)	Population Estimate July 1, 2007	Residents per 100,000 Population	2006 Percentage of Adults Who Were Forensic Status	Percentage of Adults Discharged in 30 Days or Less
Alaska	1	66	683,478	9.7	6%	92%
Alabama	6	1,210	4,627,851	26.1	17%	33%
Arkansas	1	201	2,834,797	7.1		52%
Arizona[1]	1		6,338,755			
California	5	6,327	36,553,215	17.3	82%	20%
Colorado[2]	2	519	4,861,515	10.7	75%	
Connecticut	4	623	3,502,309	17.8	34%	23%
District of Columbia[2]	1		588,292		28%	
Delaware	1	242	864,764	28.0	32%	79%
Florida	7	2,559	18,251,243	14.0	39%	1%
Georgia	7	1,188	9,544,750	12.4		91%
Hawaii[1]	2		1,283,388		83%	
Iowa	4	134	2,988,046	4.5	2%	
Idaho[1]	2		1,499,402			
Illinois	10	1,145	12,852,548	8.9	10%	
Indiana	6	1,109	6,345,289	17.5	16%	7%
Kansas	3	634	2,775,997	22.8		
Kentucky	4	490	4,241,474	11.6	3%	87%
Louisiana	5	867	4,293,204	20.2	13%	86%
Massachusetts	10	869	6,449,755	13.5	33%	45%
Maryland	10	1,192	5,618,344	21.2	50%	53%
Maine	2	86	1,317,207	6.5		46%
Michigan	6	803	10,071,822	8.0		21%
Minnesota	11	396	5,197,621	7.6		39%
Missouri	11	1,363	5,878,415	23.2	39%	86%
Mississippi[2]	4		2,918,785			
Montana	1	209	957,861	21.8		38%
North Carolina	4	1,080	9,061,032	11.9	2%	89%
North Dakota	1	262	639,715	41.0	55%	64%
Nebraska[2]	3		1,774,571			
New Hampshire	1	177	1,315,828	13.5		75%
New Jersey	5	2,233	8,685,920	25.7	8%	24%
New Mexico	1	69	1,969,915	3.5	52%	71%
Nevada	2	185	2,565,382	7.2	26%	75%
New York	27	5,199	19,297,729	26.9	19%	18%
Ohio	5	1,044	11,466,917	9.1	20%	70%
Oklahoma	4	311	3,617,316	8.6	54%	81%
Oregon	2	721	3,747,455	19.2	65%	13%
Pennsylvania	8	1,932	12,432,792	15.5	41%	4%
Rhode Island[3]	0	150	1,057,832	14.2		3%
South Carolina	3	676	4,407,709	15.3	40%	67%
South Dakota	1	254	796,214	31.9	4%	77%
Tennessee	5	809	6,156,719	13.1	26%	93%
Texas	12	2,409	23,904,380	10.1	29%	62%
Utah	1	335	2,645,330	12.7	30%	24%
Virginia	11	1,544	7,712,091	20.0	39%	54%
Vermont	1	216	621,254	34.8		52%
Washington	3	1,290	6,468,424	19.9	30%	32%
Wisconsin	3	473	5,601,640	8.4	59%	70%
West Virginia	2		1,812,035		26%	
Wyoming	1	69	522,830	13.2	5%	60%
Total	**232**	**43,601**	**301,098,327**	**14.5**		**60%**
Average	**5**	**993**	**5,914,140**	**16.8**	**32%**	**52%**
Median	**3**	**655**	**4,241,474**	**13.7**	**30%**	**54%**
Minimum	**0**	**66**	**522,830**	**3.5**	**2%**	**1%**
Maximum	**27**	**6,327**	**36,553,215**	**41.0**	**83%**	**93%**

Source: 2007 SMHA Profiles, unless noted below

[1] = 2006 NRI State Profiles

[2] = 2005 CMHS Annual Census Data

[3] = Rhode Island does not have a state psychiatric hospital; has psychiatric beds in a state-operated general hospital

regional hospital that will take the place of two existing state hospitals.

6.3.2 How SMHAs Use State Psychiatric Hospitals

There are variations in how SMHAs use their state psychiatric hospitals to provide services to persons with mental illnesses. A few states have focused their state psychiatric hospitals on providing acute short-term (length of stay of 30 days or less) inpatient care, while other states have focused on providing only long-term inpatient psychiatric treatment. Table 14 shows how SMHAs report use of their state psychiatric hospitals for different age groups.

All SMHAs have inpatient psychiatric beds for treating adult mental health consumers. In three states, state psychiatric hospitals are focused on providing acute or intermediate-length inpatient services (less than 90 days) to adults. As Table 13 shows, over half of all patients discharged from state hospitals had a length of stay of 30 days or less. In a few states (Arkansas, Georgia, and Tennessee), over 90 percent of discharged patients had a length of stay of 30 days or less. Other states had very few clients discharged so quickly (Florida, Indiana, Pennsylvania, and Rhode Island had under 10 percent of clients discharged in 30 days or less).

Some states dedicate their state psychiatric inpatient beds for adults and forensic clients and do not have inpatient beds for children. There were 32 states that reported they focus state hospitals on serving children and adolescents in state psychiatric hospitals, and 12 of these SMHAs focus on acute/intermediate length of stays for children and adolescents.

6.3.3 Use of Non-SMHA General Hospitals and Other Local Hospitals

In several states, the SMHA has developed a policy to use local hospitals to provide inpatient psychiatric treatment as an initial admission site prior to using state psychiatric hospitals. Under these policies, persons in need of inpatient psychiatric services first use local hospital beds and only go on to the state psychiatric hospital if they need additional inpatients services. These policies are more frequently in place for adults, where 35 percent of the states (18 states) reported having such a policy in place. Nine states reported having a policy to use local hospitals as an initial admission site for children and adolescents.

6.4 Psychiatric Acute Care Shortages

As the previous section demonstrated, state psychiatric hospitals have undergone a tremendous downsizing over the last 50 years. However, state psychiatric hospitals are not the only type of psychiatric beds that have declined in numbers over time. CMHS

Table 14: Number of States Using State Psychiatric Hospitals by Age and Service

Population	Acute Inpatient (Less than 30 days)		Intermediate Inpatient (30–90 days)		Long-Term Inpatient (More Than 90 days)	
	Number of States	Percent	Number of States	Percent	Number of States	Percent
Children	23	47%	20	41%	15	31%
Adolescents	29	59%	26	53%	20	41%
Adults	41	84%	43	88%	43	88%
Elderly	37	76%	40	82%	40	82%
Forensic	36	73%	41	84%	43	88%

has been tracking the number of psychiatric facilities and beds across both public and private sectors, and data show a decline in overall state psychiatric bed capacity. In 1970, there were over 500,000 psychiatric beds in the United States, but that number declined by 81 percent over the last 32 years. From 1990 to 2002, the number of dedicated psychiatric beds did not just decline in state psychiatric hospitals, but also in private psychiatric hospitals, Veterans Affairs psychiatric centers, and general hospitals, which all declined at least 25 percent (see Table 15). Only "other" mental health organizations and residential treatment centers for emotionally disturbed children increased their number of psychiatric beds over the most recent 12 years.

As Table 16 shows, when the increase of population in the United States is factored in, the number of beds per 100,000 civilian population has declined by 72 percent since 1970, from 263 beds per 100,000 to 73.3 beds per 100,000 civilian population.

The PNFC on mental health cited acute care as an area in need of further study and

Table 15: Number of 24-Hour Hospital and Treatment Beds

Year	State Hospitals	Private Psychiatric Hospitals	VA Psychiatric Services	General Hospitals	Other Mental Health Organizations	Residential Treatment Centers	Total Psychiatric Beds	State Hospitals as Percent of Total Psychiatric Beds
1970	413,066	14,295	50,688	22,394	1,198	15,129	516,770	80%
1976	222,202	16,091	35,913	28,706	993	18,029	321,934	69%
1980	156,482	17,157	33,796	29,384	1,433	20,197	258,449	61%
1986	119,033	30,201	26,874	45,808	21,150	24,547	267,613	44%
1990	98,789	44,871	21,712	53,479	23,646	29,756	272,253	36%
1998	68,872	33,408	16,973	54,434	62,144	31,965	267,796	26%
2000	60,675	26,484	9,363	39,690	43,034	33,375	212,621	29%
2002	57,263	25,095	9,672	40,202	39,918	39,049	211,199	27%
Change 1970–1990	-76%	214%	-57%	139%	1874%	97%	-47%	
Change 1990–2002	-42%	-44%	-55%	-25%	69%	31%	-22%	
Change 1970–2002	-86%	76%	-81%	80%	3232%	158%	-59%	

Table 16: 24-Hour Hospital and Residential Treatment Beds per 100,000 Population

Year	State Hospitals	Private Psychiatric Hospitals	VA Psychiatric Services	General Hospitals	Other Mental Health Organizations	Residential Treatment Centers	Total Psychiatric Beds	State Hospitals as Percent of Total Psychiatric Beds
1970	207.4	7.2	25.5	11.2	0.6	7.6	263.6	79%
1976	105.1	7.6	17.0	13.6	0.5	8.5	160.3	12%
1980	70.2	7.7	15.7	13.7	0.6	9.1	124.3	56%
1986	49.7	12.6	11.2	19.1	8.8	10.3	111.7	44%
1990	40.5	18.4	8.9	21.9	9.7	12.2	111.6	36%
1998	31.6	12.4	6.3	20.2	23.1	11.9	99.5	32%
2000	21.5	9.4	3.3	14.1	15.3	11.8	75.4	29%
2002	19.9	8.7	3.4	14.0	13.9	13.6	73.3	27%
Change 1970–1990	19%	156%	-65%	96%	1517%	61%	-58%	
Change 1990–2002	-51%	-53%	-62%	-36%	43%	11%	-34%	
Change 1970–2002	-90%	21%	-87%	25%	2217%	79%	-72%	

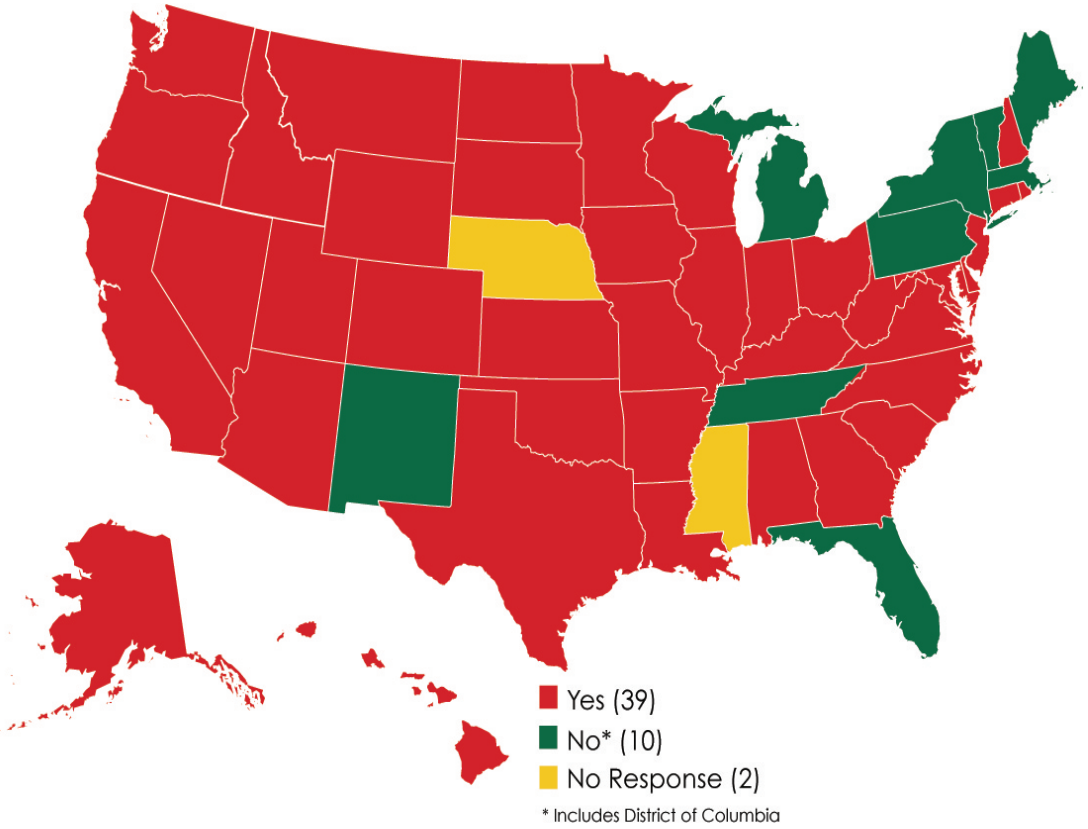
found that "shortages exist in the availability of psychiatric beds and other levels of acute care in many regions of the country" (US DHHS, 2003). Over the last 5 years, 64 percent of states (29 of 45) have experienced declines in the number of general hospital specialty unit psychiatric beds, and 10 states have experienced a decline in the number of private psychiatric hospital beds. The impact of all these closings is that 80 percent of the states (39 of 49) are experiencing a shortage in psychiatric beds.

In 37 states, the result is a shortage of acute care beds, in 15 states a shortage of long-term care beds, and in 27 states a shortage of forensic beds. SMHAs report that the impact of these bed shortages include: increased waiting lists for state hospital beds in 27 states, increased waits for other psychiatric beds in 15 states, overcrowding in state hospitals in 19 states, and increased resistance to closing additional state hospital beds in 16 states.

In 22 states, the SMHA reported that consumers remain in emergency departments when they are ready to be discharged because there are no suitable placements (e.g., no available hospital beds and/or residential beds for those who need them). In 27 states, the SMHAs reported they are working with general hospital emergency departments to improve crisis services for individuals with mental illnesses.

SMHAs describe undertaking a variety of activities and expenditures to address these problems. Initiatives include increasing

Figure 17: SMHAs Experiencing a Shortage of Psychiatric Inpatient Beds, 2007



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure17.html

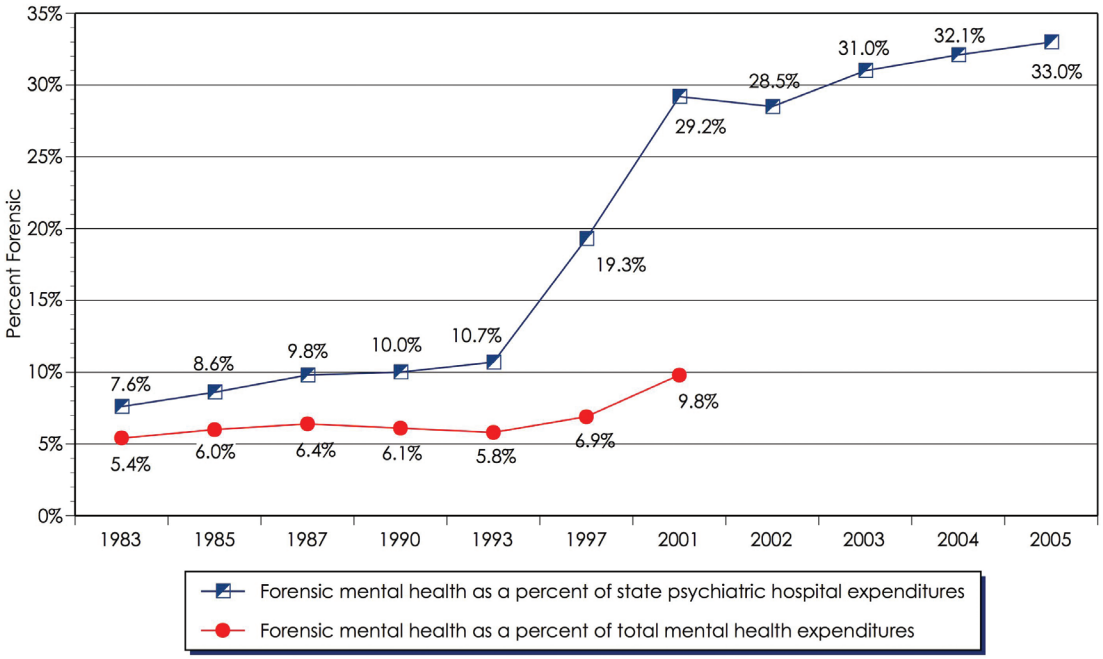
funding to community providers to provide inpatient and crisis services, increasing the number of ACT programs, and launching studies of the problem. There were 48 states that reported they are developing or supporting alternative forms of mental health treatment to reduce the need for these hospitalizations.

6.5 Forensic Mental Health Services

As discussed in Section III of this report, SMHAs vary widely in their responsibilities for providing mental health services to forensic clients. In recent years, increasing shares of state psychiatric hospital expenditures have been devoted to forensic services. In FY 2005, SMHAs expended $2.3 billion of their state hospital expenditures on services for forensic status clients (30 percent of state hospital inpatient expenditures) and an additional $257 million for sex offender services (3.3 percent of state hospital-inpatient expenditures). SMHAs also vary in the amount of psychiatric hospital expenditures that are devoted to forensic status clients and sex offender services. For example, a few states have no forensic service responsibilities, while in eight states, over half of state hospital expenditures were for forensic and sex offender services. These eight states ranged from Vermont, where 50 percent went to forensics, to California, where 87 percent of expenditures went to these services.

Since 1983, forensic and sex offender services in state psychiatric hospitals have increased from 7.6 percent (in FY 1983) of state hospital inpatient spending to 10 percent in FY 1990 and 33 percent in FY 2005 (see Figure 18). The growth in expenditures for forensic and sex offender services appears to be continuing as several states have recently expanded their sexual

Figure 18: SMHA-Controlled Forensic and Sex Offender Mental Health Expenditures, FY 1983–FY 2005



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure18.html

offender treatment programs in state psychiatric hospitals.

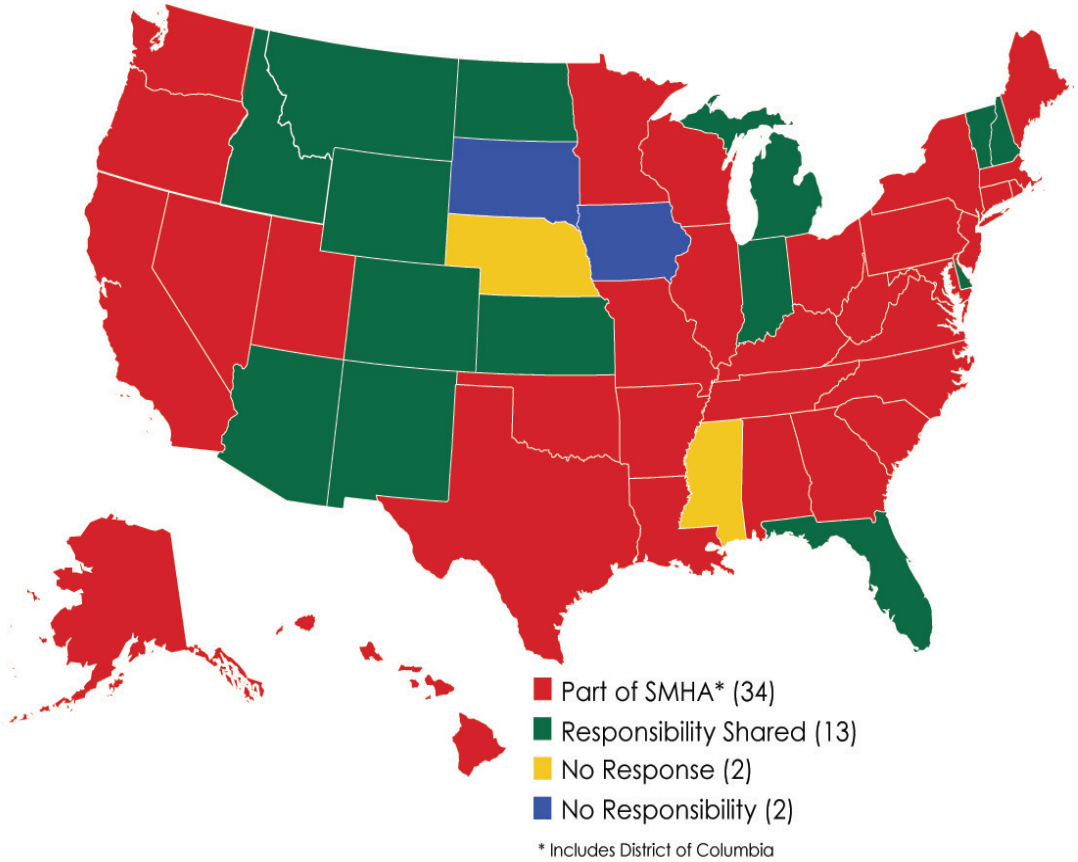
6.5.1 Organization of State Forensic Mental Health Services

Almost all SMHAs (47 out of 49 reporting) have statutory responsibility for providing some mental health services to forensic clients. In over two-thirds (69 percent) of the states and the District of Columbia (34 states), the SMHA is responsible for adult forensic services. In 13 states, the SMHA shares the responsibility with another agency. Only in Iowa and South Dakota does the SMHA have no responsibility for adult forensic services (see Figure 19).

Most SMHAs play a role in administering court evaluation of mental health status. In over half (56 percent) of the states (27), the SMHA is responsible for court evaluations of mental health status. In 16 states, the responsibility is shared with another agency. In five states (Arizona, Minnesota, North Dakota, South Dakota, and Texas), the SMHA has no responsibility for court evaluations of mental health status.

A majority of SMHAs play a role in administering services to persons with mental illness in prisons and jails. In five states (Louisiana, New York, Oregon, Pennsylvania, and South Dakota), the SMHA is responsible for services in prisons and jails. In 23 states, the responsibility is shared with another agency. In 20 states, the SMHA has

Figure 19: SMHA Responsibility for Forensic Mental Health Services, 2007



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure19.html

no responsibility for services in prisons and jails.

The SMHA has a central administrative management unit responsible for planning, administration, and/or monitoring of forensic services in 31 states. There is a designated forensic director within the SMHA in 28 states. In 12 states, forensic responsibilities are part of the responsibility of multiple individuals or are part of the responsibility of persons with additional responsibilities (e.g., hospital directors, medical directors). In seven states, there is no single person charged with responsibility for forensic services.

6.5.2 Not Guilty by Reason of Insanity and Guilty but Mentally Ill Statutes

Most states (48) have a Not Guilty by Reason of Insanity (NGRI) statute, where persons charged with crimes can be found not guilty or not criminally responsible due to their mental illness. Persons found NGRI are usually sent to a state psychiatric treatment facility until such time as they are found to be well and safe enough to be released to their community. Twenty-seven states reported a total of 852 individuals had been found NGRI during the last year. The range was from 1 person found NGRI last year (in several states) to a high of 107 (Maryland). The median number of persons found NGRI last year was 15. At the end of 2006, there were 4,686 adult residents in state psychiatric hospitals who were there with NGRI status (34 states reporting). The average number of adult residents with NGRI status was 138, and the median number of NGRI-status adult residents was 46. The range was from 1 in several states to 1,220 in California.

There were 14 states that have a Guilty but Mentally Ill (GBMI) statute, where a criminal defendant can be found guilty of a crime but also to have had a mental illness. There were two states with both NGRI and GMBI statutes (only Oregon reported having only a GBMI statute). A total of 170 persons were reported as having been found GBMI last year (6 states reporting), with a range from 1 to a high of 84. The median number of persons found GBMI last year was 21. At the end of 2006, there were 480 adult residents in state psychiatric hospitals who were there with GBMI status (4 states reporting). The average number of adult residents with GBMI status was 120, and the median number of GBMI-status adult residents was 65. The range was from 11 in Delaware to 340 in Oregon.

6.5.3 Scope of Forensic Mental Health Services

At the end of 2006, 41 states reported an adult forensic census of 17,660 adults in their state psychiatric hospitals. In 13 states, an additional 261 juveniles were forensic residents in state psychiatric hospitals. As Table 17 shows, among adult forensic patients, Incompetent To Stand Trial (30 percent) and NGRI (27 percent) were the two most common forensic statuses of residents. Among juvenile forensic residents, the most common status was Pretrial Evaluations (30 percent) and Incompetent To Stand Trial (26 percent).

6.5.4 Sex Offenders

There are now 19 states that have laws providing specifically for the hospitalization/commitment of sex offenders, including sexually violent predators, sexually dangerous persons, etc. The use of these sexual offender laws has increased since the 1997 U.S. Supreme Court decision in *Kansas*

Table 17: Forensic Status of State Psychiatric Hospital Residents

	Adult Residents	Juvenile Residents
Incompetent to stand trial	30%	26%
Not guilty by reason of insanity	27%	2%
Guilty, but mentally ill	3%	0%
Pretrial evaluation	4%	30%
State prisoners transferred to mental health	4%	10%
Jail detainees transferred to mental health	3%	3%
Sexual offenders committed to mental health	11%	0%
Other (includes status not available)	18%	30%
Total forensic residents	17,660	261

v. Hendricks, which affirmed state laws that allow persons completing prison sentences to be committed to psychiatric institutions for treatment if they are deemed a danger by the courts (US Supreme Court of the United States, 1997).

Since that decision, states have reported an increasing number of persons being committed to state psychiatric hospitals under these statutes. However, SMHAs vary widely regarding their responsibilities for providing services to sexual offenders. As Table 18 shows, in most states with sex offender statutes, the SMHA is responsible for administering the mental health facility and providing clinical services to persons committed under sex offender statutes. However, in several states, sexual offenders are housed in facilities administered by the department of corrections, with the SMHA providing mental health services.

In 2007, states reported an adult forensic census of 2,026 sexual offenders (an increase from 1,727 in 2005). The number of adult sexual offenders in SMHA psychiatric hospitals varied from a high of 678 in California to a low of 4 in the District of Columbia (where most sex offenders are served in a Federal prison). The median number of sexual offenders in a state with sex offender statutes was 142 persons.

6.5.5 Provision of Mental Health Services to Persons in Prison or Jails

In most states (42), the state department of corrections is responsible for providing mental health services to adults in prison. In seven states, the SMHA system is responsible for providing mental health services to adults

Table 18: Responsibilities for Sex Offender Services

Services	SMHA	Department of Corrections	SMHA With Corrections or Another Agency	Other	Total
Screening Corrections inmates to identify candidates for commitment proceedings	2	11	4	9	26
Evaluating individuals whose commitment someone else has petitioned	10	3	2	12	27
Providing for the facility in which the committed individual has served	11	5	0	11	27
Providing for administration of the committed facility	13	3	0	9	25
Providing or paying for clinical services	13	3	0	9	25
Providing or paying for security services	11	5	2	9	27

in prison. For juveniles who are in the state's juvenile justice system, the SMHA is responsible for providing direct mental health services in only four states. In most states, either the state corrections agency (22 states) or some other agency (25 states) is responsible for providing mental health services.

Only one state (Maine) reported that the SMHA has the responsibility for providing mental health services to persons with SMI in local jails or detention centers. Three additional states reported that the SMHA shares responsibility for providing these mental health services with the city/county jails. In most states, the provision of mental health services to persons with SMI in jails is the responsibility of the city/county jail or the sheriff's office that administers the jail. Most SMHAs reported they have initiatives under way to work with jails to improve mental health services in these settings.

The SMHA funds, operates, or provides community mental health programs that provide mental health services to:

- Adults in local jails or detention centers in 28 states and to juveniles in 19 states
- Adults among the community corrections population (probation, parole, alternatives to incarceration, juvenile probation/ suspensions, etc.) in 30 states and to juveniles in 24 states
- Adults in local sheriffs' offices in 10 states and to juveniles in 4 states

VII. New Freedom Commission Activities

As described in Section I, the PNFC established six major goals for transforming mental health care in America. SMHAs have been actively working to implement changes in their system to address the goals laid out by the PNFC. This section summarizes some of the SMHA activities designed to address each of those six goals.

7.1 Goal 1: Americans Understand That Mental Health Is Essential to Overall Health

Goal 1 is subdivided as follows:

1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

1.2 Address mental health with the same urgency as physical health.

Key to the achievement of the first PNFC goal are activities by SMHAs and others to improve the public's understanding of mental health and to reduce the stigma and discrimination related to mental illnesses. The SMHAs reported engaging in a wide variety of initiatives to achieve this goal.

7.1.1 Public Information Initiatives

Sixty-eight percent of SMHAs (34 of 50) reported they have public information initiatives to promote a better understanding of the role of mental health to overall health. Twenty-nine of these states had initiatives geared toward children, and 30 had initiatives geared towards adults. Initiatives in this area include radio and television public service announcements, billboards, booklets, supporting speakers, community forums, and other educational activities.

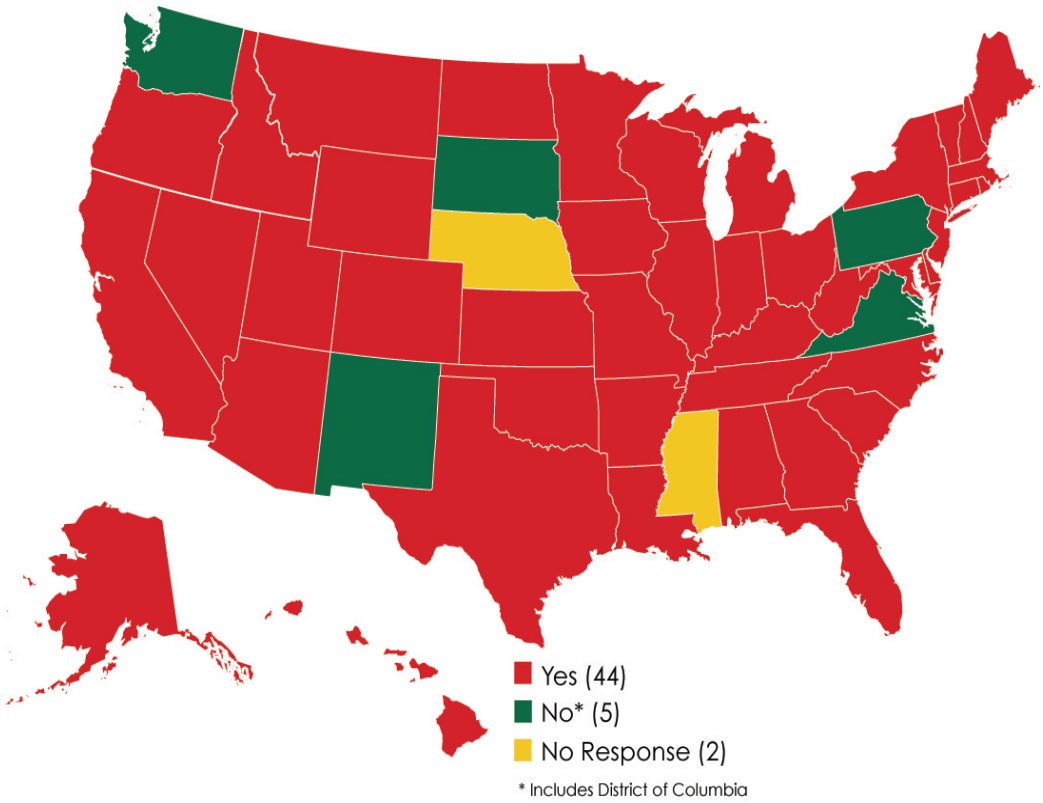
7.1.2 Stigma

Eighty-eight percent of the SMHAs (44 of 50 reporting) are involved in stigma or discrimination reduction activities. In 30 states, these are universal initiatives (designed to address all population groups), while in 37 states, the initiatives are targeted toward specific population groups. The most common focus of these targeted antistigma efforts include:

- Children/adolescents (27 states)
- Adults (30 states)
- Older adults (16 states)
- Cultural and minority groups (11 states)

SMHA antistigma activities included working with consumer groups to combat stigma in five states, developing and supporting television announcements in five

Figure 20: SMHA Has Stigma and Discrimination Initiatives



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure20.html

New Mexico described its antistigma campaign as follows:

"Citizen organizers (contract employees) are developing grass roots initiatives in several communities statewide. Most of these programs address stigma issues in the community. Also, through the Behavioral Health Purchasing Collaborative culturally appropriate and sensitive services are a priority. The New Mexico Behavioral Health Collaborative is in the process of creating a Stigma Reduction Campaign. Prior to the launch of the campaign we will conduct a baseline survey to determine the attitude, awareness, knowledge and behavior of the general public when it comes to mental illness and substance abuse. After the Stigma-Reduction campaign is rolled out through television and radio public service announcements we will go back and survey the general public to see if their attitudes, awareness and knowledge of mental illness and substance abuse have changed."

states, and working with business/civic groups in three states.

7.1.3 Suicide Prevention

Most SMHAs (90 percent or 45 SMHAs) operate or fund suicide prevention programs. In 42 States, the SMHA operates or funds suicide prevention programs targeted for adolescents, in 37 states targeted for adults, and in 32 states targeted towards older adults.

SMHAs in most states (80 percent) have developed a plan to reduce suicide attempts or initiate suicide prevention programs. In 38 states, these plans are focused on adolescents, in 36 on children, in 36 on adults, and in 30 on older adults.

Thirty-one SMHAs reported they operate, fund, or participate in postsuicide attempt activities. Examples of postsuicide attempt activities of SMHAs include: sponsoring suicide survivor groups and emergency response teams to work with families and schools after suicide attempts. For example, Texas reported: "The SAMHSA funded Texas Youth Suicide Prevention grant provides follow-up for youth who have attempted suicide. Suicide prevention gatekeeper training is offered to the schools these youth attend. School staff and parents (PTA) are the target audience for this training."

7.2 Goal 2: Mental Health Care Is Consumer- and Family-Driven

Goal 2 is subdivided as follows:

2.1 *Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.*

Kansas reported a number of initiatives for PNFC Goal 1, including:

1. *Veterans and family initiatives to identify gaps in needed services*
2. *Outreach to rural and frontier areas*
3. *PSA efforts to decrease stigma associated with seeking help in the general population and consumers sharing their recovery journey and encouraging sensitivity towards individuals with mental illness*
4. *Poster campaigns to display statistics and prevalence of mental illness among children through older adults to encourage help-seeking behavior*
5. *Producing an annual children's calendar featuring children's art from consumers of mental health services*
6. *Educational presentations at local schools to raise awareness of suicide prevention*

2.2 *Involve consumers and families fully in orienting the mental health system toward recovery.*

2.3 *Align relevant Federal programs to improve access and accountability for mental health services.*

2.4 *Create a comprehensive state mental health plan.*

2.5 *Protect and enhance the rights of people with mental illnesses.*

7.2.1 Insurance Coverage and Parity for Mental Health Services

In 66 percent of reporting states (33 of 50), the state mandates mental health insurance benefits. In 28 states, the mandate includes parity with physical health service benefits. In 14 states, these mental health insurance benefits are limited to specific mental health diagnoses. For example, in several states mental health services are limited to diagnoses of: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive compulsive disorder, and autism. In 5 states, the insurance benefits are limited to mental illnesses, but not substance abuse services, and in 10 states, both mental health and substance abuse services are covered.

7.2.2 Recognition and Treatment of Persons With Mental Illnesses by Primary Care Providers

In 64 percent of the states (32), the SMHA is collaborating with the state health department to increase the recognition and treatment of persons with mental illnesses. In 31 states, the SMHA is working with the state Medicaid agency regarding primary care providers.

In 70 percent of the states (35), the SMHA is working with public health providers (community health clinics, state health agencies, and other public providers) to increase the recognition and treatment of the physical health needs of persons with mental illnesses. In 27 states, the SMHA is working with private health providers (e.g., local hospitals, physician groups).

7.2.3 Individualized Treatment Plans

Almost all SMHAs (96 percent or 48 of 50) report having initiatives under way to ensure every consumer receives an individualized person-centered treatment plan to meet his or her unique needs. Among the states that reported having no initiatives under way, some reported this is a well-established requirement, and thus no new initiatives were needed. In 34 states, the SMHA provides training and assistance to providers in developing person-centered treatment plans. In 28 states, the SMHA receives information on individualized treatment plans from community mental health providers.

7.2.4 Recovery Orientation

The PNFC recommended that mental health systems "involve consumers and families fully in orienting the mental health system toward recovery." SAMHSA has developed a consensus definition of recovery as follows:

> *Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential (SAMHSA, 2004).*

State mental health agencies have embraced the concept of recovery for consumers, and most SMHAs (43) have now adopted a mission statement or policy about the potential for consumers to recover from their illnesses and to reorient the mental health service system towards recovery.

7.2.5 Consumer Involvement in Mental Health Systems

SMHAs are working to provide consumers with choice with respect to services they receive and a stronger voice in the design of mental health systems and how resources and services are allocated. Table 19 shows several areas where SMHAs are working to provide increased decision-making and choice to consumers.

Table 19: How SMHAs Promote Consumer Choice (Number of SMHAs Reporting)

Initiatives	Children	Adults
Consumer participation in program planning at the SMHA level	45	46
Access to satisfaction and outcome data on mental health programs	41	43
Psychiatric advanced directives	16	40
Consumer participation in resource allocations at the SMHA level	33	35
Person-centered and consumer-directed individualized treatment and support plans	6	32
Consumer participation in their own resource allocations	16	18
Voucher system for individuals to purchase services of their own choice	6	10

7.2.6 Psychiatric Advanced Directives

SMHAs are supporting psychiatric advanced directives through state statutes and policies. In 28 states, there is a general state statute on advanced directives, while in 20 states, there is a statute specific to mental health (in 10 states, there is both a specific mental health statute and a general state advanced directive statute). In eight states, there is no specific advanced directive statute,

but the SMHA has a policy or rule to encourage their use. Six SMHAs reported they have no statutes or policy on advanced directives.

7.2.7 Types of Advanced Directives Supported

Living wills (expressing one's own wishes for treatment in the event she or he lacks capacity in the future) are permitted/encouraged in 32 SMHAs. The appointment of health care proxies/representatives is permitted/encouraged in 31 SMHAs.

7.2.8 Comprehensive Mental Health Plans

Many SMHAs (37 of 50) have broadened their mental health planning process to encompass the delivery of mental health services across multiple state government agencies. In 31 states, the state mental health plan addresses the mental health services and essential support services provided by state agencies other than the SMHA. In every state, representatives from other state government agencies participate as members of the SMHA's mental health planning council.

7.2.9 Fragmentation

All but one SMHA (94 percent) reported working to transform the way they deliver mental health services by restructuring or combining services in a new approach to eliminate barriers and promote consumer choice. Most SMHAs reported they are working to reduce the fragmentation in services experienced by consumers as a barrier to receiving mental health services. Substance abuse services (45 states), housing services (46 states), Medicaid (43 states), and criminal justice (43 states) were the most frequently identified areas of state initiatives.

Table 20 shows that most SMHAs have initiatives under way to work with other state government agencies to coordinate, reduce, or eliminate barriers between delivery system and funding streams to assure the provision of appropriate mental health services. Although many of these initiatives focus on reducing fragmentation between systems, many states are also working to coordinate client eligibility determinations, funding streams, and service delivery. For example, Connecticut reports that "fourteen (14) state agencies and the

Table 20: SMHAs Have Initiative Under Way to Work With Other State Government Agencies to Coordinate, Reduce, or Eliminate Barriers Between Delivery Systems and Funding Streams (Number of SMHAs Reporting)

Agency	Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	41	32	35	35
Child Welfare	42	20	29	37
Health	40	14	24	31
Education	39	13	24	33
Juvenile Justice	38	18	25	35
Corrections	37	19	19	31
Housing	38	19	29	31
Other state agency	11	5	6	8

Judicial Branch, through a signed Memorandum of Understanding, are working together through the Mental Health Transformation State Incentive Grant (MHT SIG) on a wide variety of initiatives including workforce development, different utilization of waivers, sharing data, and collaborating on models of treatment."

7.2.10 Child Custody Relinquishment

One of the problem areas identified by the PNFC was the need for some families to give up custody of their own child for the child to receive needed mental health services. This is described as "the tragic and unacceptable circumstances that result in thousands of parents being forced to place their children into the child welfare or juvenile justice system each year so that they may obtain the mental health services they need" (US DHHS, 2003, p. 33).

SMHAs and states have been working to change their eligibility requirements and policies to end the need for parents to relinquish custody for their children to receive services. Thirty of 47 reporting states indicate their state has laws or policies designed to avoid parents having to relinquish custody of children for them to obtain mental health services. For example, Iowa reported it has "a Medicaid Children's MH Waiver that started July 1, 2005; [it is] no longer necessary for parents to relinquish custody for PMIC [Psychiatric Medical Institute for Children] admissions."

Even the states who reported they do not have a policy in place to eliminate custody relinquishment frequently reported they have initiatives under way to reduce or eliminate custody relinquishment. For example, Oklahoma reported, "Oklahoma is creating a care coordination system to ensure receipt of mental health services." And Virginia reported, "There is large policy change initiative underway to issue new foster care guidelines that avoid parental relinquishment. Work is not yet complete."

7.2.11 Services to Veterans and Military Members

The mental health needs of the National Guard, the military, and veterans have been highlighted by several new studies of the needs of soldiers, sailors, and marines returning from military conflicts. SMHAs are working with the Veterans Department and Department of Defense to help meet the needs of these members:

- Twenty-seven of 49 reporting SMHAs are working with their state National Guard
- Twenty-nine are working with the Federal Department of Veterans Affairs
- Three are working with the Federal Department of Defense

With regard to examples of state activities working on veterans' mental health, Delaware reported establishing Front Door Teams at the community mental health center (CMHC) system to create an "open door" to mental health services. Individuals served, including veterans, are assisted with immediate mental health service supports. Connections are made to veteran centers, the state Veterans Administration hospital, and other outpatient providers funded by the Veterans Administration.

Maryland reported developing a pilot program with the Maryland National Guard; the Maryland Defense Force; and the Maryland, Virginia, and Federal Veterans Administrations. A pilot program provides training for the Maryland National Guard Family Readiness Program for recognizing the signs of posttraumatic stress disorder in returning veterans.

New Hampshire reported being a member of the advisory board of the Disaster Behavioral Health Response Team (DBHRT) under the Office of Homeland Security. The state participates in Operation Welcome Home with the National Guard by contracting for services from CMHCs. The state also offers some housing for mentally ill veterans.

Examples of State Activities Related to Veterans' Mental Health

Delaware: *Front Door Teams have been established in the CMHC system to create an "open door" to mental health services. Individuals serving on these teams, including veterans, are assisted with immediate mental health service supports. Connections are made to veteran centers, the state Veterans Administration (VA) hospital, and other outpatient VA-funded providers.*

Maryland: *Maryland developed a pilot program with the Maryland National Guard; the Maryland Defense Force; and the Maryland, Virginia, and Federal VA. The pilot program provides training for the Maryland National Guard Family Readiness Program on recognizing signs of PTSD of returning veterans.*

New Hampshire: *New Hampshire is a member of the Advisory Board of the Disaster Behavioral Health Response Team (DBHRT) under the Office of Homeland Security. The state participates in Operation Welcome Home with the National Guard and contracts for services of the CMHCs. There is some housing for mentally ill veterans.*

7.2.12 Housing

Most states (74 percent) have developed a housing plan to address the housing needs of persons with SMI. SMHAs reported having 211 full-time employees (FTEs) employed or contracted by the SMHA to address housing issues for persons with mental illnesses (35 states reporting). Nineteen SMHAs reported the number of FTEs working on housing has recently changed, almost always the result of an increase in the number of staff dedicated to housing. For example, Arizona reported that a new housing coordinator was established within the SMHA in the summer of 2005.

Ninety-two percent of SMHAs (46 states) and 70 percent of local mental health authorities (35 states) support and collaborate with community development corporations or housing authorities in local communities. SMHAs report they have working interagency relationships with several other agencies regarding housing issues:

- State social services agency (47 states)
- State coalition for homeless persons (45 states)
- State aging agency (40 states)
- State department of housing/community development (38 states)
- State housing finance agency (35 states)
- State affordable housing coalition (30 states)

SMHAs were asked to assess what barriers impede their ability to address consumer housing needs. Table 21 presents the percent of SMHAs that rated the housing issues as "very significant" or "significant" barriers.

7.2.13 Criminal Justice and Mental Illnesses

The PNFC found that "too often, the criminal justice system unnecessarily becomes a primary source of mental health care" (US DHHS, 2003, p. 43) and called for more programs to divert persons with mental illness from the criminal justice system into services. In 2007, most states had some form of criminal justice diversion programs (see Figure 21).

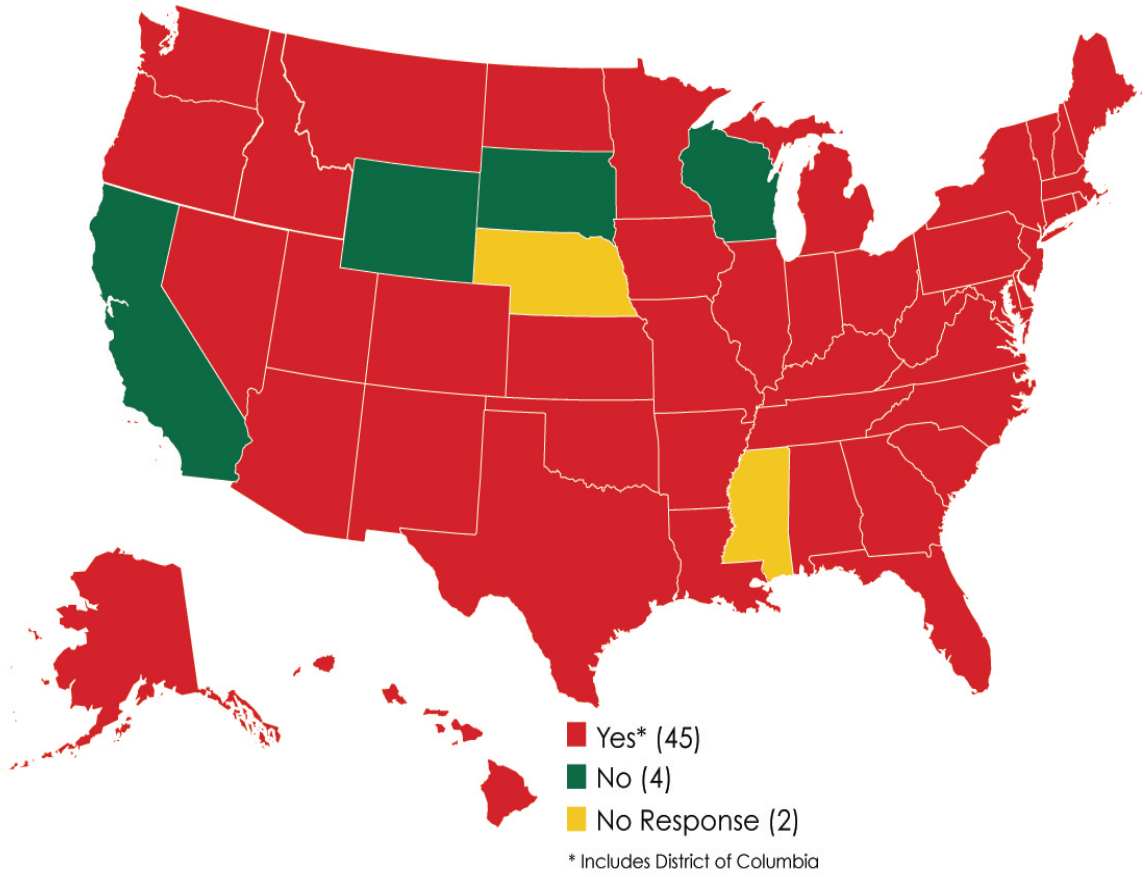
Table 21: Barriers That Impede the SMHAs' Ability to Address Consumer Housing Needs

Barriers to Housing	Percent of States
Consumer income is insufficient to afford private market rate housing	89%
Insufficient availability of subsidized housing	80%
Insufficient funding for development of affordable housing	70%
Insufficient funding for necessary support services	59%
Other housing issues	57%
Community opposition (NIMBY—not in my back yard)	29%
Lack of data/information about housing	28%
Lack of coordination between agencies	26%
Managed care organizations do not support housing	23%
Fair housing issues for consumers	11%
Poor relationship with housing agencies/housing providers	7%

7.2.14 Mental Health Courts

Thirty-six SMHAs reported they have mental health courts designed to help divert persons with mental illnesses from the criminal justice system into mental health treatment. In 2007, 29 states reported they had 134 mental health courts operating (an average of 4.6 courts per state). These mental health courts saw 6,242 persons, an average of 367.2 persons per state during the year (17 states reporting). In 16 states, the mental health courts have dedicated new resources to provide community-based mental health treatments. Eleven states reported a total of $9,661,398 devoted to mental health courts, an average of $878,309 per state.

Figure 21: States With Mental Health Court and/or Jail Diversion Programs



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure21.html

7.2.15 Prebooking Diversion Programs for Adults

Prebooking diversion programs are interventions designed to work with police to divert persons with mental illnesses into services before they are charged with a crime. In 2007, 38 states reported they have adopted such programs to help divert adults with mental illnesses into treatment. During the last 2 years, 25 SMHAs reported having activities or funding to stimulate or support prebooking diversion programs. Over the next fiscal year, 25 states anticipate they will have funding or activities to stimulate prebooking programs.

7.2.16 Postbooking, Preadjudication Diversion Programs for Adults

These programs are interventions designed to work with the police and courts to divert persons into mental health services after they have been arrested or charged with a crime. In 2007, 30 states reported they have adopted postbooking preadjudication diversion programs to divert adults with mental illnesses into treatment. During the last 2 years, 29 states reported they have had activities or funding to stimulate or support postbooking diversion programs. Over the next fiscal year, 28 states anticipate they will have funding or other activities to support postbooking, preadjudication diversion programs.

7.2.17 Youth Diversion Programs

In 2007, 29 states reported they support programs to divert youth with mental illnesses from the juvenile justice system into mental health services. In 18 states, these programs are designed to divert youths at adjudication. In 16 states, youths are diverted at intake to the juvenile justice system, and in 14 states, youths are diverted prearrest (before charges are filed). Youth diversion programs are administered by the SMHA in 8 states, while they are administered jointly by the SMHA and the state juvenile justice agency in 13 states, and by only the state juvenile justice agency in 5 states.

7.2.18 Reentry Programs

In 34 states, the SMHA has adopted, funded, or operated reentry programs designed to provide supports for prisoners or jail detainees with mental illnesses and/or co-occurring substance abuse disorders who are returning to the community. For example, in Texas, the Texas Correctional Office on Offenders with Medical and Mental Impairments provides funding for continuity of care personnel at local mental health agencies (LMHAs) statewide. LMHA continuity of care personnel are responsible for linking individuals to appropriate community supports upon release from prison.

7.3 Goal 3: Disparities in Mental Health Services Are Eliminated

Goal 3 is subdivided as follows:

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas.

7.3.1 Cultural Competence

Sixty-eight percent of SMHAs (34 of 50 states) report they have a cultural competence plan. In 24 states, the cultural competence plan covers all administrative organization components in its purview (i.e., cultural competence is a requirement and responsibility at all administrative and organizational levels within the SMHA). In

32 states, the cultural competence plan addresses linguistic competencies (see Table 22).

In 18 states, the SMHA has conducted a cultural competence assessment. The NASMHPD/NRI State Mental Health Agency Cultural Competence Assessment Instrument was used in three of these states.

7.3.2 Workforce Initiatives

Almost all SMHAs reported they are experiencing shortages of trained staff with appropriate clinical training. Most states (46 of 50) report they have initiatives to improve the quality of their mental health workforce. Figure 22 shows that almost every state is experiencing a shortage of psychiatrists willing to work in the public mental health system, but states are also experiencing major shortages of registered nurses, advanced practice nurses, social workers, and other professional disciplines.

Table 22: SMHA Cultural Competence Activities Needs

Activities	Number of States
SMHA provides or assists organizations in obtaining training materials for clinical staff in the use of interpreters	20
SMHA provides or helps organizations to obtain educational materials translated into identified languages	19
Provider and service directories are available in key languages	18
Standards exist for qualified mental health interpreters	16
Language skills of staff are monitored and updated	32

To help address these staff shortages, SMHAs are engaged in several initiatives including:

- Special university-based training initiatives (36 states)
- Training at mental health programs/providers (36 states)
- Increased salaries (33 states)
- Recruitment bonuses or other financial incentives (21 states)
- Other, such as loan forgiveness, tuition benefits (18 states)

Almost all states (88 percent) reported on special initiatives to cross-train staff to meet the needs of dual diagnosis, mental health and substance abuse services.

7.3.3 Workforce Improvement

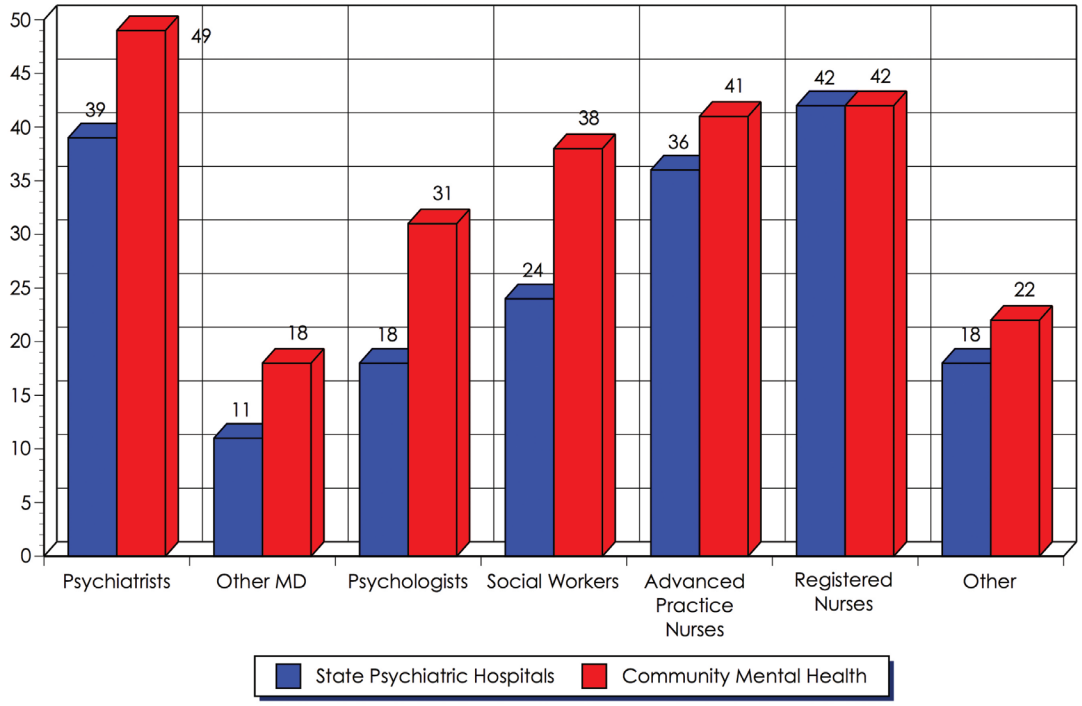
Most SMHAs (46) have initiatives to improve the quality of their mental health workforce. In most states, mental health consumers (37) and the family members of mental health consumers (33) are involved in the training of SMHA staff, including 29 where both are used.

7.3.4 Prescription Privileges and the Use of Licensed Health Care Providers

Nurse practitioners, advanced practice nurses, physician assistants, and other licensed health care providers are given prescription privileges or may monitor medications in many state psychiatric hospitals and community mental health systems. They have these privileges in state psychiatric hospitals in 35 states and with community mental health providers in 37 states.

These nonphysicians monitor medication in 35 states, are given prescription privileges in 36 states, and may collect patient histories and conduct physicals in 33 states. In some states, they are also allowed to manage and lead groups, complete diagnostic evaluation discharge summaries, consult with patients,

Figure 22: SMHA Shortages of Mental Health Staff by Discipline, 2007



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure22.html

and provide emergency certificates to have patients involuntarily transported to the emergency departments of general hospitals for psychiatric evaluations.

Psychologists are granted by state legislation privileges to use preapproved formularies, and in collaboration with a physician, to diagnose and assess, formulate treatment plans, and lead treatment teams. In 40 states, nurse practitioners have prescription privileges; in 28 states, physician assistants have prescription privileges; and in 2 states, advanced practice nurses have prescription privileges.

7.3.5 Staffing in State Psychiatric Hospitals

Forty-three states reported over 110,000 staff in 2007 in state psychiatric hospitals, 76,000 of whom were direct patient care staff and 30,000 were indirect care (support and administrative) staff.

7.3.6 Rural/Frontier Services

Almost three-quarters of the states (74 percent) reported they have initiatives to increase access to mental health services in rural and geographically remote areas. These initiatives include telemedicine initiatives in 19 states and rural outreach efforts.

In almost half (46 percent) of the states, the SMHA has initiatives to recruit and train rural mental health professionals. Examples of state initiatives include residency and traineeship programs that focus on provision of services in rural mental health settings (Ohio) and physician bonuses paid for rural service. Oklahoma reports working with the department of health on issues relating to health professional shortage areas, providing a seminar series, and linking with Oklahoma State University to focus on rural health education.

State Examples of Goal 3 Initiatives

California: *Since 1998, the Department of Mental Health has required local county mental health systems to track and report disparities and develop local objectives to reduce and/or eliminate them. The American Mental Health Alliance (AMHA) annually provided disparities Medi-Cal data to all local mental health authorities. The SMHA Cultural Competence Advisory Committee is currently updating and rewriting new cultural competence plan requirements for review and approval by SMHA for statewide distributions. The primary focus is reduction of disparities and improved quality of care. The Department of Mental Health has completed and piloted the California Brief Multicultural Competence Scale and Training program (a 32-hour training program for providers to improve cross-cultural mental health services). This is a comprehensive multicultural curriculum developed in partnership with University of Le Verne and the California Mental Health Directors Association. This product will be available nationally through Sage publishing company. The department has engaged in a contract with the Center for Reducing Health Disparities, at UC Davis, to develop resources and provide technical support to local counties to improve their community outreach and engagement with communities that have a history of disparities in mental health. Language access: SMHA is now completing a mental health interpreter's training program to address disparities resulting from limited language access. The State Quality Improvement Council tracks statewide disparities and reports out to local mental health plans. The Medi-Cal State External Quality Review contractor includes items in the review protocol on mental health disparities and reports out results.*

Connecticut: *The Department of Mental Health and Addiction Services (DMHAS) has developed gender-specific guidelines for providers to ensure responsiveness to the particular characteristics and needs of women in treatment programs at all levels of care. Data collection, data sharing, and the use of data to identify disparities and inform decision-making to eliminate those disparities is an area of focus for the MHT SIG. Connecticut's Network of Care website www.ct.networkofcare.org contains mental health–related information in 14 different languages.*

Georgia: *The Georgia Crisis and Access Line (G-CAL) coordinates with community providers and crisis stabilization programs to provide access to routine and emergency mental health and substance abuse services. G-CAL provides triage and direct access to appointments with community providers and deployment of crisis services. The group can also provide consumers with choices based on time of access, distance, and consumer preference.*

7.4 Goal 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

Goal 4 is subdivided as follows:

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

4.3 Screen for co-occurring mental health and substance use disorders and link with integrated treatment strategies.

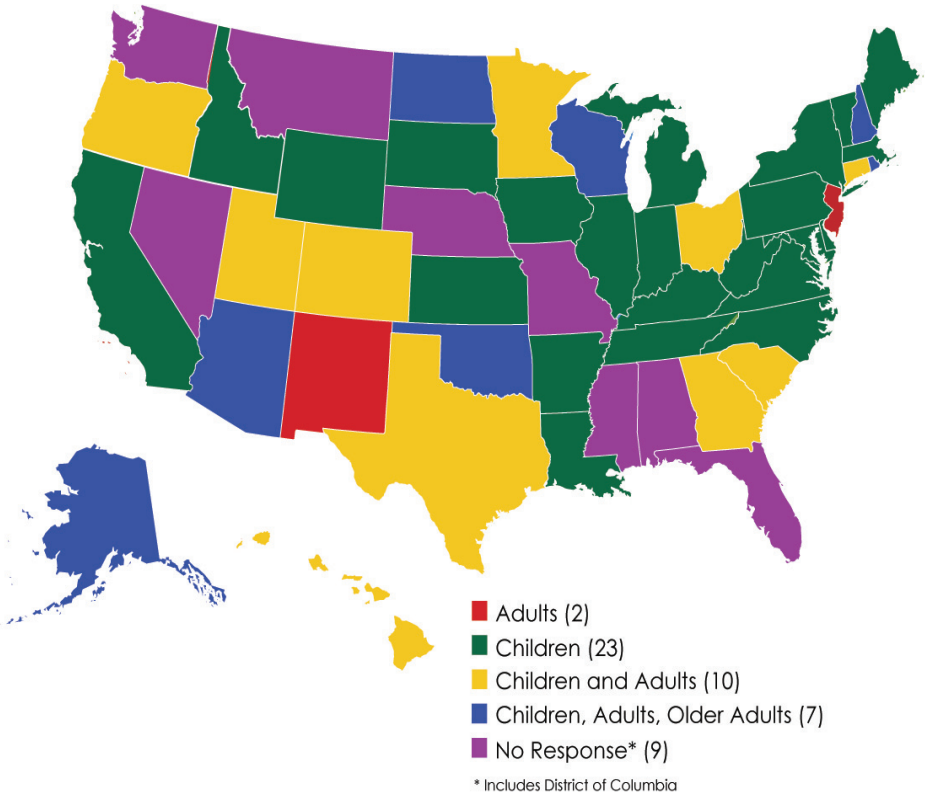
4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

7.4.1 Screening for Mental Health Problems

Almost all SMHAs report they have initiatives for the early detection of mental health problems (see Figure 23). Most states (84 percent or 42 of 45 reporting) have some form of early detection initiative. In 40 states, these initiatives are for children, in 19 states for adults, and in 10 states for older adults.

Nearly all SMHAs (92 percent) report they are working with schools to expand and improve mental health services for children. State initiatives with schools include providing training and technical assistance to schools and funding services provided in schools. For example, Texas reported a "school-based services initiative and early childhood mental health project. SMHA

Figure 23: SMHA Early Detection of Mental Health Problem Initiatives



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contracted providers to provide mental health services within schools to eligible youth. The SMHA also funds staff within the 20 regional educational resource centers to provide training and technical assistance to school personnel and community stakeholders about improving mental health services for children in schools."

Almost all SMHAs (96 percent) require or work with mental health providers to screen for co-occurring mental health and substance abuse disorders. Over half (56 percent or 28 states) of the SMHAs that reported require or work with mental health providers to screen for histories of trauma in persons served by the public mental health system. Nine SMHAs reported they provide or make referrals for specialized trauma treatments or services. Fifteen states compile information on the number of persons with a history of trauma who are receiving mental health services.

7.4.2 Older Adult Mental Health Services

Half (50 percent) of the SMHAs (25 states) have a specialized plan for the provision of mental health services for older adults (persons aged 65 and over). In 24 states, the SMHA provides specialized training to providers regarding older adult mental health services needs and issues in the recognition of mental illnesses.

7.5 Goal 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated

Goal 5 is subdivided as follows:

5.1 Accelerate research to promote recovery

State Examples of Goal 4 Initiatives

Delaware: *Community mental health utilizes Early Periodic Screening Diagnosis Testing (EPSTD) to identify children who may be in need of help with behavioral and/or emotional problems and/or have risk factors associated with the development of behavioral and/or emotional problems. The tool facilitates early detection of mental health problems, documentation of service entry needs, and identification of strengths. The Division of Substance Abuse and Mental Health (DSAMH) is collaborating with state emergency rooms (ERs) to provide appropriate assessment of mental health/substance abuse conditions to prevent inpatient care. The Crisis and Psychiatric Emergency Services (CAPES) and high-end user programs assure clients are provided with access to appropriate services and supports.*

Delaware: *DSAMH is collaborating with the adult justice system to connect consumers to mental health treatment through a Court of Common Pleas Mental Health Court and a Superior Court Drug Court. The community mental health center (CMHC) is planning to implement a child and family-oriented mental health court. DSAMH is collaborating to provide substance abuse and mental health treatment services to offenders involved in a statewide reentry initiative. The PATH Program connects homeless consumers who are mentally ill with services. The Comprehensive Neuroscience (CNS) program looks at psychiatric medication prescriptions from all doctors for Medicaid programs. The program can identify addictive medications and monitor best practice standards among doctors' prescriptions.*

Indiana: *The SMHA implemented a project with the Department of Child Services (DCS) for mental health screening of all youth placed in substitute care. This project has expanded to include other youth served by DCS. The project has included an evaluation component implemented by a local university researcher. The evaluation is demonstrating that early intervention with these youth results in greater stability of living situation and lower cost over time. The SMHA is working with the state bar association on a similar project to screen youth in juvenile detention facilities.*

and resilience, and ultimately to cure and prevent mental illnesses.

5.2 Advance evidence-based practices using dissemination and demonstration projects, and create a public-private partnership to guide their implementation.

5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

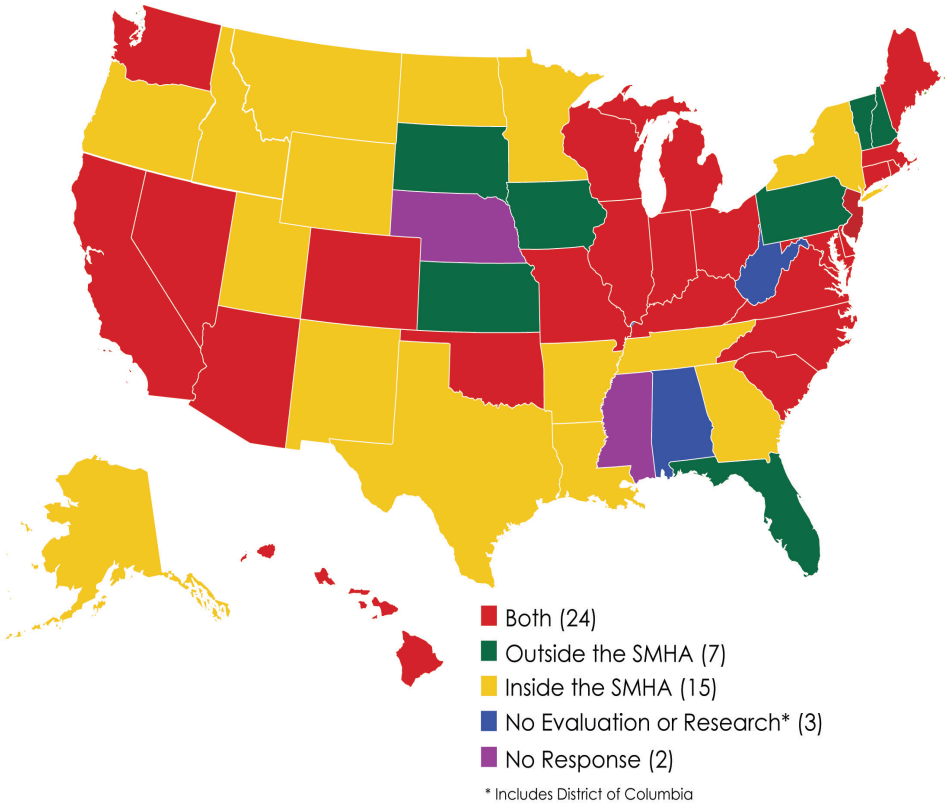
7.5.1 Moving Research and Evaluations Into Practice

The PNFC found there is too long a delay in research reaching practice for mental health services. SMHAs are undertaking several initiatives to shorten this delay. In 2007, 72 percent of SMHAs (36) had formal agreements to work with academia to help move research results into better mental health services. The purpose is to help ensure research and evaluation are carried out in areas of high priority to public mental health systems; in 60 percent of the states (30), the SMHA has formal agreements with academia and other researchers to study mental health service issues identified by the SMHA.

7.5.2 Research and Evaluations by SMHAs

In 2007, most SMHAs were supporting research and evaluation on the mental health services they provide. Thirteen SMHAs reported mental health research is sponsored or conducted both within the SMHA and outside the SMHA, while in 12 states, research is conducted only within the

Figure 24: Organizational Location of Research and Evaluation



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SMHA, and in 12 other states, research is only conducted by programs outside the SMHA (often at universities with relationships to the SMHA). Twelve states reported they do not conduct or sponsor research (see Figure 24).

Evaluations of mental health programs (which are usually less formal than research studies) are often designed to understand the effectiveness or outcomes of mental health services or trainings. More states reported they are involved in evaluations than research. In 16 SMHAs, mental health evaluations are sponsored or conducted both within and outside the SMHA, while in 22 states, evaluations are conducted only within the SMHA, and in 6 other states, evaluations are only conducted by programs outside the SMHA (often at universities with relationships to the SMHA). Only three states reported they do not conduct or sponsor evaluations.

In seven states, the state has an SMHA-operated research center/institute. In 13 states, the state funds a research center/institute that is not part of the SMHA.

7.5.3 Types of SMHA-Conducted Research/Evaluation

SMHAs report they are focusing their research and evaluation efforts on several areas, the most common being: client outcomes (42 states), service activity utilization rates (40), changes in functioning and service utilization (35), client utilization/penetration rates (35), and expenditures per

outcomes—cost-benefit and cost-effectiveness studies (14).

7.5.4 Evidence-Based Services

The following is from a 1999 Surgeon General's Report:

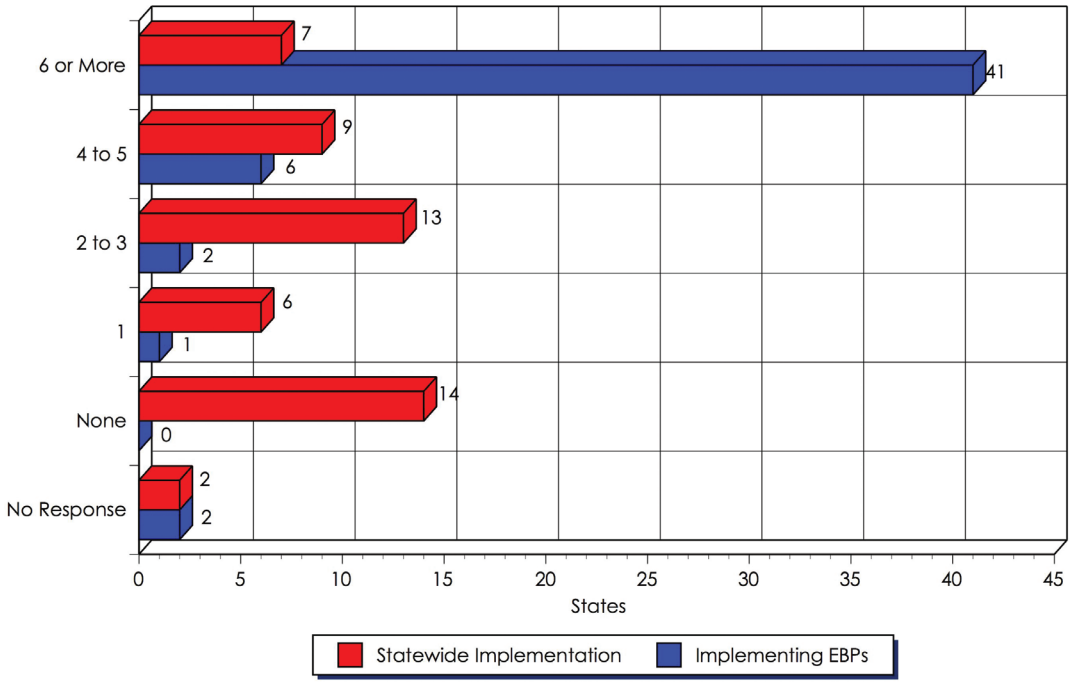
> *State-of-the-art treatments, carefully refined through years of research, are not being translated into community settings. . . . A gap persists in the broad introduction and application of these advances in services delivery to local communities, and many people with mental illness are being denied the most up-to-date and advanced forms of treatment (US DHHS, 1999, p. 455).*

For several years, SMHAs have focused on improving the quality of the mental health services they provide to reflect the latest scientific research on effective services. However, for many years, the difficulty of moving the most effective treatments from clinical research studies into common practice has been recognized as a major issue in both general medicine and in public mental health services in particular. In 1999, the above-mentioned Surgeon General's report on mental health found that "gaps also exist between optimally effective treatment and what many individuals receive in actual practice setting" (US DHHS, 1999, p. 102). The report also identified several practices and steps to improve the quality of care provided to mental health consumers.

In 2006, the Institute of Medicine concluded that "poor care hinders improvement and recovery for many. Numerous studies document the discrepancy between the [mental health and substance use] care that is known to be effective and the care that is actually delivered" (IOM, 2006, p. 35).

To help public mental health systems address the difficulties of implementing EBPs, SAMHSA has undertaken several major initiatives. CMHS supported the development of six toolkits to help states,

Figure 25: Number of EBPs Being Implemented by States



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure25.html

providers, clinicians, and consumers and families implement and use EBP services for adults with SMI. Since the original six toolkits were published by CMHS, work on additional toolkits for supported housing, consumer-operated services, and a variety of child, adolescent, and older adult EBPs have been under development by CMHS. SMHAs have responded to Federal leadership on EBPs by focusing their attention on increasing the number and level of EBPs being provided. In 2007, every reporting state was implementing at least one of the EBPs in the CMHS toolkit, and most states were implementing multiple EBPs.

Among EBPs designed for adults with SMI, the most frequently implemented EBPs were ACT (being implemented in 45 states), integrated mental health and substance abuse services (in 45 states), and supported employment (in 42 states).

Table 23 shows that not all these EBPs are being implemented statewide, but many of them are being implemented in parts of a state (e.g., ACT teams may be offered only in the large urban areas of a state instead of statewide). In addition to the EBPs being implemented in parts of a state, there are a few EBPs being piloted by SMHAs (piloting means the SMHA has only one or two initial EBPs). There are several EBPs not yet implemented by SMHAs, but SMHAs have announced plans to implement them. For example, family psychoeducation programs were in the planning stage in nine states during 2007.

Among EBPs designed for children with mental illnesses, therapeutic foster care (35 states), multisystemic therapy (31 states), and school-based interventions (30 states) were the most frequently implemented EBPs. Therapeutic foster care is the EBP with the most statewide implementation (17 states), while school-based interventions and multisystemic therapy (MST) are often not available statewide, but instead are offered in parts of a state. Wraparound was the most frequently listed "other" EBP for children (8 states). See Table 24 for the implementation status of child/adolescent EBPs.

7.5.5 Assertive Community Treatment (ACT)

ACT is a multidisciplinary clinical team approach to providing intensive community mental health services to help persons with SMI live in the community. Multiple studies have demonstrated that ACT services are effective in helping individuals with mental illnesses avoid psychiatric hospitalizations

Table 23: Number of SMHAs Implementing or Planning to Implement Adult EBPs

EBP	Implementing Statewide	Implementing Parts of State	Piloting	Planning To Implement	Total Implementing (Statewide or Part)
Assertive Community Treatment (ACT)	11	34	0	1	45
Integrated Mental Health and Substance Abuse	14	29	2	4	45
Supported Employment	20	24	1	1	45
Supported Housing	22	20	0	3	42
Consumer-Operated Services	12	23	2	4	37
Illness Self-Management	7	22	2	6	31
Family Psychoeducation	6	20	0	9	26
Medication Algorithms (Schizophrenia)	6	14	5	4	25
Medication Algorithms (Bipolar)	4	8	1	5	13
Other Adult EBPs	3	13	1	2	17

Table 24: Number of SMHAs Implementing or Planning to Implement Child/Adolescent EBPs

EBP	Implementing Statewide	Implementing Parts of State	Piloting	Planning To Implement	Total Implementing (Statewide or Part)
Therapeutic Foster Care	17	18	0	3	35
School-Based Interventions	5	24	1	1	30
MST (Conduct Disorders)	1	22	8	1	31
Functional Family Therapy	3	19	3	3	25
Other Child EBPs	4	8	0	5	12

and lead more productive lives in the community.

As described above, ACT was the adult EBP most frequently offered by states (provided in 40 of 51 states responding). In 11 states, ACT services are available statewide, while in 34 states, ACT services are available in portions of the state. One additional state indicated it is currently planning to implement ACT statewide.

Forty states reported they are implementing ACT programs consistent with published national standards. In 27 states, the SMHAs are measuring the fidelity of ACT programs. The most frequently used method of assessing fidelity is the use of the Dartmouth Assertive Community Treatment Scale (DACTS) by eight states. States reported that ACT teams average a patient-to-staff ratio of 14.2 to 1, with a median ratio of 10 to 1, a high of 100 to 1, and a low of 6 to 1.

A total of 747 ACT programs were reported by 40 states, with the median state having 6 ACT programs. The range was from a high of 88 ACT programs in Michigan to a low of 1 ACT program in Vermont. The number of persons receiving ACT programs was 55,469 (with 31 states reporting), and the median number of persons receiving ACT was 920. ACT services are paid for by a number of funding sources, with state general revenues through the SMHA and Medicaid the most frequently cited methods (see Table 25).

Twenty-four states reported a single bundled rate under Medicaid that they have used to pay for ACT services. The most frequently used Medicaid options to pay for ACT services were the Rehabilitation Option (30 states) and Medicaid Managed Care waivers (10 states).

7.5.6 Supported Employment

Supported employment programs typically assist people in obtaining competitive employment—that is, community jobs paying at least minimum wage for which any person can apply—in accord with client choices and capabilities, without requiring extended prevocational training. Unlike other vocational approaches, supported employment programs do not screen people for work readiness, but help all who indicate they want to work. They do not provide intermediate work experiences, such as prevocational work units, transitional employment, or sheltered workshops. They actively facilitate job acquisition, often sending staff to accompany clients on interviews, and they provide ongoing support once the client is employed.

In the 38 states implementing supported employment, there were 622 programs serving 25,000 individuals. The assessment and monitoring of the fidelity of the programs was conducted by 14 states using

Table 25: Funding Sources for ACT

Funding Source	Number of States
State General Funds	36
Medicaid	36
Federal Mental Health Block Grant	23
Local Funds	14
Other Funds	6

the following methods: Supported Employment Fidelity Scale; EBSE Supported Employment Scale; Medicaid Provider Manual; DACTS; Quality Supported Employment Implementation Scale; PORT/IPS; and Toolkit Model (SAMHSA). State general funds were used to provide supported employment services in 36 states, Medicaid in 17, the Federal Mental Health Block Grant in 24, local sources in 12, and various others in 15.

7.5.7 Medication Algorithms

A medication algorithm translates the latest available knowledge about medications into practical pharmacotherapy suggestions and promotes the optimal recovery in the consumer population. A central objective of the algorithm is to optimize pharmacotherapy for consumers and clinicians via a consensus of consumer experience, research evidence, expert advice, practitioner knowledge, and supportive technology (i.e., computer-based).

In the 15 states implementing medication algorithms for schizophrenia, there were 115 programs serving 54,541 individuals. The assessment and monitoring of the fidelity of the programs was conducted by three states using the following: CAL MAP Fidelity Scale, the Inpatient Residential Kit Fidelity Measure, and monitoring by Department of Mental Health and Developmental Disabilities (DMHDD) staff.

State general funds were used to provide medication algorithms (schizophrenia) services in 17 states, Medicaid in 9, the Federal Mental Health Block Grant in 2, local sources in 2, and various others in 7.

In the 9 states implementing medication algorithms for bipolar disorders, there were 40 programs serving 34,491 individuals. The assessment and monitoring of the fidelity of the programs were conducted by one state.

State general funds were used to provide medication algorithm (bipolar disorders) services in seven states, Medicaid in three, the Federal Mental Health Block Grant in one, local sources in two, and various others in three.

7.5.8 Family Psychoeducation

Family psychoeducation programs are offered as part of an overall clinical treatment plan for individuals with mental illness to achieve the best possible outcome through the active involvement of family members in treatment and management and to alleviate the suffering of family members by supporting them in their efforts to aid the recovery of their loved ones. The programs may be either multifamily or single-family focused. Core characteristics of family psychoeducation programs include the provision of emotional support, education, and resources during periods of crisis, and problem-solving skills.

In the 25 states implementing family psychoeducation, there were 222 programs serving 8,556 individuals. The assessment and monitoring of the fidelity of the programs was conducted by seven states using the following: agency self-report, SAMHSA Fidelity Scale, and Dartmouth Fidelity Scale.

State general funds were used to provide family psychoeducation services in 23 states, Medicaid in 13, the Federal Mental Health Block Grant in 16, local sources in 7, and various others in 5.

7.5.9 Integrated Dual Diagnosis Treatment (Mental Illness and Substance Abuse)

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the level of the clinical encounter. Hence, integrated treatment means that the same clinicians or teams of clinicians, working in one setting, provide appropriate mental health and substance abuse interventions in a coordinated fashion. In other words, the caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The need to negotiate with separate clinical teams, programs, or systems disappears. The goal of dual diagnosis interventions is recovery from two serious illnesses.

In the 33 states implementing integrated dual diagnosis treatment, there were 965 programs serving 22,180 individuals. The assessment and monitoring of the fidelity of the programs was conducted by 16 states using the following: IDDT Fidelity Scare, onsite review, DDCAT, Minkoff-Cline, Dartmouth/SAMHSA Fidelity scale, and SAMI/CCOE Fidelity Measure.

State general funds were used to provide integrated dual diagnosis treatment services in 36 states, Medicaid in 28, the Federal Mental Health Block Grant in 21, local sources in 10, and various others in 10 states.

7.5.10 Illness Self-Management

Illness self-management includes a broad range of health, lifestyle, and self-assessment and treatment behaviors by the individual with mental illness, often with the assistance and support of others, so the individual can take care of himself or herself, manage symptoms, and learn ways to cope better with the illness. Self-management includes psychoeducation, behavioral tailoring, early warning sign recognition, coping strategies, social skills training, and cognitive behavioral treatment.

In the 20 states implementing self-management, there were 255 programs serving 112,428 individuals. The assessment and monitoring of the fidelity of the programs was conducted by seven states using the following: IMR, Dartmouth/SAMHSA Fidelity scale, and the General Organization Index and SE Toolkit.

State general funds were used to provide self-management services in 25 states, Medicaid in 9, the Federal Mental Health Block Grant in 16, local sources in 4, and various others in 5.

7.5.11 Supported Housing

Supported housing refers to services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised on the idea that certain clients are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. These staff assist clients in selecting, obtaining, and maintaining safe, decent, affordable housing and maintaining a link to other essential services provided within the community. The

objective of supported housing is to help obtain and maintain an independent living situation.

Supported housing is a specific program model in which a consumer lives in a house, apartment, or similar setting, alone or with others, and has considerable responsibility for residential maintenance but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing programs include housing choice, functional separation of housing from service provision, affordability, integration (with persons who do not have mental illness), right to tenure, service choice, service individualization, and service availability.

In the 36 states implementing supported housing, there were 944 programs serving 36,227 individuals. The assessment and monitoring of the fidelity of the programs was conducted by two states using the following: onsite review, Data Source-USTF Forms, and site visits, interviews, records, and policy reviews.

State general funds were used to provide supported housing services in 32 states, Medicaid in 11, the Federal Mental Health Block Grant in 14, local sources in 8, and various others in 12.

7.5.12 Consumer-Operated Services

In the 26 states implementing consumer-operated services, there were 401 programs serving 66,120 individuals. The assessment and monitoring of the fidelity of the programs was conducted by five states using the following: MSU (self-survey), Drop-In Self-Assessment, and monitoring by SMHA staff.

State general funds were used to provide consumer-operated services in 28 states, Medicaid in 7, the Federal Mental Health Block Grant in 22, local sources in 6, and various others in 5.

7.5.13 Multisystemic Therapy

Multisystemic therapy (MST) is an intensive family and community-based treatment that addresses the multiple determinants of serious antisocial behavior in juvenile offenders. The multisystemic approach views individual, family, and extrafamilial (peer group, school, neighborhood) factors. Interventions may be necessary in any one or a combination of these systems. MST interventions typically aim to improve caregiver discipline practices; enhance family affective relations; decrease youth association with deviant peers; increase youth association with prosocial peers; improve youth school or vocational performance; engage youth in prosocial recreational outlets; and develop an indigenous support network of extended family, neighbors, and friends to help caregivers achieve and maintain such changes.

In the 21 states implementing MST, there were 129 programs serving 3,151 individuals. The assessment and monitoring of the fidelity of the programs was conducted by nine states using the following: consultation with model developer/approved consultants, Therapist Adherence Measure, MST training and supervision, Adherence Measure and Fidelity Implementation (FIMP), and MST Fidelity Scale.

State general funds were used to provide MST services in 25 states, Medicaid in 21, the Federal Mental Health Block Grant in 9, local sources in 7, and various others in 7.

7.5.14 Therapeutic Foster Care

Children are placed with foster parents who are trained to work with children with special needs. Usually, each foster home takes one child at a time, and caseloads of supervisors in agencies overseeing the program remain small. Therapeutic foster parents are given a higher stipend than that for traditional foster parents, and they receive extensive preservice training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed.

In the 30 states implementing therapeutic foster care, there were 196 programs serving 7,843 individuals. The assessment and monitoring of the fidelity of the programs was conducted by three states using the TFC Fidelity Scale and the Parole Model.

State general funds were used to provide therapeutic foster care services in 26 states, Medicaid in 19, the Federal Mental Health Block Grant in 4, local sources in 4, and various others in 7.

7.5.15 Functional Family Therapy

Functional family therapy is a phasic program where each step builds on another to enhance protective factors and reduce risk by working with both the youth and their family. The phases are engagement, motivation, assessment, behavior change, and generalization.

In the 18 states implementing functional family therapy, there were 62 programs serving 911 reported individuals. Using the FTT Fidelity Scale, five states conducted assessment and monitoring of program fidelity.

State general funds were used to provide functional family therapy services in 19 states, Medicaid in 14, the Federal Mental Health Block Grant in 4, local sources in 4, and various others in 4.

7.5.16 School-Based Interventions

School-based interventions are evidence-based interventions delivered in school settings, such as Incredible Years (a teacher professional development program to prevent and manage disruptive behavioral disorder) or Second Step (a violence prevention program that teaches children to change attitudes and behaviors to reduce aggressiveness).

In the 25 states implementing school-based interventions, there were 1,402 programs serving 44,194 reported individuals. The assessment and monitoring of the fidelity of the programs was conducted by four states using Positive Behavioral Support, Better Attitudes and Skills in Children (BASIC), and Mental Health 101.

State general funds were used to provide school-based intervention services in 17 states, Medicaid in 9, the Federal Mental Health Block Grant in 7, local sources in 6, and various others in 6.

7.5.17 Older Adult Evidence-Based Practices

Only 11 states were implementing any EBPs for older adults. Among those being implemented were: ACT; Family Psychoeducation; CHARG (consumer-

Rhode Island reported an extensive array of older adult EBP programs:

The Pre-Admission Screening and Annual Resident Review (PASARR) program provides training, consultation, and recommendations for treatment planning for nursing facility applicants and residents with mental illness.

The Home Alone Project: Rhode Island Community Mental Health Center (CMHC) Older Adults Services, in collaboration with the Leon Mathieu Senior Center Outreach Program, conducts case findings, outreach, assessment, treatment, and coordination of services for seniors at risk. The project is funded through a grant from the U S Administration on Aging.

Rhode Island CMHC Older Adult Outreach, Emergency Services and Consultation, Gateway Healthcare, Inc., provides master's-level clinician services through the Older Adult Service Program within the CMHC Emergency Department; provides in-home assessments and crisis intervention services as needed.

Rhode Island CMHC Interagency Agreement with visiting nurse agency (VNA); the Visiting Nurse Services of Greater Rhode Island is a Rhode Island CMHC (NRI Community Services, Inc.) that established formal written agreements (referred to as "strategic alliances," "cross referral agreements," "staff leasing contracts") with the VNA and organizations that serve seniors. Example of services include regular team building and mental health emergency consultation to homecare supervisors.

Rhode Island CMHC Agreement With State Department of Elderly Affairs; CRA (casework, referral, and advocacy) is a Rhode Island CMHC (NRI Community Services, Inc.) that provides CRA to an area agency on aging for elders at risk, connecting them to services.

Rhode Island CMHC Agreement with nonprofit assisted living residence; Evergreen House, NRI Community Services, Inc., Housing Corporation, Blackstone Valley Mental Health Realty Corporation, bought, renovated, and rented an assisted living residence (ALR) to another nonprofit agency Community Staffing Resources (CSR). CSR manages the home as a specialized behavioral health in an ALR.

operated service); PATCH Project in Baltimore City; Health Ideas (Self-Management for Depression); Integrated Illness Management and Recovery; Dialectical Behavioral Therapy; OATS Grant, CSAT Tip 26, Older Adults and Substance Abuse; and training on an integrated MH/SA model, STAR model.

Older adult EBPs were planned in 14 states. Among the older adult EBPs that SMHAs were planning to implement were outcome-based treatment, planning (Bartels), supported employment, ACT, integrated mental health/substance abuse services, family psychoeducation, cognitive behavioral therapy (CBT) for older adult services, implementation of SAMHSA toolkit, primary care/mental health integration model, and illness management.

7.5.18 Training for Evidence-Based Practices

States use varying methods to provide ongoing training to providers related to implementing EBPs. Most states (45) use expert consultants, internal staff (43), collaboration with universities (33), and provider-to-provider training (27). Some states also establish research/training institutes to provide training (14), outside accreditation organizations (5), SMHA training institute (1), funding an ACT center to provide training (1), area health education centers (1), family-to-family training (1), and outside conferences/trainings (1). Half of the states (25) are working with academia to develop curricula to reflect EBPs, promising practices, and value-based practices.

Half of the SMHAs (26) provide training for their workforce for child and adolescent EBPs. Some SMHAs provide training for consumers (15) and family members (17) for child and adolescent EBPs. Most SMHAs (34) provide training for their workforce for adult EBPs. Half of the SMHAs provide training for consumers (24) and family members (22) for adult EBPs. Some SMHAs

(10) provide training for their workforce, for consumers (5), and for older adult EBPs (6).

7.5.19 Barriers to Implementing Evidence-Based Practices

Nearly all states have experienced barriers to implementing EBPs. The most reported barriers were shortages of an appropriately trained workforce (46 states), attaining or maintaining fidelity to their EBP model standards (45), financing programs (44), the modification of the EBP model to meet local needs (37), and resistance by providers to implementing practices (32). Other barriers included defining/treating, measuring practices, the need for revisions to Medicaid rules, lack of consumer and family advocacy, and unknown cost/benefit tradeoffs based on implementation.

7.5.20 SMHA Initiatives to Support the Adoption of Evidence-Based Practices

All reporting states have initiatives to promote the adoption of EBPs. Most states have undertaken consensus-building among stakeholders (45), promoting awareness and providing training (42), monitoring the fidelity of practices (35), and incorporating EBPs into contracts with service providers (31). Many states are modifying information systems and data reports (27) and specifically requesting funding for EBPs in their SMHA budgets (26). Some states are providing financial incentives to service providers to provide EBPs (13). Other states are establishing a best practice advisory committee under a court mandate to provide EBPs, providing technical assistance to service providers, developing an SMHA EBP workgroup, establishing a wellness and recovery implementation committee, providing specialized assistance in change management, providing training to parent groups, publishing a quarterly best-practices newsletter, and establishing stakeholder groups.

7.5.21 Emerging Evidence-Based Practices

Emerging EBPs and innovative practices are practices for which the research evidence base has not been finalized but appears very promising. Most SMHAs (34) are implanting or providing emerging EBPs or other innovative practices.

Among the emerging EBPs states are pursuing for children and adolescents are: trauma treatments, in-home intervention, aggression replacement, dialectical behavior therapy, child and family wraparound teams, restraint reduction using the National Technical Assistance Center (NTAC) principles, child psychiatric rehabilitation, intensive home-based treatment, parents and child interactive therapy, juvenile justice diversion, suicide prevention, peer support, CBT, children's ACT, consumer-run services, psychosocial rehabilitation, transition to independence, collaborative problem-solving, restraint reduction, and school-based mental health services.

Among the emerging EBPs states are pursuing for adults are: peer-led support groups; employment/psychiatric rehabilitation; self-help centers; Wellness and Recovery Action Plans (WRAP); restraint reduction; family functional therapy; Procovery; jail diversion/reentry programs; Native American traditional practices; consumer assistance; integrated services for mental illness/mental retardation/ developmental disabilities; supported education; Fair Weather Lodge; trauma screening; wellness clinics; recovery education; leadership academies; specific mental illness/substance abuse treatment; cultural enhancements to treatment;

dialectical behavior therapy; sequential intercept model/CIT crisis intervention; strengths-based case management; Compeer, peer support; person-centered planning; tribal integration in planning; consumer assessment; motivational interviewing; consumer-run drop-in centers; and suicide prevention.

Among the emerging EBPs that states are pursuing for older adults are: integrated mental health/primary care, cultural enhancements to family psychoeducation, outreach, PATCH project in senior housing, geriatric specialty teams, and Real Choice Grants.

7.5.22 Clinical Practice Guidelines

Clinical practice guidelines and treatment recommendations, based on research results regarding their efficacy, have been developed regarding particular treatments or medications. Most SMHAs (26) are engaged in education and/or dissemination activities related to clinical guidelines and treatment recommendations. Twenty-three SMHAs reported using clinical guidelines and treatment recommendations: 11 were following the American Psychiatric Association, 9 were following the Texas Medication Algorithm Project (TMAP), and 8 were using the schizophrenia Patient Outcome Research Team (PORT).

Individual SMHAs were also following guidelines and recommendations of:

- Consensus "Tri-University" Project, American Society of Addiction Medicine
- DMHAS Recovery Guidelines
- Florida Psychotherapeutic Guidelines
- NASMHPD, TIP 42
- Psychopharmacological Guidelines, Minkoff (1998)
- Sowers and Gold (1999)
- AMHD, Comprehensive Neuroscience (CNS) Clinical Indicators
- New Jersey DMHS Pharmacological Practice Guidelines for the Treatment of Schizophrenia
- New York Medication Algorithm Project
- South Carolina Medication Algorithm Project
- Psychotropic Medication Utilization Parameters for Foster Children
- Texas Department of State Health
- Hawaii Interagency Performance Standard and Practice Guidelines, CAMHD
- Texas Resiliency and Disease Management (Clinical Guidelines)

Several states are using multiple clinical guidelines. In Arizona, "Guidelines are published via website links to originating source or, if proprietary, purchased for use. All clinical improvement guidelines are matched/compared prior to implementation to ensure consistency." Connecticut is "allowing a decentralized approach to the use of clinical and recovery guidelines." In New Jersey, "For the guidelines, the Division's work group looked at the American Psychiatric Association guidelines for the treatment of schizophrenia and Texas Medication Algorithm Project (TMAP). Some aspects of these two guidelines were incorporated into the DMHS guidelines." In New Mexico, the Addiction Severity Index (ASI) measures client change over time, and the American Society of Addiction Medicine's (ASAM) patient placement criteria are used for patient placement.

State Examples of Goal 5 Initiatives

Maryland: *The SMHA Partnership with the University of Maryland School of Medicine, Division of Mental Health Services Research, serves to coordinate training/workforce development; train providers in EBPs; and perform system evaluation/outcome studies. The SMHA partnership with the University of Maryland and Johns Hopkins University Departments of Child Psychiatry and Maryland Coalition of Families for Children's Mental Health serves to implement identified child EBPs and conduct practice-based research.*

North Carolina: *The North Carolina Practice Improvement Collaborative brings together researchers, mental health service providers, consumers, and families to identify and make recommendations regarding EBPs for implementation.*

Tennessee uses them as part of best practice guidelines that are made available to providers of behavioral health across the state. In Vermont, "These guidelines are distributed to the CMHCs for their use. If cases have a problematic outcome, the CMHCs are requested to review the application of the guidelines to that situation as part of the review to assure appropriate outcomes."

Clinical guidelines have been selected or adopted as official state policy in 10 states for the treatment of persons with particular mental disorders. Colorado has adopted the best practice guidelines of the American Psychiatric Association. Florida has adopted guidelines in conjunction with Medicaid. In Hawaii, "Minkoff's CCISC, Continuous Comprehensive Integrated System of Care (Adult Mental Health) and Hawaii's Interagency Performance Standard and Practice Guidelines are attached to all contracts (children's MH)." New York supports consultation with the OMH facilities to develop quality assurance (QA) indicators and certification requirements. Rhode Island has adopted PACT and Individual Placement Support (IPS) for individuals who are severely and persistently mentally ill (SPMI). Texas has adopted TMAP and resiliency and disease management (RDM). Utah has adopted guidelines "not in community mental health centers but in the state hospital." Vermont has adopted guidelines "for schizophrenia, major depressive disorder, bipolar disorder, and borderline personality disorder."

Clinical guidelines are being used by mental health programs funded, but not operated, by the SMHA in 16 states, and by community mental health programs operated by the SMHA in 10 states. Clinical guidelines are being used in all parts of state inpatient psychiatric facilities in 14 states. In six states, they are used in certain units in state psychiatric facilities, such as adult treatment units.

Most of the states using clinical guidelines are using them for schizophrenia (22), mood disorders (17), and bipolar disorder (13). Many of the states are also using them for dual disorders (mental and addictive) (12), major unipolar depression (11), alcohol abuse and dependence (10), substance abuse and dependence (8), and anxiety disorders (7). Some states are also using them for other psychiatric disorders (6), such as Axis II (Personality and Mental Retardation Disorders) in Diagnostic and Statistical Manual of Mental Disorders (DSM) and borderline personality disorder and dementia (1). Individual states are using clinical guidelines for DSM V-codes (V Codes are defined in the DSM-IV as "other conditions or problems that may be a focus of clinical attention," such as "Noncompliance With

Treatment" or "Parent-Child Relational Problems") related to parent/child, disruptive behavior or misconduct, attention deficit disorder, and internal and externalizing disorders for children.

7.6 Goal 6: Technology Is Used to Access Mental Health Care and Information

Goal 6 is subdivided as follows:

6.1 Use health technology and telehealth to improve access and coordination to mental health care, especially for Americans in remote areas or in underserved populations.

6.2 Develop and implement integrated electronic health record and personal health information systems.

In 41 states (82 percent), technology is being used by SMHAs to help consumers access mental health care and treatment information. In 42 states, SMHAs are using technology and the Internet to provide consumers with information about where and how to access care. Forty-one states are providing information about mental illnesses. Seven states are working to make electronic personal health information accessible to consumers.

Forty SMHAs have initiatives to use the SMHA's website to promote education about mental health treatments, services, and eligibility (see Table 26). In 21 states, the SMHA sponsors a call center to provide information about mental health treatments and eligibility.

Table 26: Type of Information the SMHA Makes Available via the Internet

Activities	Number of States
SMHA provides or assists organizations in obtaining training materials for clinical staff in the use of interpreters	20
SMHA provides or helps organizations to obtain educational materials translated into identified languages	19

7.6.1 Telemedicine

Most SMHAs (90 percent or 44 states) are now engaged in activities to promote the use of telemedicine to provide mental health services (see Figure 26). In 33 states, the state Medicaid Agency reimburses for mental health telemedicine services. In 28 states, the SMHA itself reimburses for telemedicine mental health services. There are four states (Arizona, Massachusetts, Oregon, and Tennessee) that have recently changed licensure or scope-of-practice restrictions to promote and encourage the use of telemedicine.

7.6.2 Electronic Health Records

Almost all (94 percent) of the reporting 50 states are implementing or considering the adoption of an electronic health record (EHR) in their state psychiatric hospitals and/or community mental health system (see Figure 27).

Four states reported they are already operating an EHR with all components in their state psychiatric hospitals, while 19 states reported they have an EHR with some components implemented. Nine additional states reported they are currently installing an EHR system in their state psychiatric hospitals, and 14 states are currently considering the adoption of an EHR in their state psychiatric hospitals (see Figure 28).

Twenty-one states reported they have EHRs installed and operating in the community mental health providers that are part of the SMHA-funded-or-operated

Figure 26: SMHA Uses or Promotes Telemedicine for Mental Health

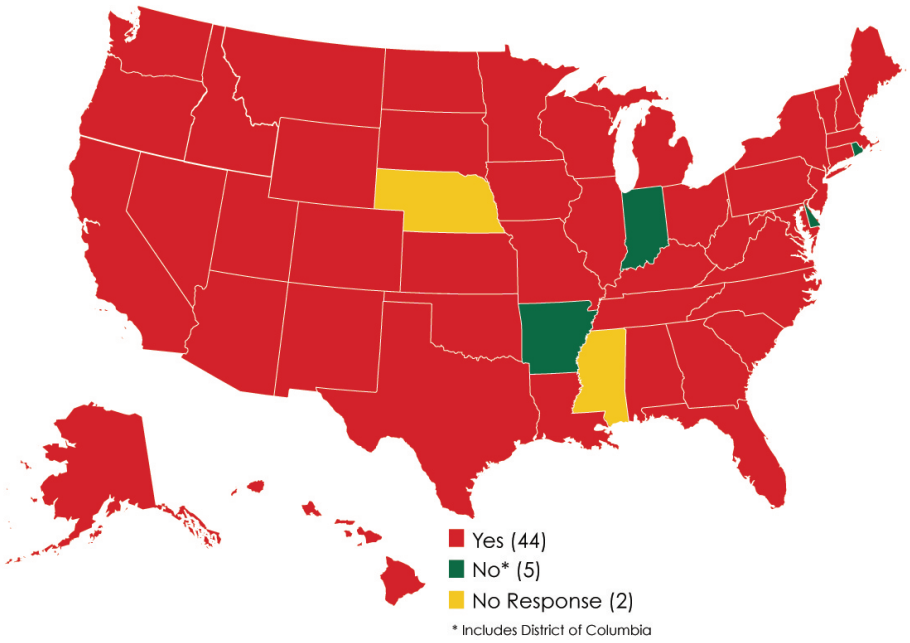


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Figure 27: Implementation of EHRs

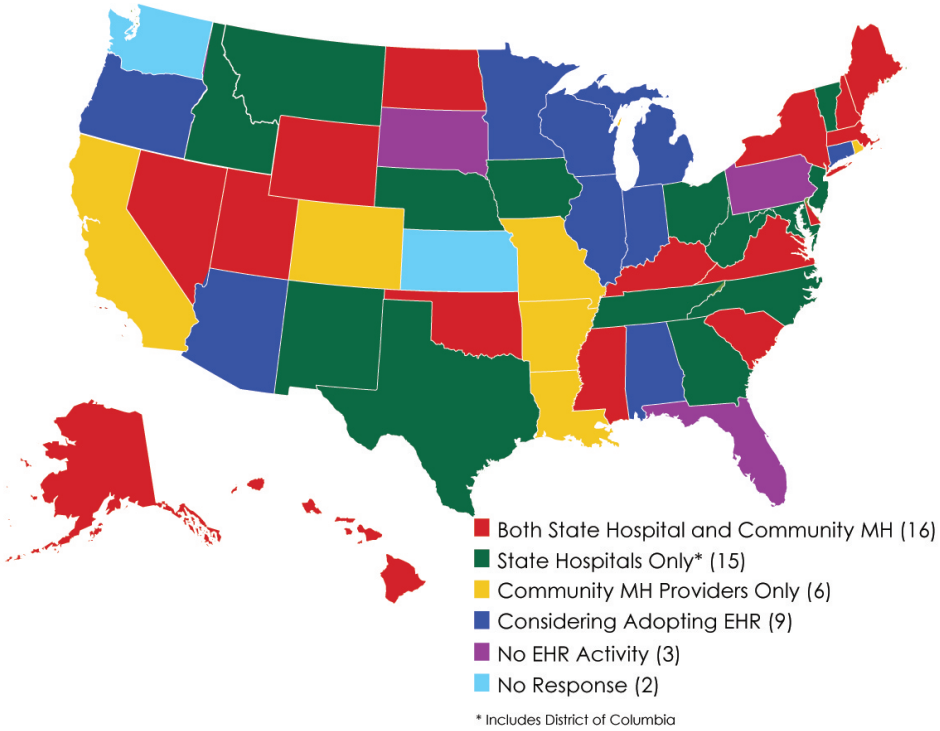

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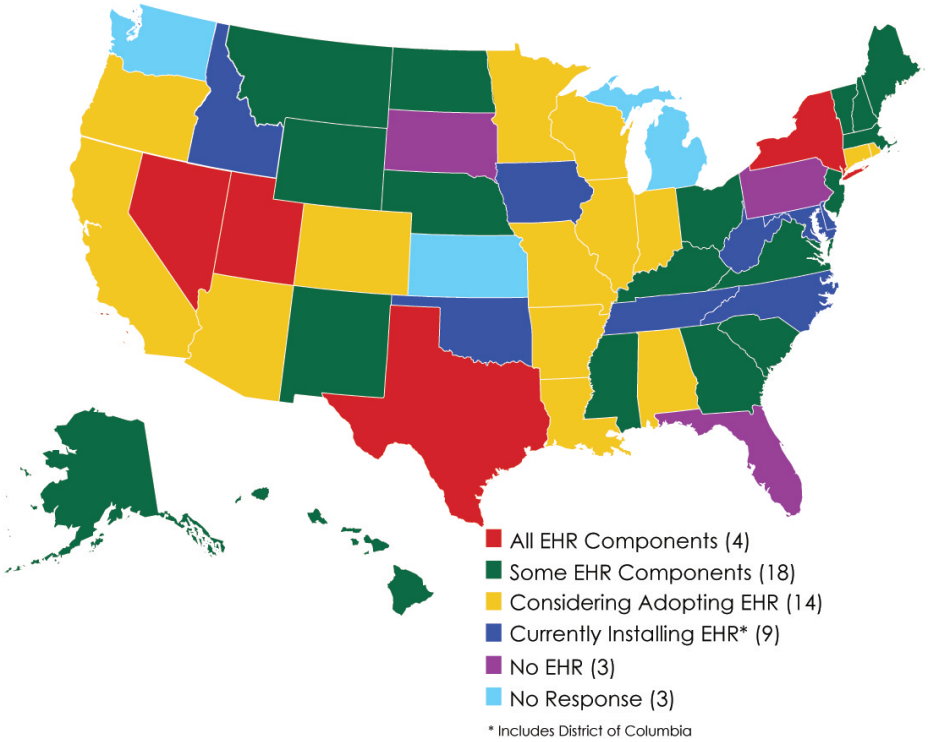
Figure 28: EHR Status in State Psychiatric Hospitals



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure28.html

system, and four states reported EHRs are being installed. An additional 11 states are currently considering the adoption of an EHR in their community mental health provider systems. In four states (the District of Columbia, North Dakota, Nevada, South Carolina), a single EHR system is used for all community mental health providers (all of which are operated by the SMHA), while in most states (33), community providers use a variety of EHR systems.

7.6.3 Implementation of EHR Components

Electronic health records have a variety of components that may be implemented by mental health providers, and many providers have only implemented selected components. The level of implementation of components varies widely in either state psychiatric hospitals or community programs. The most commonly implemented components are electronic patient admission, discharge, transfer components, billing components, reporting systems, progress/case documentation, and pharmacy. The least implemented components are exchanging electronic client information with other providers for external consultations and medication algorithms (see Table 27).

7.6.4 Sharing EHR Information

Twenty states have agreements that allow the sharing of EHR client data between providers to improve care. In 18 states, these agreements allow the sharing of client EHR information among the state psychiatric hospitals within the SMHA system. In the States of North Dakota, South Carolina, Texas, Utah, and Virginia, these agreements allow sharing information between community mental health providers and state psychiatric hospitals, while the State of New

Table 27: EHR Modules Implemented in State Psychiatric Hospitals and Community Mental Health Providers

EHR Components	State Hospitals		Community Providers	
	N	Percent	N	Percent
Patient admissions, discharge, transfers	27	84%	16	76%
Pharmacy	23	72%	5	24%
Billing as part of EHR system	23	72%	14	67%
Reporting	20	63%	16	76%
Progress/case documentation	18	56%	17	81%
Treatment planning	16	50%	14	67%
Physician order entry	17	53%	5	24%
Clinical assessments	17	53%	15	71%
Scheduling	12	38%	12	57%
Dietary	14	44%	2	10%
Medication algorithms	9	28%	2	10%
Exchanging client info with other providers	3	9%	5	24%
External consultations	2	6%	4	19%
Other EHR functions	1	3%	3	14%

York allows the sharing of EHR client information between state psychiatric hospitals and general hospitals. In Colorado, there is an agreement to allow sharing of EHR client information between HMOs and other managed care firms that are part of the public mental health system and the SMHA (see Table 28).

Fourteen states (Arkansas, California, Georgia, Maine, Michigan, Ohio, Oklahoma, Rhode Island, Tennessee, Utah, Virginia, Vermont, Wyoming, and the Virgin Islands) have a Regional Health Information Organization (RHIO) that includes mental health in its plans to share electronic health information. Several other states are beginning to assess the inclusion of mental health information in an RHIO.

Table 28: Sharing EHR Information

Sharing EHR Information Between:	N	Percent
State hospitals within the State	18	55%
Community providers and state hospitals	5	16%
Community providers	5	17%
HMOs, other MCOs, and the SMHA	1	3%

7.6.5 Reported Benefits of Using EHRs

SMHAs reported a variety of benefits from implementing and using EHR systems. The major benefits reported include improved reporting capabilities (17 states), enhanced quality assurance (14 states), improved productivity (13 states), and reduced billing errors (12 states).

7.6.6 Electronic Pharmacy/Medication Ordering System

Twenty-six states reported they have implemented an electronic pharmacy/ medications ordering system in their state psychiatric hospitals, while five states have implemented this system in their community mental health providers. The electronic pharmacy/medications ordering system software being used by states includes HCS, Meta, Mediworx/Pyxis® system, QSI, Quadramed, and WORXS.

7.6.7 Medication Administration Recording

Eleven states reported they have implemented the medication administration recording (MAR) system in their state psychiatric hospitals (Arkansas, Alabama, Connecticut, Indiana, Maine, New Hampshire, Nevada, Ohio, Utah, Vermont, and Wyoming), while no state reported having MAR systems in community providers.

7.6.8 Electronic Personal Health Records

SMHAs are in the early stages of implementing electronic personal health

State Examples of Goal 6 Initiatives

California: *The SMHA, through the Mental Health Services Act, is promoting and funding development of EHRs that will increase access to information. The SMHA also funded development of care in every county. The California Department of Mental Health's website (http://www.dmh.ca.gov/Links/default.asp) provides access to a broad range of information on effective treatment and available services.*

North Dakota: *The North Dakota Department of Human Services has implemented an electronic record at the regional human service centers. The Department's website offers a wide range of information on services provided.*

South Carolina: *Through telemedicine, services of psychiatrists fluent in American Sign Language (ASL) are provided to all deaf DMH clients. There is ongoing work toward having "telepsych" consultations available to all emergency rooms. South Carolina's DMH is implementing electronic medical records to have information available to on-call staff. This will be linked to the DHHS database to provide more medical information to facilitate service delivery in the mental health clinics and emergency departments.*

records (PHRs). The State of Missouri reported being in the processes of implementing a PHR, and Oklahoma is designing a PHR system for mental health clients. The SMHAs in California, Montana, New Jersey, Ohio, and Utah are working with other providers to support PHRs, while Connecticut's Children's Mental Health Department, Maryland, and Virginia are planning on implementing PHR systems.

VIII. SMHA Financing of Mental Health Services

This section provides a discussion of the funding sources and expenditures of SMHAs.

8.1 Mental Health Expenditures Controlled by State Mental Health Agencies

In state FY 2005 (the fiscal year that ended during calendar year 2005), the 50 states and the District of Columbia spent over $29.4 billion to provide mental health services. States averaged mental health expenditures of $100 per every resident in their state, and SMHA expenditures for mental health averaged almost 2 percent of total state government expenditures. Because of differences in how SMHAs are organized and structured, the types of mental health services offered and the priority populations covered by states, there is considerable variation in the level of expenditures among the states. State mental health expenditures ranged from less than $60 per state resident to over $200 per resident in several states (see Figure 29). In FY 2005, SMHAs reported they provided mental health services to nearly 6 million persons (CMHS, 2008). The average expenditure per mental health service recipient was $4,738, and the median was $4,074 per client served.

8.2 Change in SMHA-Controlled Expenditures Over Time

From FY 2001 to FY 2005, SMHA-controlled expenditures for mental health services increased from $23.1 billion to $29.4 billion (see Figure 30). This was an increase of 27.9 percent or an average annual increase of 6.3 percent. Adjusted for inflation, expenditures increased only 8 percent or an average annual increase of 1.9 percent. From FY 2001 to FY 2005, 46 SMHAs increased mental health expenditures, while 5 decreased their expenditures. During the last year (from FY 2004 to FY 2005), 46 SMHAs reported an increase in total mental health expenditures, while 5 states reported a decline in mental health expenditures. Controlling for inflation, total SMHA-controlled expenditures failed to keep pace with inflation since FY 2001 in 23 states, while in 28 states the expenditures surpassed inflation.

From FY 2001 to FY 2005, expenditures for community mental health services increased by 8.2 percent per year, while state psychiatric hospital-inpatient expenditures

Figure 29: Total FY 2005 SMHA-Controlled per Capita Mental Health Expenditures (in Billions)

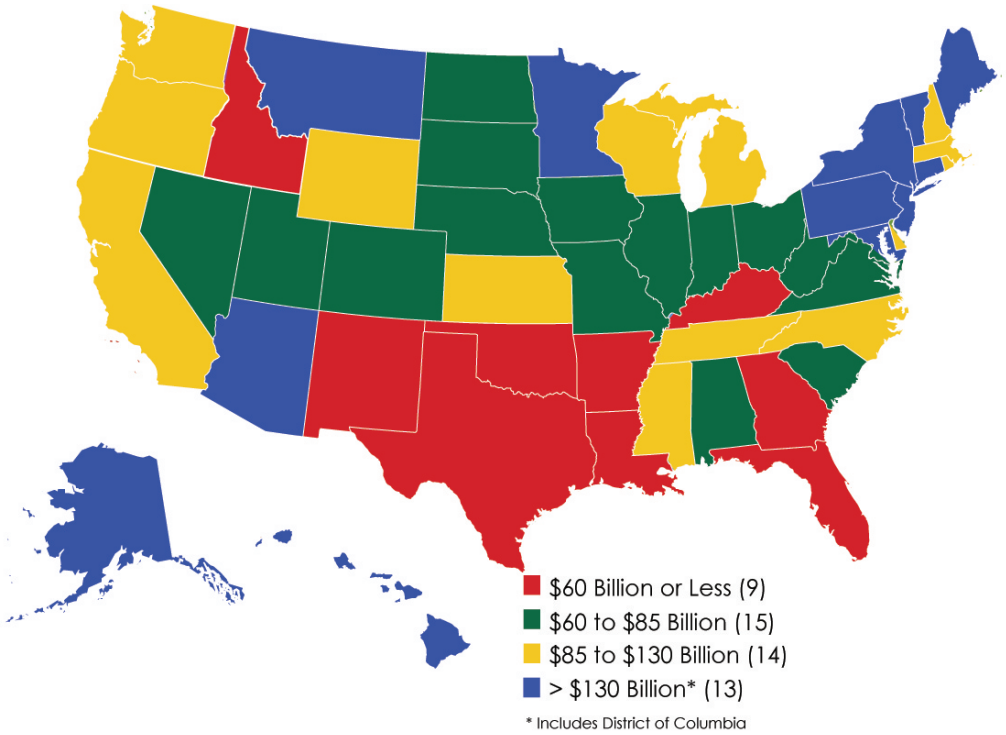


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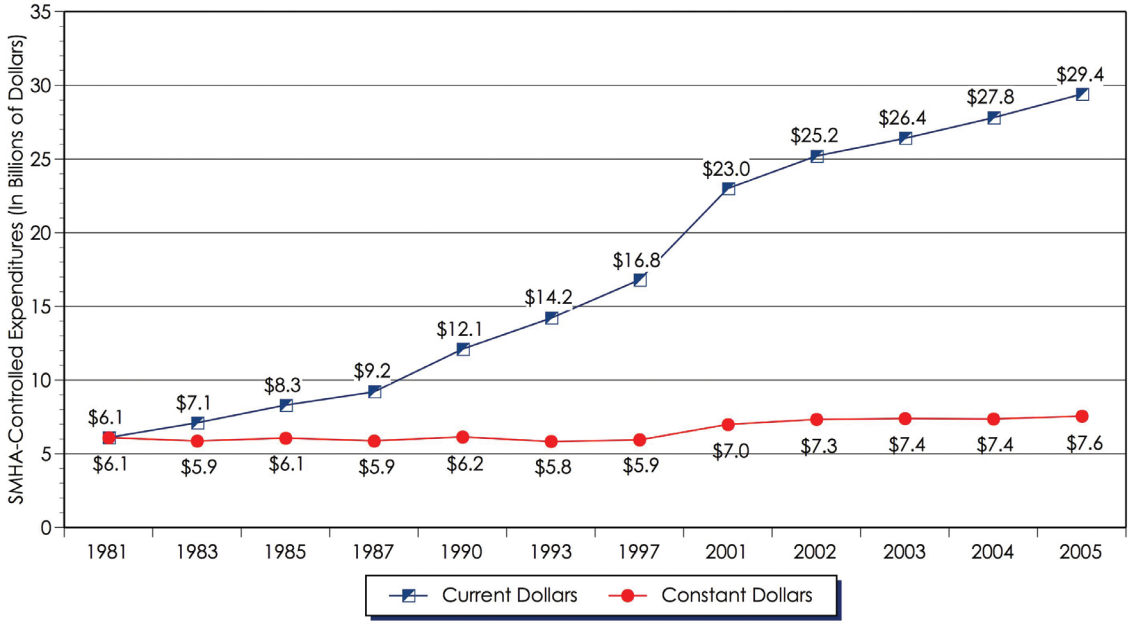
Figure 30: Trend in SMHA-Controlled Mental Health Spending, FY 1981 to FY 2005



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increased 2.8 percent per year over the 4 years. When controlled for inflation and population growth, community mental health expenditures increased 2.6 percent per year, while state psychiatric hospitals declined by 2.5 percent per year.

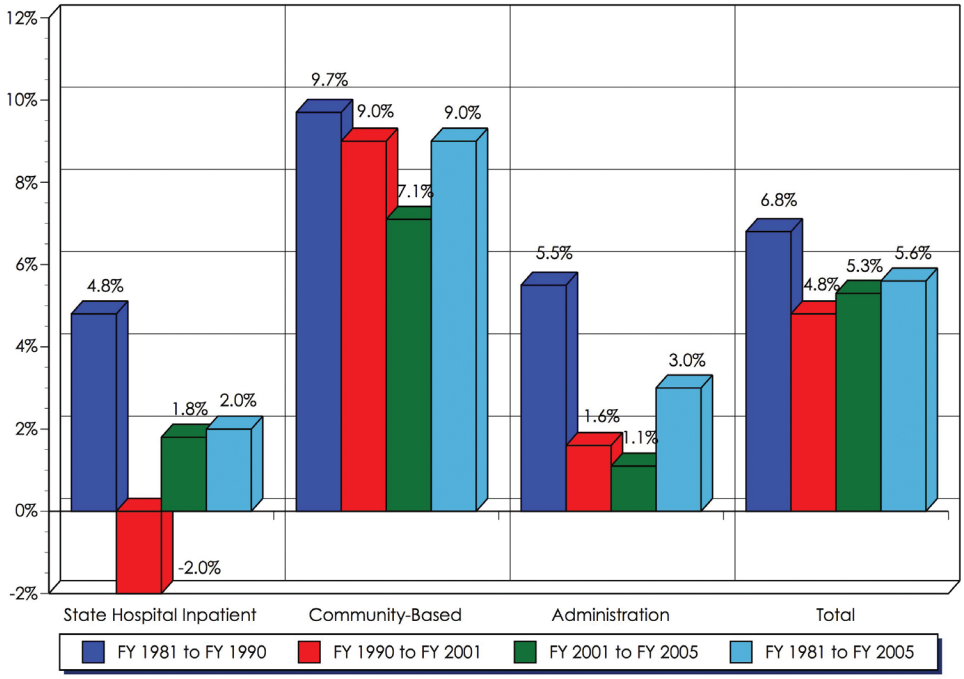
From FY 2001 to FY 2005, 46 SMHAs increased their expenditures for community mental health services, while 5 SMHAs decreased these expenditures. Forty SMHAs increased their psychiatric-inpatient hospital expenditures, while 11 decreased their expenditures. Since FY 2001, inflation-adjusted expenditures for community mental health increased in 32 states, while they declined in 19 states. Inflation-adjusted state psychiatric hospital expenditures declined in 36 states and increased in only 15 states.

Over the 24-year period from FY 1981 to FY 2005, SMHA-controlled expenditures increased from $6.1 billion to $29.4 billion, an increase of 382 percent (an average annual rate of 6.8 percent) (see Figure 31).

However, when SMHA expenditures are adjusted for inflation, total SMHA-controlled expenditures increased by only 23.6 percent over the last 24 years (an annualized increase of 0.9 percent). When SMHA expenditures are adjusted for inflation and population growth, SMHA expenditures declined slightly (down 4.6 percent over the 24 years or 0.2 percent per year).

From FY 1981 to FY 2005, community mental health expenditures increased from $2 billion to over $20.5 billion, an increase of 916 percent (an average increase of 10.1 percent per year). When community mental health expenditures are adjusted for population growth and inflation, they increased by 101 percent (an average annual increase of 3 percent). During this same

Figure 31: Average Annual Change in SMHA-Controlled Mental Health Expenditures, 1981 to 2005, by Decade and Type of Program



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25-year time interval, state psychiatric hospital-inpatient expenditures increased from $3.8 billion to $8 billion, an increase of 108.5 percent (an average annual increase of 3.1 percent per year). When state psychiatric hospital-inpatient expenditures are adjusted for both population growth and inflation, expenditures actually decreased by 58.7 percent (an average annual decrease of 3.6 percent).

8.3 Shift From State Psychiatric Hospital-Based Services to Community-Based Mental Health

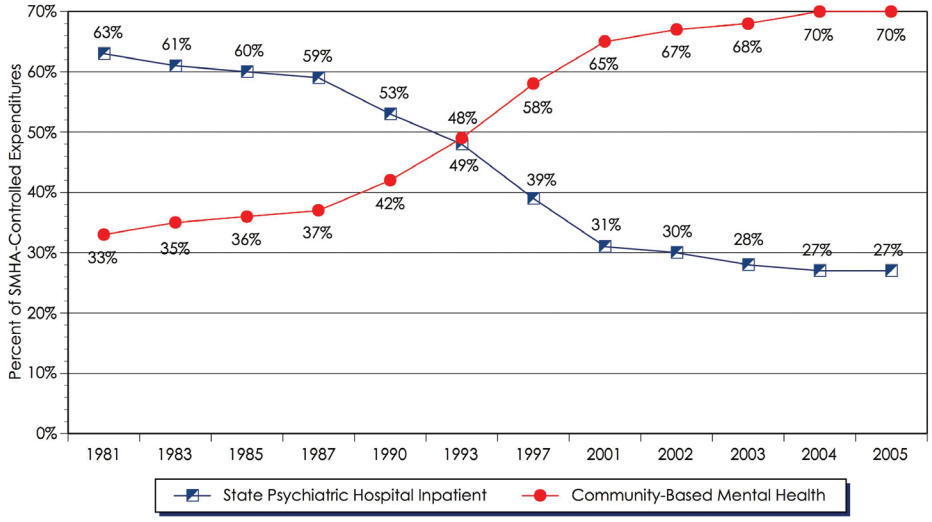
Over the last quarter century, SMHAs have shifted their treatment paradigm to focus on providing comprehensive mental health services in the community. As a result, community mental health expenditures have grown much faster than state psychiatric hospital expenditures. In FY 2005, community mental health expenditures accounted for 70 percent of total SMHA-controlled expenditures, and state psychiatric hospital-inpatient expenditures were 27 percent. This is an historic shift from FY 1981, when community-mental health expenditures accounted for 33 percent of SMHA expenditures and state psychiatric hospitals were 63 percent of expenditures. FY 1993 was the year when community mental health expenditures first equaled state psychiatric hospital-inpatient expenditures (Figure 32).

8.3.1 Variations in SMHA Expenditures

The $29.4 billion in SMHA-controlled expenditures in FY 2005 amount to $99.55 per every civilian resident of the United States. The median state—the point where 25 states were above and 25 states were below—expended $89.19 per capita. There was wide variation among states in their per capita expenditures ($24.23 in New Mexico to $269.64 in Alaska). See Figure 33 and Tables 29 through 33 for individual state data.

SMHAs also varied widely in the distribution of their mental health expenditures between community-based services and state psychiatric hospitals. The national average was 70 percent of SMHA-

Figure 32: SMHA Expenditures for State Psychiatric Hospital Inpatient and Community-Based Services as a Percent of Total Expenditures: FY 1981 to FY 2005



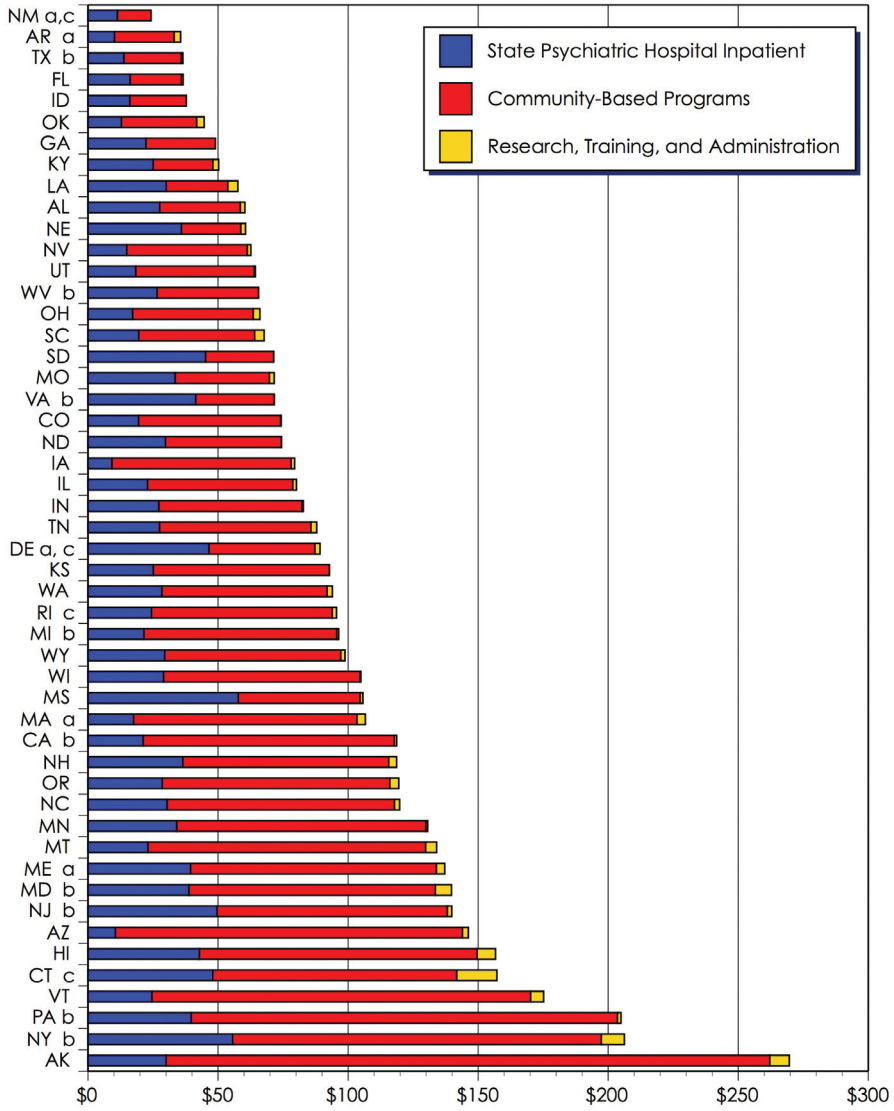
Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure32.html

controlled funds spent on community mental health services, which ranged from 91 percent (in Arizona) to 37 percent (in South Dakota).

8.4 SMHA-Controlled Expenditures by Type of Mental Health Service

States expended the majority of their mental health services monies on community-based ambulatory (less than 24-hour) services, a category that includes individual and group outpatient services, partial-day treatment, medication maintenance visits, and a host of other ambulatory services (including various EBPs such as ACT, supported employment, and integrated dual

Figure 33: FY 2005 SMHA-Controlled Per Capita Expenditures for Mental Health Services



a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.
c = Children's mental health expenditures are not included in SMHA-controlled expenditures.

Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure33.html

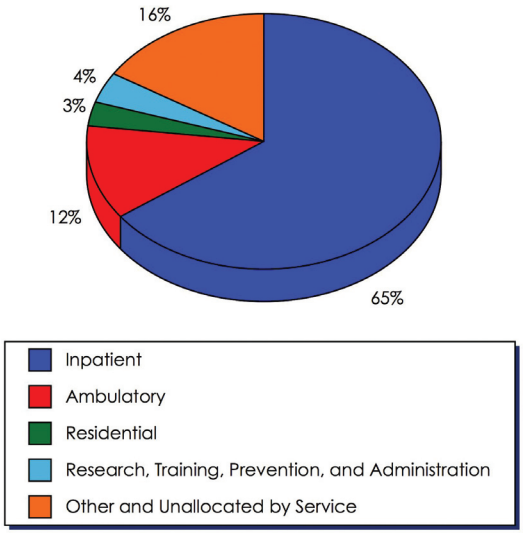
diagnosis treatment). In FY 2005, SMHAs reported they expended $12.8 billion on ambulatory services (44 percent) of total SMHA expenditures. Almost all (97.5 percent) of the ambulatory services were provided by community-based providers, but in some states, the state psychiatric hospitals provided outpatient and other ambulatory services. In FY 2005, state psychiatric hospitals provided $339 million worth of ambulatory services.

Psychiatric inpatient expenditures were the second largest type of service reported by SMHAs. In FY 2005, $10.5 billion (36 percent of total SMHA expenditures) was expended on inpatient services. Although the majority of these inpatient services were provided in state psychiatric hospitals ($8 billion), a substantial amount ($2.5 billion or 23.5 percent) of inpatient expenditures was provided by community-based providers including CMHCs and general hospitals.

Residential services accounted for $3 billion of SMHA expenditures in FY 2005 (10 percent of total SMHA expenditures). Although the majority of residential services were provided by community-based providers ($2.66 billion), $295 million worth of services were provided at state psychiatric hospitals. In FY 2005, $2.4 billion (8 percent) in SMHA expenditures were reported as either an "other" type of service or the SMHA was unable to allocate expenditures by service type.

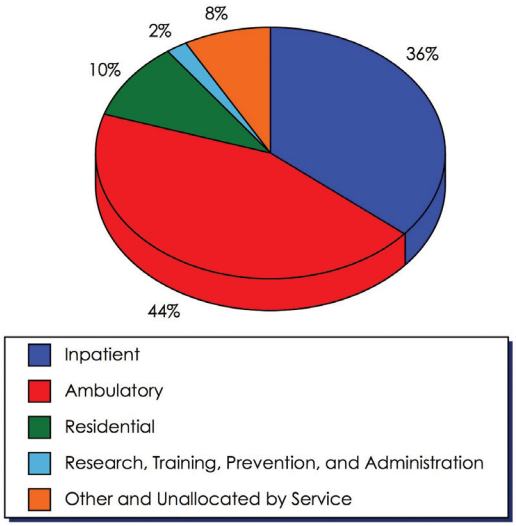
Since FY 1981, SMHAs have steadily shifted from providing inpatient services in state psychiatric hospitals to a system that provides more community-based ambulatory services. In FY 1981, only 12 percent of SMHA expenditures were reported in the ambulatory service category, while 65 percent of total expenditures were reported for "inpatient" services (see Figures 34, 35, and 36 and Tables 39 and 40).

Figure 34: SMHA-Controlled Mental Health Expenditures by Type of Service: FY 1981



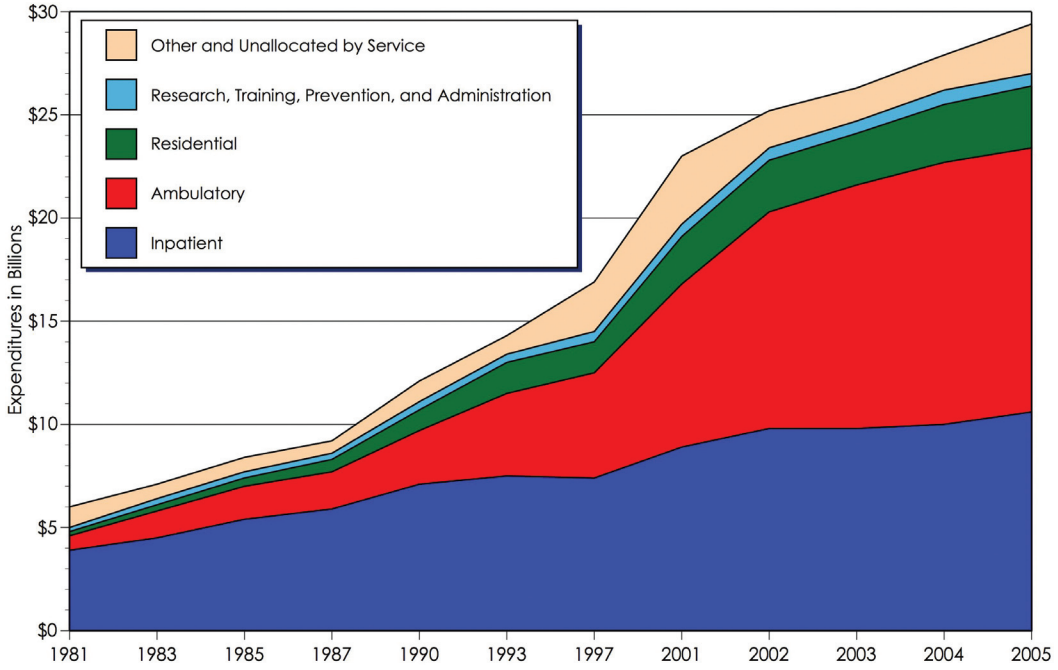
Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure34.html

Figure 35: SMHA-Controlled Mental Health Expenditures by Type of Service: FY 2005



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure35.html

Figure 36: SMHA-Controlled Expenditures by Type of Mental Health Service: FY 1981 to FY 2005 (in Billions)



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure36.html

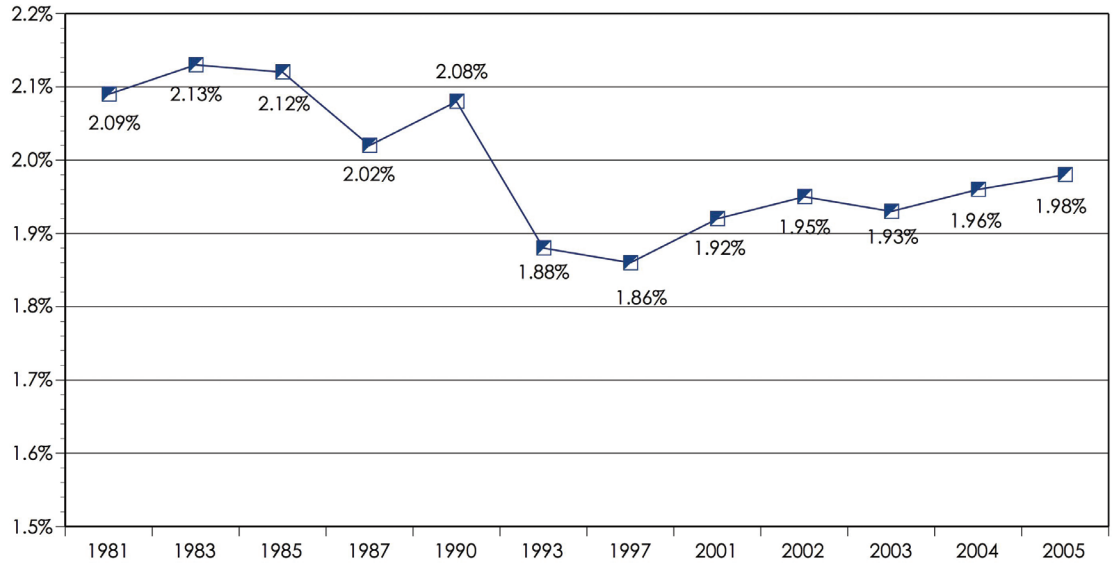
8.5 SMHA-Controlled Mental Health Spending and Total State Government Expenditures

Over the last quarter century, total state government expenditures for all purposes have grown at a faster rate than SMHA-controlled expenditures. According to the US Census Bureau's annual report on state government finances, in FY 1981, state governments expended $291.5 billion for all their operations. In FY 1981, SMHAs reported expenditures for mental health of $6.1 billion, which represented 2.09 percent total state government expenditures. Twenty-four years later, SMHA-controlled expenditures for mental health were 1.98 percent of total state government expenditures (see Figure 37). If SMHAs had received in FY 2005 the same percentage of total state expenditures, their expenditures would be $1.4 billion, or over 5 percent higher than reported for FY 2005.

Over the last 15 years, SMHA expenditures as a share of total state government expenditures have increased slightly. This growth is largely due to the increase in SMHA revenues from Medicaid. State general fund expenditures for mental health have increased more slowly than state general fund expenditures for other state services over this time period (see Table 29).

Since FY 1997, total SMHA expenditures for mental health increased at 9 percent per year, a faster annual growth than overall state government (which grew 7 percent per year), and a rate that was only matched by state spending for higher education. However, over this time period, most of the growth of funds came from Federal sources (up 12 percent per year), while state

Figure 37: Total SMHA-Controlled Mental Health Expenditures as a Percent of Total State Government Expenditures: FY 1981 to FY 2005



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure37.html

government funding increased only 6 percent per year, a rate of increase below that of total state government (where state government sources increased at a rate of 7 percent per year).

Figure 38 shows that SMHA spending as a percentage of total state government varies widely across the states. Pennsylvania and New York devoted the highest percent of state budgets to mental health, while New Mexico, West Virginia, and Arkansas reported the lowest share of state expenditures.

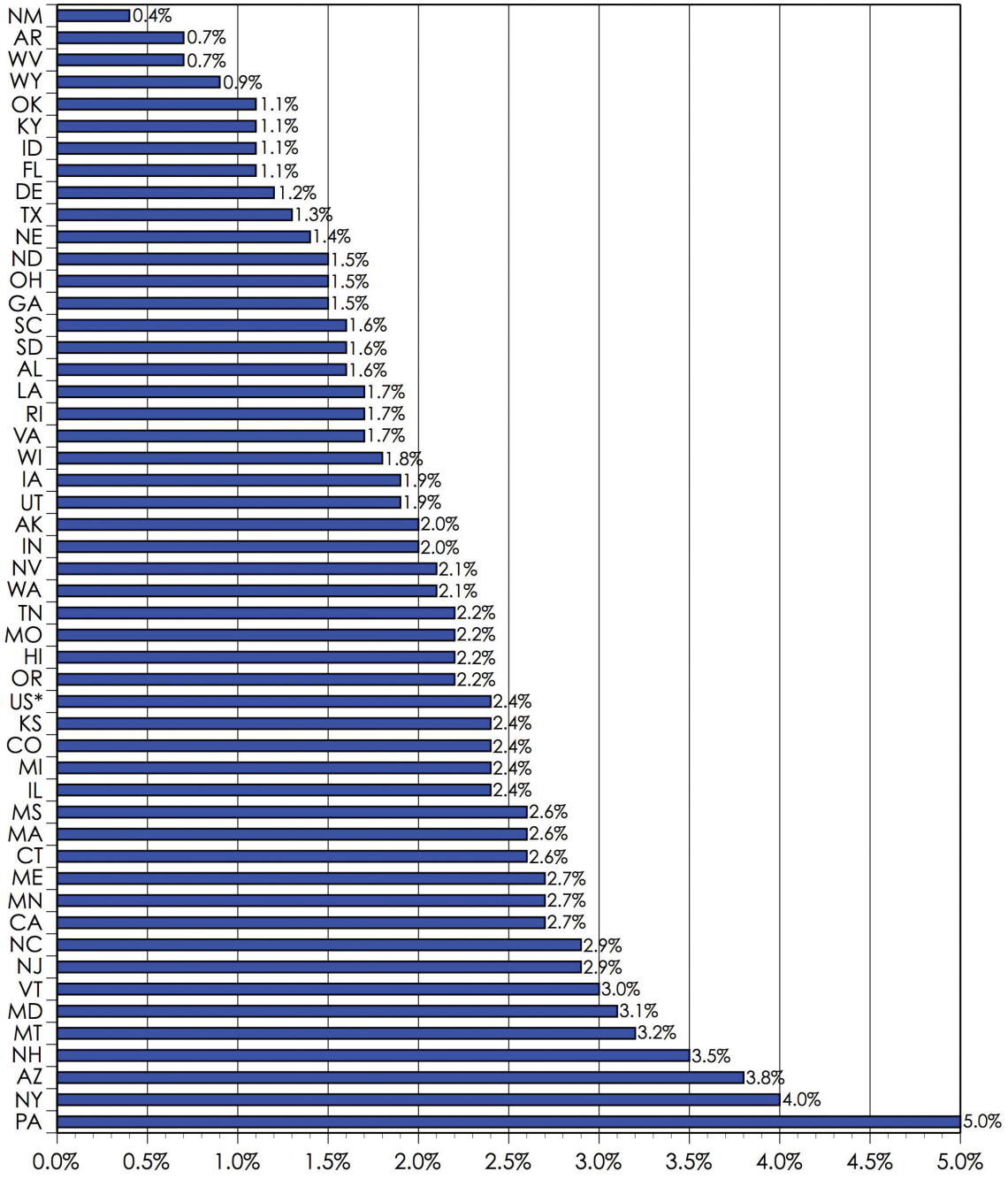
8.6 State Tax Dollars Remain the Major Source of Funding of SMHAs

In FY 2005, 63 percent of SMHA funding came from state government sources. This is a slight decline from 67 percent in FY 2001. In FY 2005, state tax dollars accounted for $18.8 billion of funding for SMHA mental

Table 29: Average Annual Change in State Government Expenditures: FY 1997 to FY 2005

	Average Annual FY 1997 to FY 2001			Annual FY 2001 to FY 2005 Change		
	State Funds	Federal Funds	Total	State Funds	Federal Funds	Total
Total state government	7%	7%	7%	4%	8%	5%
K–12 education	7%	8%	8%	3%	12%	4%
Higher education	7%	25%	9%	2%	4%	3%
Public assistance	-3%	0%	-2%	1%	4%	2%
Medicaid	6%	7%	7%	10%	9%	9%
Corrections	8%	1%	7%	3%	8%	3%
Transportation	5%	10%	7%	3%	6%	4%
Capital	11%	7%	9%	-3%	6%	2%
All other	8%	5%	7%	3%	7%	4%
SMHA	6%	12%	9%	5%	8%	6%

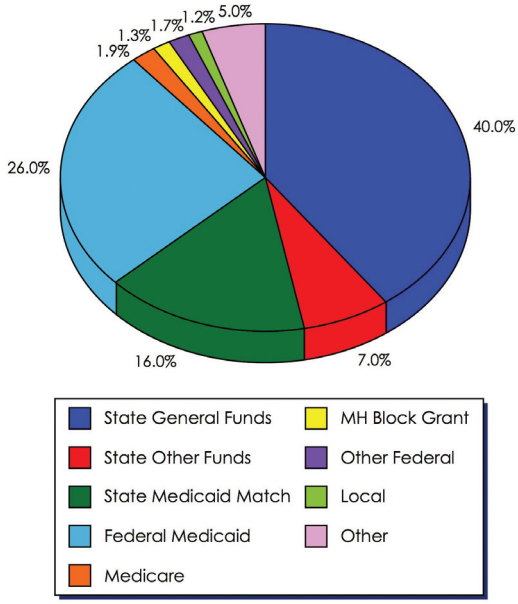
Figure 38: SMHA-Controlled Expenditures as a Percent of Total State Government Expenditures: FY 2005



* = US Average

Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure38.html

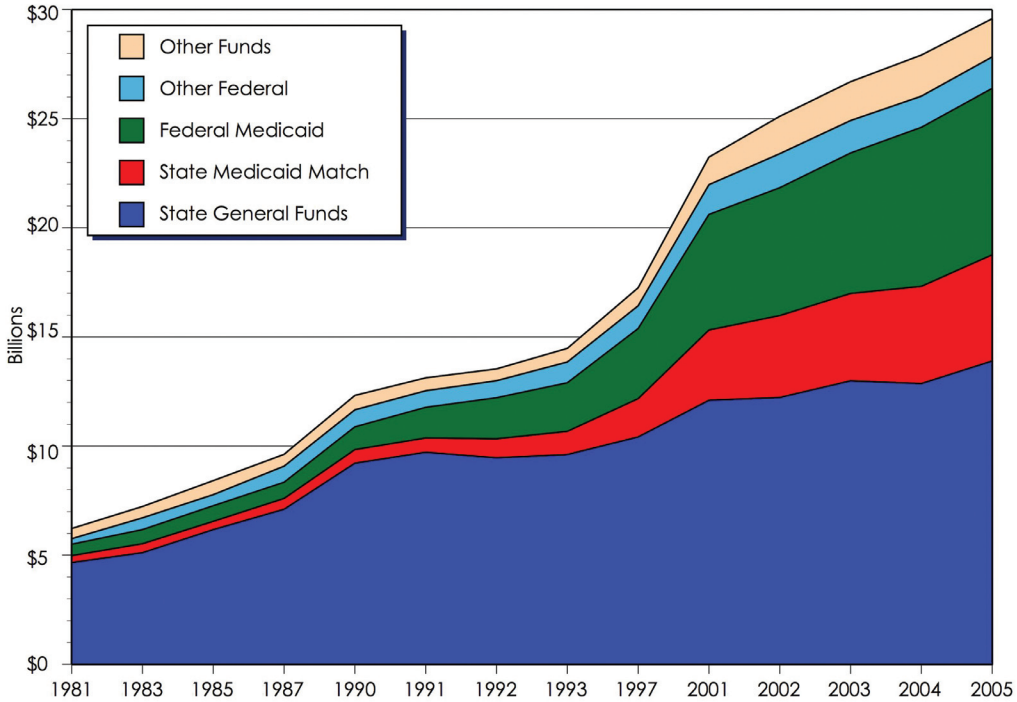
Figure 39: SMHA-Controlled Revenues for Mental Health, FY 2005



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure39.html

health services. These funding sources included state general and special funds of over $13.9 billion, and state Medicaid match of almost $4.8 billion. The Federal government was the second largest funder of SMHA services, with FY 2005 dollars totaling $9 billion (31 percent of total SMHA funding). The majority of Federal revenues came from Medicaid ($7.6 billion), followed by Medicare ($54 million), other Federal Funds ($498 million), and the Community Mental Health Block Grant ($40 million). Local governments contributed $407 million (1 percent), and other funds contributed the remaining $1.3 billion (see Figure 39). Total Medicaid funds (State Match and Federal Share) received by SMHA-funded programs represented $12.5 billion (42 percent) of SMHA resources.

Figure 40: SMHA-Controlled Revenues for Mental Health Services: FY 1981 to FY 2005 (in Billions)



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure40.html

SMHA-funded programs represented $12.5 billion (42 percent) of SMHA resources.

8.7 SMHA Revenue Trends Over Time

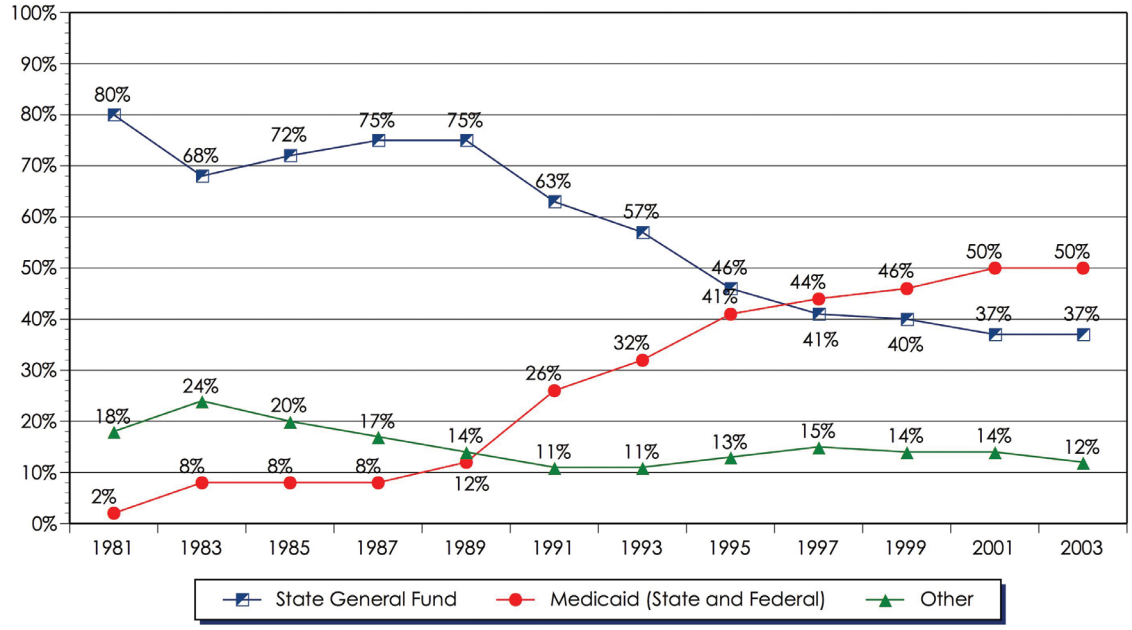
During the first half of this decade, many state governments encountered major budget shortages, and total state government spending slowed greatly. During this time, total SMHA-controlled revenues for mental health services increased by 6.3 percent per year from FY 2001 to FY 2005. Medicaid funding (Federal and state match) increased 10 percent per year to $12.5 billion, representing a slower increase than the prior decade (FY 1990 to FY 2001 increased an average of 16 percent per year). From FY 1981 to FY 2005, state general funds averaged an increase of 4.7 percent per year, while Medicaid grew an average of 11.8 percent. Other Federal funds increased 7.5 percent per year over this time period.

As a result of the different rates of growth in funding, most of the new funds available for SMHA-funded services have come from Medicaid. From FY 2001 to FY 2005, 62 percent of new SMHA funds were from Medicaid, while 30 percent of new SMHA funds were derived from state general revenues to the SMHA. Over the longer time period from FY 1981 to FY 2005, half (50 percent) of all new funds were from Medicaid, while state general funds were the source of 40 percent of new funds (see Figure 42 and Tables 36–39).

Most of the growth of Medicaid revenues for mental health was used to fund community mental health services. From FY 1981 to FY 2005, Medicaid funds for community mental health grew an average of 25 percent per year. As a result, Medicaid (state and Federal shares combined) paid $10 billion for the SMHA-controlled community mental health spending and represented half (50 percent) of all funds (see Figure 41).

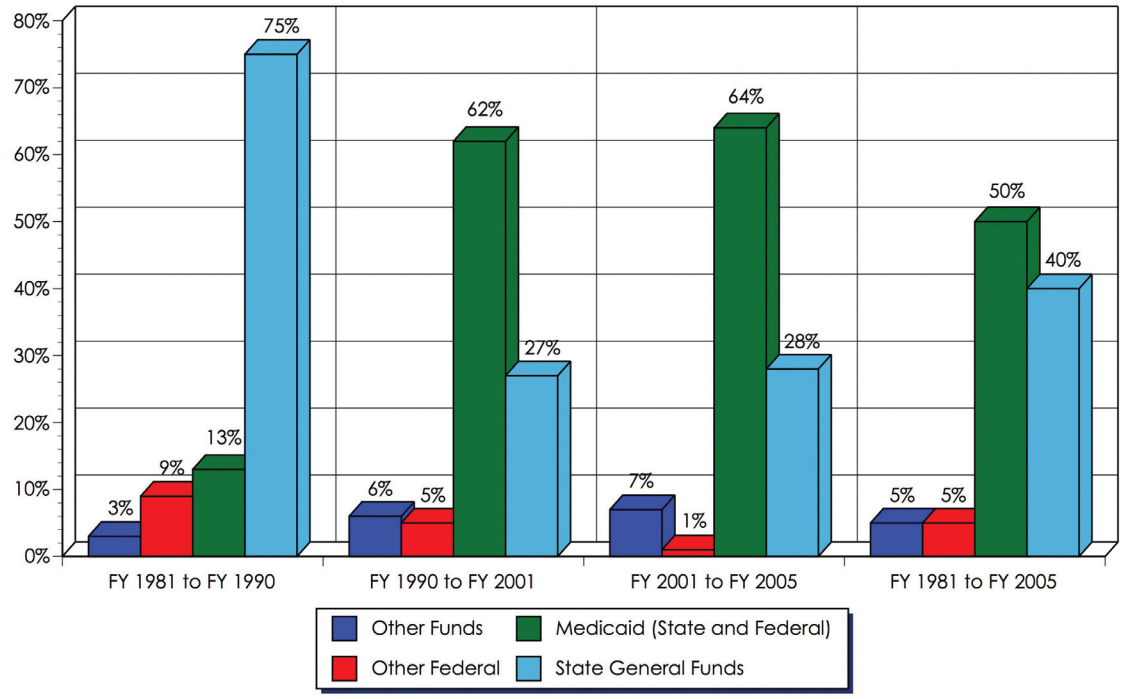
For state psychiatric hospitals, Medicaid funds grew at a much slower rate (4.5 percent per year annual rate) and now

Figure 41: Percent of SMHA-Controlled Community Mental Health Revenues by Major Sources: FY 1981 to FY 2005



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure41.html

Figure 42: Percent Increase in SMHA-Controlled Revenues From Major Funding Sources: FY 1981 to FY 2005



Text description of this graphic available at: http://www.mentalhealth.samhsa.gov/cmhs/MentalHealthStatistics/Figure42.html

Table 30: SMHA Mental Health Actual Dollar and per Capita Expenditures by State, FY 2005

State	SMHA Expenditure Total	Total Rank	2005 Civilian Population	Population Rank	FY 2005 per Capita	Per Capita Rank
Alabama	$273,700,000	27	4,538,375	23	$60.31	42
Alaska	$173,537,901	35	643,593	47	$269.64	2
Arizona	$867,300,000	8	5,931,329	17	$146.22	8
Arkansas (a)	$98,639,615	45	2,770,780	32	$35.60	50
California (b)	$4,270,200,000	1	35,991,095	1	$118.65	17
Colorado	$343,753,830	24	4,627,945	22	$74.28	32
Connecticut (c)	$549,200,000	17	3,493,448	29	$157.21	6
Delaware (a, c)	$74,768,052	46	838,292	45	$89.19	26
District of Columbia (b)	$233,804,705	31	578,151	50	$404.40	1
Florida	$647,169,422	14	17,699,814	4	$36.56	48
Georgia	$443,973,313	21	9,064,226	9	$48.98	45
Hawaii	$192,627,775	33	1,229,552	42	$156.67	7
Idaho	$53,884,900	48	1,425,313	39	$37.81	47
Illinois	$1,021,700,000	6	12,746,732	5	$80.15	29
Indiana	$518,658,624	20	6,264,902	14	$82.79	28
Iowa	$235,552,698	30	2,965,148	30	$79.44	30
Kansas	$253,700,000	29	2,733,483	33	$92.81	25
Kentucky	$208,442,100	32	4,150,496	26	$50.22	44
Louisiana	$258,500,000	28	4,488,495	24	$57.59	43
Maine (a)	$180,300,000	34	1,314,590	40	$137.15	11
Maryland (b)	$776,500,000	10	5,556,347	19	$139.75	10
Massachusetts (a)	$685,600,000	12	6,429,227	13	$106.64	18
Michigan (b)	$973,500,000	7	10,098,168	8	$96.40	22
Minnesota	$669,275,671	13	5,124,774	21	$130.60	13
Mississippi	$305,899,702	25	2,894,507	31	$105.68	19
Missouri	$414,012,967	23	5,783,136	18	$71.59	34
Montana	$124,816,250	40	931,236	44	$134.03	12
Nebraska	$106,050,000	43	1,751,276	38	$60.56	41
Nevada	$150,500,000	39	2,403,365	35	$62.62	40
New Hampshire	$154,908,224	38	1,305,628	41	$118.65	16
New Jersey (b)	$1,215,827,000	4	8,694,221	10	$139.84	9
New Mexico (a, c)	$46,400,000	51	1,914,935	36	$24.23	51
New York (b)	$3,977,500,000	2	19,288,828	3	$206.21	3
North Carolina	$1,027,800,736	5	8,577,921	11	$119.82	14
North Dakota	$46,760,516	50	628,607	48	$74.39	31
Ohio	$757,733,206	11	11,463,260	7	$66.10	37
Oklahoma	$157,300,000	37	3,521,352	28	$44.67	46
Oregon	$434,558,178	22	3,637,148	27	$119.48	15
Pennsylvania (a, c)	$2,541,278,736	3	12,401,208	6	$204.92	4
Rhode Island (c)	$102,353,080	44	1,071,255	43	$95.55	23
South Carolina	$285,200,000	26	4,212,930	25	$67.70	36
South Dakota	$55,081,896	47	771,677	46	$71.38	35
Tennessee	$522,000,000	19	5,937,718	16	$87.91	27
Texas (b)	$832,200,000	9	22,816,723	2	$36.47	49
Utah	$159,884,700	36	2,485,098	34	$64.34	39
Vermont	$109,000,000	42	622,302	49	$175.16	5
Virginia (b)	$531,500,000	18	7,420,772	12	$71.62	33
Washington	$585,485,304	15	6,230,964	15	$93.96	24
West Virginia (b)	$118,900,000	41	1,813,479	37	$65.56	38
Wisconsin	$579,728,296	16	5,526,732	20	$104.90	20
Wyoming	$49,954,234	49	505,654	51	$98.79	21
Total	**$29,396,921,631**		**$295,316,207**		**$99.54**	
Average (Mean)	**$576,410,228**		**$5,679,158**		**$103.43**	
Median	**$285,200,000**		**$3,893,822**		**$89.19**	
Number of States Reporting	**51**		**51**		**51**	

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.

(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 31: SMHA Mental Health Actual Dollar and per Capita Expenditures by State, FY 2005

State	Inpatient	Percent	Other 24-Hour Services	Percent	Less Than 24-Hour Services	Percent	Other Services	Percent	Research and Training	Percent	Total SMHA-Controlled	Total Rank	FY 2005 per Capita	Per Rank
Alabama	$125	45.8%	$33.20	12.1%	$107	39.2%			$7.80	2.8%	$274	27	$60.31	42
Alaska	$21	12.2%	$64.82	37.4%	$14	8.0%	$68.97	39.7%	$4.83	2.8%	$174	35	$269.64	2
Arizona	$153	17.7%	$67.20	7.7%	$634	73.1%			$13.30	1.5%	$867	8	$146.22	8
Arkansas (a)	$28	28.6%	$28.84	29.2%	$35	35.1%			$6.90	7.0%	$99	45	$35.60	50
California (b)	$1,100	25.8%	$274.20	6.4%	$2,487	58.2%	$377.10	8.8%	$31.70	0.7%	$4,270	1	$118.65	17
Colorado	$90	26.2%	$3.04	0.9%	$2	0.6%	$247.39	72.0%	$1.30	0.4%	$344	24	$74.28	32
Connecticut (c)	$206	37.5%	$79.60	14.5%	$210	38.2%			$53.90	9.8%	$549	17	$157.21	6
Delaware (a, c)	$42	55.5%	$6.68	8.9%	$25	33.4%			$1.63	2.2%	$75	46	$89.19	26
District of Columbia (b)	$80	34.3%	$33.67	14.4%	$99	42.2%			$21.25	9.1%	$234	31	$404.40	1
Florida	$386	59.6%	$80.15	12.4%	$169	26.2%			$12.07	1.9%	$647	14	$36.56	48
Georgia	$202	45.5%	NA	NA	$3	0.8%	$238.43	53.7%			$444	21	$48.98	45
Hawaii	$66	34.4%	$46.85	24.3%	$71	36.8%			$8.70	4.5%	$193	33	$156.67	7
Idaho	$23	42.6%	$5.81	10.8%	$25	46.6%					$54	48	$37.81	47
Illinois	$532	52.1%	$98.60	9.7%	$373	36.5%			$18.10	1.8%	$1,022	6	$80.15	29
Indiana	$171	32.9%	NA	NA			$344.71	66.5%	$3.11	0.6%	$519	20	$82.79	28
Iowa	$30	12.6%	$44.05	18.7%			$157.85	67.0%	$3.92	1.7%	$236	30	$79.44	30
Kansas	$69	27.1%	NA	NA			$185.00	72.9%			$254	29	$92.81	25
Kentucky	$104	49.9%	$21.53	10.3%	$74	35.4%			$9.12	4.4%	$208	32	$50.22	44
Louisiana	$151	58.5%	$4.60	1.8%	$85	33.0%			$17.20	6.7%	$259	28	$57.59	43
Maine (a)	$53	29.2%	$10.60	5.9%	$113	62.6%			$4.20	2.3%	$180	34	$137.15	11
Maryland (b)	$299	38.5%	$115.80	14.9%	$327	42.2%			$34.50	4.4%	$777	10	$139.75	10
Massachusetts (a)	$194	28.3%	$264.00	38.5%	$207	30.2%			$20.60	3.0%	$686	12	$106.64	18
Michigan (b)	$335	34.4%	$154.40	15.9%	$477	49.0%			$7.30	0.7%	$974	7	$96.40	22
Minnesota	$276	41.3%	$71.51	10.7%	$318	47.5%			$3.47	0.5%	$669	13	$130.60	13
Mississippi	$167	54.7%	$0.75	0.2%	$7	2.3%	$127.61	41.7%	$3.04	1.0%	$306	25	$105.68	19
Missouri	$196	47.4%	$37.06	9.0%	$170	41.1%			$10.66	2.6%	$414	23	$71.59	34
Montana	$26	20.8%	$42.10	33.7%	$53	42.3%			$3.91	3.1%	$125	40	$134.03	12
Nebraska	$72	67.7%	$4.50	4.2%	$23	21.8%	$3.50	3.3%	$3.15	3.0%	$106	43	$60.56	41
Nevada	$36	23.9%	$26.10	17.3%	$85	56.6%			$3.30	2.2%	$151	39	$62.62	40
New Hampshire	$50	32.0%	$27.41	17.7%	$65	42.0%	$9.05	5.8%	$3.95	2.5%	$155	38	$118.65	16
New Jersey (b)	$623	51.2%	$144.44	11.9%	$434	35.7%			$14.48	1.2%	$1,216	4	$139.84	9
New Mexico (a, c)	$22	46.8%	NA	NA	$25	53.2%					$46	51	$24.23	51
New York (b)	$1,584	39.8%	$506.50	12.7%	$1,716	43.2%			$171.00	4.3%	$3,978	2	$206.21	3
North Carolina	$309	30.1%	$179.72	17.5%	$486	47.3%	$36.50	3.6%	$16.88	1.6%	$1,028	5	$119.82	14
North Dakota	$19	40.8%	$6.91	14.8%	$21	44.3%			$0.04	0.1%	$47	50	$74.39	31
Ohio	$207	27.3%	$46.18	6.1%	$475	62.7%			$29.51	3.9%	$758	11	$66.10	37
Oklahoma	$63	40.2%	$5.90	3.8%	$78	49.6%			$10.10	6.4%	$157	37	$44.67	46
Oregon	$119	27.3%	$83.30	19.2%	$89	20.5%	$131.16	30.2%	$12.41	2.9%	$435	22	$119.48	15
Pennsylvania (a, c)	$691	27.2%	$35.95	1.4%	$1,798	70.7%			$16.79	0.7%	$2,541	3	$204.92	4
Rhode Island (c)	$29	28.5%	$13.29	13.0%	$58	56.8%			$1.75	1.7%	$102	44	$95.55	23
South Carolina	$84	29.5%	$38.50	13.5%	$146	51.2%	$1.40	0.5%	$15.20	5.3%	$285	26	$67.70	36
South Dakota	$35	63.3%	$20.21	36.7%							$55	47	$71.38	35
Tennessee	$246	47.1%	$20.20	3.9%	$243	46.5%			$13.10	2.5%	$522	19	$87.91	27
Texas	$329	39.5%	$20.00	2.4%			$469.90	56.5%	$13.60	1.6%	$832	9	$36.47	49
Utah[b]	$71	44.6%	$42.95	26.9%	$45	27.8%			$1.10	0.7%	$160	36	$64.34	39
Vermont	$19	17.2%	$17.60	16.1%	$70	63.9%			$3.10	2.8%	$109	42	$175.16	5
Virginia	$316	59.5%	$48.10	9.0%	$167	31.4%					$532	18	$71.62	33
Washington (b)	$226	38.6%	$16.25	2.8%	$328	56.1%	$1.91	0.3%	$12.77	2.2%	$585	15	$93.96	24
West Virginia	$48	40.5%	$1.00	0.8%	$70	58.6%					$119	41	$65.56	38
Wisconsin (b)	$227	39.1%	$50.22	8.7%	$301	52.0%			$1.18	0.2%	$580	16	$104.90	20
Wyoming	$15	29.9%	$6.91	13.8%	$27	54.7%			$0.81	1.6%	$50	49	$98.79	21
Total	**$10,563**	**35.9%**	**$2,951.19**	**10.0%**	**$12,836**	**43.7%**	**$2,400.49**	**8.2%**	**$646.72**	**2.2%**	**$29,397**		**$99.54**	
Average (Mean)	**$207**		**$62.79**		**$252**		**$47.07**		**$12.68**		**$576**		**$103.43**	
Median	**$119**		**$35.95**		**$85**				**$6.90**		**$285**		**$89.19**	

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.
(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 32: SMHA Mental Health per Capita Expenditures for State Mental Hospitals, Community-Based Programs, and State Mental Health Support Activities by Type of Service Setting and by State, FY 2005 (in Millions)

State	Inpatient	Percent	Other 24-Hour Services	Percent	Less Than 24-Hour Services	Percent	Other Services	Percent	Research, Training, and Administration	Percent	SMHA-Expenditures	Total Rank
Alabama	$27.61	45.8%	$7.32	12.1%	$23.66	39.2%	$0.00	0.0%	$1.72	2.8%	$60.31	42
Alaska	$32.76	12.2%	$100.72	37.4%	$21.48	8.0%	$107	$0	$7.50	2.8%	$269.64	2
Arizona	$25.81	17.7%	$11.33	7.7%	$106.84	73.1%	$0	$0	$2.24	1.5%	$146.22	8
Arkansas (a)	$10.19	28.6%	$10.41	29.2%	$12.51	35.1%	$0	$0	$2.49	7.0%	$35.60	50
California (b)	$30.57	25.8%	$7.62	6.4%	$69.10	58.2%	$10.48	8.8%	$0.88	0.7%	$118.65	17
Colorado	$19.46	26.2%	$0.66	0.9%	$0.42	0.6%	$53.46	72.0%	$0.28	0.4%	$74.28	32
Connecticut (c)	$58.91	37.5%	$22.79	14.5%	$60.08	38.2%	$0	$0	$15.43	9.8%	$157.21	6
Delaware (a, c)	$49.53	55.5%	$7.97	8.9%	$29.76	33.4%	$0	$0	$1.94	2.2%	$89.19	26
District of Columbia (b)	$138.82	34.3%	$58.24	14.4%	$170.59	42.2%	$0	$0	$36.76	9.1%	$404.40	1
Florida	$21.78	59.6%	$4.53	12.4%	$9.57	26.2%	$0	$0	$0.68	1.9%	$36.56	48
Georgia	$22.31	45.5%	NA	NA	$0.37	0.8%	$26.30	53.7%	$0.00	0.0%	$48.98	45
Hawaii	$53.85	34.4%	$38.10	24.3%	$57.63	36.8%	$0	$0	$7.08	4.5%	$156.67	7
Idaho	$16.10	42.6%	$4.08	10.8%	$17.63	46.6%	$0.00	0.0%	$0.00	0.0%	$37.81	47
Illinois	$41.74	52.1%	$7.74	9.7%	$29.26	36.5%	$0	$0	$1.42	1.8%	$80.15	29
Indiana	$27.27	32.9%	NA	NA	$0.00	0.0%	$55.02	66.5%	$0.50	0.6%	$82.79	28
Iowa	$10.03	12.6%	$14.86	18.7%	$0.00	0.0%	$53.24	67.0%	$1.32	1.7%	$79.44	30
Kansas	$25.13	27.1%	NA	NA	$0.00	0.0%	$67.68	72.9%	$0.00	0.0%	$92.81	25
Kentucky	$25.06	49.9%	$5.19	10.3%	$17.78	35.4%	$0	$0	$2.20	4.4%	$50.22	44
Louisiana	$33.71	58.5%	$1.02	1.8%	$19.03	33.0%	$0	$0	$3.83	6.7%	$57.59	43
Maine (a)	$40.09	29.2%	$8.06	5.9%	$85.81	62.6%	$0	$0	$3.19	2.3%	$137.15	11
Maryland (b)	$53.79	38.5%	$20.84	14.9%	$58.91	42.2%	$0	$0	$6.21	4.4%	$139.75	10
Massachusetts (a)	$30.17	28.3%	$41.06	38.5%	$32.20	30.2%	$0	$0	$3.20	3.0%	$106.64	18
Michigan (b)	$33.13	34.4%	$15.29	15.9%	$47.26	49.0%	$0	$0	$0.72	0.7%	$96.40	22
Minnesota	$53.91	41.3%	$13.95	10.7%	$62.05	47.5%	$0	$0	$0.68	0.5%	$130.60	13
Mississippi	$57.82	54.7%	$0.26	0.2%	$2.47	2.3%	$44.09	41.7%	$1.05	1.0%	$105.68	19
Missouri	$33.91	47.4%	$6.41	9.0%	$29.43	41.1%	$0	$0	$1.84	2.6%	$71.59	34
Montana	$27.89	20.8%	$45.21	33.7%	$56.73	42.3%	$0	$0	$4.20	3.1%	$134.03	12
Nebraska	$41.00	67.7%	$2.57	4.2%	$13.19	21.8%	$2	$0	$1.80	3.0%	$60.56	41
Nevada	$14.94	23.9%	$10.86	17.3%	$35.45	56.6%	$0	$0	$1.37	2.2%	$62.62	40
New Hampshire	$37.92	32.0%	$20.99	17.7%	$49.78	42.0%	$6.93	5.8%	$3.02	2.5%	$118.65	16
New Jersey (b)	$71.62	51.2%	$16.61	11.9%	$49.95	35.7%	$0	$0	$1.67	1.2%	$139.84	9
New Mexico (a, c)	$11.33	46.8%	NA	NA	$12.90	53.2%	$0	$0	$0.00	0.0%	$24.23	51
New York (b)	$82.10	39.8%	$26.26	12.7%	$88.98	43.2%	$0	$0	$8.87	4.3%	$206.21	3
North Carolina	$36.03	30.1%	$20.95	17.5%	$56.62	47.3%	$4.25	3.6%	$1.97	1.6%	$119.82	14
North Dakota	$30.37	40.8%	$11.00	14.8%	$32.96	44.3%	$0	$0	$0.06	0.1%	$74.39	31
Ohio	$18.05	27.3%	$4.03	6.1%	$41.45	62.7%	$0	$0	$2.57	3.9%	$66.10	37
Oklahoma	$17.98	40.2%	$1.68	3.8%	$22.15	49.6%	$0	$0	$2.87	6.4%	$44.67	46
Oregon	$32.60	27.3%	$22.90	19.2%	$24.50	20.5%	$36.06	30.2%	$3.41	2.9%	$119.48	15
Pennsylvania (a, c)	$55.69	27.2%	$2.90	1.4%	$144.98	70.7%	$0	$0	$1.35	0.7%	$204.92	4
Rhode Island (c)	$27.27	28.5%	$12.41	13.0%	$54.23	56.8%	$0	$0	$1.63	1.7%	$95.55	23
South Carolina	$19.99	29.5%	$9.14	13.5%	$34.63	51.2%	$0	$0	$3.61	5.3%	$67.70	36
South Dakota	$45.19	63.3%	$26.19	36.7%	$0.00	0.0%	$0	$0	$0.00	0.0%	$71.38	35
Tennessee	$41.40	47.1%	$3.40	3.9%	$40.91	46.5%	$0	$0	$2.21	2.5%	$87.91	27
Texas (b)	$14.41	39.5%	$0.88	2.4%	$0.00	0.0%	$21	$1	$0.60	1.6%	$36.47	49
Utah	$28.70	44.6%	$17.28	26.9%	$17.91	27.8%	$0	$0	$0.44	0.7%	$64.34	39
Vermont	$30.05	17.2%	$28.28	16.1%	$111.84	63.9%	$0	$0	$4.98	2.8%	$175.16	5
Virginia (b)	$42.62	59.5%	$6.48	9.0%	$22.52	31.4%	$0	$0	$0.00	0.0%	$71.62	33
Washington	$36.28	38.6%	$2.61	2.8%	$52.72	56.1%	$0.31	0.3%	$2.05	2.2%	$93.96	24
West Virginia (b)	$26.58	40.5%	$0.55	0.8%	$38.43	58.6%	$0.00	0.0%	$0.00	0.0%	$65.56	38
Wisconsin	$41.06	39.1%	$9.09	8.7%	$54.53	52.0%	$0	$0	$0.21	0.2%	$104.90	20
Wyoming	$29.51	29.9%	$13.66	13.8%	$54.02	54.7%	$0	$0	$1.60	1.6%	$98.79	21
Average (Mean)	**$35.77**	**35.9%**	**$10.72**	**10.8%**	**$49.41**	**49.6%**	**$5.87**	**5.9%**	**$2.39**	**2.4%**	**$99.54**	
Median	**$30.57**	**34.3%**	**$10.41**	**11.7%**	**$32.96**	**37.0%**	**$0.00**	**0.0%**	**$1.72**	**1.9%**	**$89.19**	

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.
(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 33: SMHA-Controlled Mental Health Expenditures by Type of Program, FY 2005 (in Millions)

State	State Psychiatric Inpatient	Hospital Rank	Percent	Community-Based Programs	Rank	Percent	Prevention, Research, and Training	Rank	Percent	SMHA Administration	Rank	Percent	Total SMHA Expenditures	Total Rank
Alabama	$125	23	46%	$141	29	51%	$0.00			$7.80	24	3%	$274	27
Alaska	$19	48	11%	$149	28	86%	$0.97	13	1%	$3.86	27	2%	$174	35
Arizona	$63	32	7%	$791	4	91%	$1.00	12	0%	$12.30	16	1%	$867	8
Arkansas (a)	$28	42	29%	$64	44	64%	$4.43	4	4%	$2.47	34	3%	$99	45
California (b)	$764	2	18%	$3,474	1	81%	$0.00			$31.70	3	1%	$4,270	1
Colorado	$90	27	26%	$252	21	73%	$0.00			$1.30	39	0%	$344	24
Connecticut (c)	$168	18	31%	$328	19	60%	$12.80	2	2%	$41.10	2	7%	$549	17
Delaware (a, c)	$39	39	52%	$34	47	46%	$0.00			$1.63	36	2%	$75	46
District of Columbia (b)	$80	29	34%	$132	31	57%	$0.00			$21.25	6	9%	$234	31
Florida	$287	8	44%	$348	16	54%	$0.00			$12.07	18	2%	$647	14
Georgia	$202	12	46%	$242	22	54%	$0.00			$0.00			$444	21
Hawaii	$53	33	27%	$131	32	68%	$0.00			$8.70	22	5%	$193	33
Idaho	$23	45	43%	$31	48	57%	$0.00			$0.00			$54	48
Illinois	$292	7	29%	$711	8	70%	$0.00			$18.10	7	2%	$1,022	6
Indiana	$171	17	33%	$345	18	66%	$0.88	14	0%	$2.24	35	0%	$519	20
Iowa	$27	43	12%	$204	25	87%	$0.00			$3.92	26	2%	$236	30
Kansas	$69	30	27%	$185	27	73%	$0.00			$0.00			$254	29
Kentucky	$104	25	50%	$95	40	46%	$0.00			$9.12	21	4%	$208	32
Louisiana	$135	22	52%	$106	36	41%	$0.00			$17.20	8	7%	$259	28
Maine (a)	$52	34	29%	$124	33	69%	$3.30	7	2%	$0.90	42	0%	$180	34
Maryland (b)	$216	11	28%	$526	11	68%	$4.40	5	1%	$30.10	4	4%	$777	10
Massachusetts (a)	$113	24	16%	$552	9	81%	$9.80	3	1%	$10.80	19	2%	$686	12
Michigan (b)	$217	10	22%	$749	7	77%	$0.60	16	0%	$6.70	25	1%	$974	7
Minnesota	$175	16	26%	$491	13	73%	$0.09	20	0%	$3.38	29	1%	$669	13
Mississippi	$167	19	55%	$136	30	44%	$0.00			$3.04	33	1%	$306	25
Missouri	$194	14	47%	$210	24	51%	$0.00			$10.66	20	3%	$414	23
Montana	$21	47	17%	$99	39	80%	$0.14	19	0%	$3.77	28	3%	$125	40
Nebraska	$63	31	59%	$40	45	38%	$1.70	10	2%	$1.45	38	1%	$106	43
Nevada	$36	40	24%	$111	35	74%	$0.00			$3.30	31	2%	$151	39
New Hampshire	$48	36	31%	$103	37	67%	$0.63	15	0%	$3.32	30	2%	$155	38
New Jersey (b)	$432	4	35%	$770	5	63%	$0.00			$14.48	10	1%	$1,216	4
New Mexico (a, c)	$22	46	47%	$25	50	53%	$0.00			$0.00			$46	51
New York (b)	$1,073	1	27%	$2,734	2	69%	$65.60	1	2%	$105.40	1	3%	$3,978	2
North Carolina	$261	9	25%	$750	6	73%	$0.00			$16.88	9	2%	$1,028	5
North Dakota	$19	49	40%	$28	49	60%	$0.00			$0.04	44	0%	$47	50
Ohio	$197	13	26%	$531	10	70%	$2.18	9	0%	$27.33	5	4%	$758	11
Oklahoma	$45	38	29%	$102	38	65%	$1.40	11	1%	$8.70	22	6%	$157	37
Oregon	$104	26	24%	$318	20	73%	$0.00			$12.41	15	3%	$435	22
Pennsylvania (a, c)	$492	3	19%	$2,033	3	80%	$3.50	6	0%	$13.29	12	1%	$2,541	3
Rhode Island (c)	$26	44	26%	$74	42	73%	$0.18	18	0%	$1.57	37	2%	$102	44
South Carolina	$82	28	29%	$188	26	66%	$2.30	8	1%	$12.90	14	5%	$285	26
South Dakota	$35	41	63%	$20	51	37%	$0.00			$0.00			$55	47
Tennessee	$164	20	31%	$345	17	66%	$0.00			$13.10	13	3%	$522	19
Texas (b)	$315	5	38%	$504	12	61%	$0.00			$13.60	11	2%	$832	9
Utah	$46	37	29%	$113	34	71%	na			$1.10	41	1%	$160	36
Vermont	$15	50	14%	$91	41	83%	$0.00			$3.10	32	3%	$109	42
Virginia (b)	$308	6	58%	$224	23	42%	$0.00			$0.00			$532	18
Washington	$177	15	30%	$395	15	68%	$0.52	17	0%	$12.25	17	2%	$585	15
West Virginia (b)	$48	35	41%	$71	43	59%	$0.00			$0.00			$119	41
Wisconsin	$161	21	28%	$418	14	72%	$0.00			$1.18	40	0%	$580	16
Wyoming	$15	51	30%	$34	46	69%	na			$0.81	43	2%	$50	49
Total	**$8,077**		**27%**	**$20,673**		**70%**	**$116.42**		**0.4%**	**$530.30**		**1.8%**	**$29,397**	
Average (Mean)	**$158**		**33%**	**$405**		**65%**	**$2.38**		**0.9%**	**$10.40**		**2.4%**	**$576**	
Median	**$104**			**$188**			**$0.00**			**$3.92**			**$285**	

Note: "Community services" include expenditures from state mental hospitals for ambulatory and residential services.
(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.
(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 34: SMHA Mental Health-Controlled per Capita Expenditures for State Mental Hospital Inpatient Services, Community Services Research, Training, and Administration: FY 2005

State	State Psychiatric Inpatient	Hospital Rank	Percent	Community-Based Programs	Rank	Percent	Prevention, Research, and Training	Rank	Percent	SMHA Administration	Rank	Percent	Total SMHA Expenditures	Total Rank
Alabama	$27.61	25	46%	$30.98	39	51%				$1.72	22	3%	$60.31	42
Alaska	$30.04	19	11%	$232.10	1	86%	$1.51	6	1%	$5.99	4	2%	$269.64	2
Arizona	$10.55	49	7%	$133.43	6	91%	$0.17	15	0%	$2.07	17	1%	$146.22	8
Arkansas (a)	$10.19	50	29%	$22.92	46	64%	$1.60	4	4%	$0.89	32	3%	$35.60	50
California (b)	$21.24	37	18%	$96.53	9	81%				$0.88	33	1%	$118.65	17
Colorado	$19.46	39	26%	$54.53	29	73%				$0.28	42	0%	$74.28	32
Connecticut (c)	$47.98	5	31%	$93.80	13	60%	$3.66	1	2%	$11.76	2	7%	$157.21	6
Delaware (a, c)	$46.54	6	52%	$40.72	36	46%				$1.94	20	2%	$89.19	26
District of Columbia (b)	$138.82	1	34%	$228.82	2	57%				$36.76	1	9%	$404.40	1
Florida	$16.23	43	44%	$19.66	50	54%				$0.68	36	2%	$36.56	48
Georgia	$22.31	35	46%	$26.67	42	54%							$48.98	45
Hawaii	$42.86	8	27%	$106.73	8	68%				$7.08	3	5%	$156.67	7
Idaho	$16.10	44	43%	$21.70	49	57%							$37.81	47
Illinois	$22.93	34	29%	$55.80	27	70%				$1.42	27	2%	$80.15	29
Indiana	$27.27	27	33%	$55.02	28	66%	$0.14	17	0%	$0.36	41	0%	$82.79	28
Iowa	$9.22	51	12%	$68.90	22	87%				$1.32	29	2%	$79.44	30
Kansas	$25.13	29	27%	$67.68	23	73%							$92.81	25
Kentucky	$25.06	30	50%	$22.97	45	46%				$2.20	16	4%	$50.22	44
Louisiana	$30.08	18	52%	$23.68	44	41%				$3.83	9	7%	$57.59	43
Maine (a)	$39.48	11	29%	$94.48	12	69%	$2.51	3	2%	$0.68	35	0%	$137.15	11
Maryland (b)	$38.84	12	28%	$94.70	11	68%	$0.79	8	1%	$5.42	6	4%	$139.75	10
Massachusetts (a)	$17.53	41	16%	$85.90	17	81%	$1.52	5	1%	$1.68	23	2%	$106.64	18
Michigan (b)	$21.51	36	22%	$74.17	20	77%	$0.06	19	0%	$0.66	37	1%	$96.40	22
Minnesota	$34.13	15	26%	$95.79	10	73%	$0.02	20	0%	$0.66	38	1%	$130.60	13
Mississippi	$57.82	2	55%	$46.81	30	44%				$1.05	31	1%	$105.68	19
Missouri	$33.52	16	47%	$36.23	38	51%				$1.84	21	3%	$71.59	34
Montana	$23.07	33	17%	$106.77	7	80%	$0.15	16	0%	$4.05	8	3%	$134.03	12
Nebraska	$35.92	14	59%	$22.84	47	38%	$0.97	7	2%	$0.83	34	1%	$60.56	41
Nevada	$14.94	45	24%	$46.31	32	74%				$1.37	28	2%	$62.62	40
New Hampshire	$36.50	13	31%	$79.12	18	67%	$0.48	10	0%	$2.54	12	2%	$118.65	16
New Jersey (b)	$49.63	4	35%	$88.55	14	63%				$1.67	24	1%	$139.84	9
New Mexico (a, c)	$11.33	48	47%	$12.90	51	53%							$24.23	51
New York (b)	$55.62	3	27%	$141.72	5	69%	$3.40	2	2%	$5.46	5	3%	$206.21	3
North Carolina	$30.42	17	25%	$87.43	16	73%				$1.97	18	2%	$119.82	14
North Dakota	$29.80	20	40%	$44.53	35	60%				$0.06	44	0%	$74.39	31
Ohio	$17.16	42	26%	$46.37	31	70%	$0.19	13	0%	$2.38	14	4%	$66.10	37
Oklahoma	$12.86	47	29%	$28.94	41	65%	$0.40	11	1%	$2.47	13	6%	$44.67	46
Oregon	$28.53	23	24%	$87.54	15	73%				$3.41	10	3%	$119.48	15
Pennsylvania (a, c)	$39.67	10	19%	$163.90	3	80%	$0.28	12	0%	$1.07	30	1%	$204.92	4
Rhode Island (c)	$24.43	32	26%	$69.48	21	73%	$0.17	14	0%	$1.46	26	2%	$95.55	23
South Carolina	$19.54	38	29%	$44.55	34	66%	$0.55	9	1%	$3.06	11	5%	$67.70	36
South Dakota	$45.19	7	63%	$26.19	43	37%							$71.38	35
Tennessee	$27.57	26	31%	$58.14	26	66%				$2.21	15	3%	$87.91	27
Texas (b)	$13.81	46	38%	$22.07	48	61%				$0.60	39	2%	$36.47	49
Utah	$18.39	40	29%	$45.51	33	71%	NA		NA	$0.44	40	1%	$64.34	39
Vermont	$24.59	31	14%	$145.59	4	83%				$4.98	7	3%	$175.16	5
Virginia (b)	$41.45	9	58%	$30.17	40	42%							$71.62	33
Washington	$28.45	24	30%	$63.46	25	68%	$0.08	18	0%	$1.97	19	2%	$93.96	24
West Virginia (b)	$26.58	28	41%	$38.99	37	59%							$65.56	38
Wisconsin	$29.11	22	28%	$75.57	19	72%				$0.21	43	0%	$104.90	20
Wyoming	$29.51	21	30%	$67.68	24	69%	NA		NA	$1.60	25	2%	$98.79	21
Average (Mean)	**$27.35**		**27%**	**$70.00**		**70%**	**$1.06**		**1%**	**$1.96**		**2%**	**$99.54**	
Median	**$27.57**		**29%**	**$58.14**		**68%**				**$1.46**		**2%**	**$89.19**	

Note: "Community Services" include expenditures from state mental hospitals for ambulatory and residential services.
(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.
(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 35: SMHA Mental Health-Controlled Expenditures per Inpatient Day, All Civil (Voluntary and Involuntary) Patients in State Psychiatric Hospitals by Age and State, FY 2005 (in Millions)

State	Children and Adolescents Patient Days	Expenditures	Per Patient	Rank	Adult Patient	Expenditures	Per Patient	Rank	Total Civil Patients Patient Days	Expenditures	Per Patient	Rank
Alabama	NA	NA	NA	NA	NA	NA	NA	NA	369,268	$114.1	309.0	40
Alaska	3,201	$2.7	845.6	7	16,928	$14	845.2	1	20,129	$17.0	845.2	2
Arizona	2,298	$3.0	1,305.5	3	49,121	$27	541.5	13	51,419	$29.6	575.7	9
Arkansas (a)	7,700	$2.2	283.6	34	33,893	$21	628.2	4	41,593	$23.5	564.4	12
California (b)	11,268	$5.1	452.6	27	199,187	$91	454.3	28	210,455	$95.6	454.3	30
Colorado	11,871	$10.6	895.2	6	82,235	$39	468.8	25	94,106	$49.2	522.6	18
Connecticut (c)	NA	NA	NA	NA	NA	NA	NA	NA	96,265	$91.6	951.5	1
Delaware (a, c)	NA	NA	NA	NA	74,165	$34	452.9	29	74,165	$33.6	452.9	31
District of Columbia (b)	NA	NA	NA	NA	88,260	$50	563.1	10	88,260	$49.7	563.1	13
Florida	NA	NA	NA	NA	522,444	$160	307.0	39	522,444	$160.4	307.0	41
Georgia	34,654	$16.0	462.6	25	315,613	$159	503.2	21	350,267	$174.8	499.2	26
Hawaii	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Idaho	4,032	$2.2	542.6	22	38,997	$18	473.9	24	43,029	$20.7	480.4	28
Illinois	4,317	$2.5	579.1	21	289,420	$165	569.1	9	293,737	$167.2	569.2	10
Indiana	69,001	$30.4	439.9	28	250,304	$110	439.9	30	319,305	$140.5	439.9	33
Iowa	21,199	$7.5	353.2	31	59,942	$15	242.6	43	81,141	$22.0	271.5	44
Kansas	6,336	$5.2	820.7	8	95,881	$37	389.0	35	102,217	$42.5	415.8	35
Kentucky	NA	NA	NA	NA	180,892	$93	515.2	19	180,892	$93.2	515.2	20
Louisiana	26,710	$20.9	782.5	9	90,682	$39	433.4	31	117,392	$60.2	512.8	22
Maine (a)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maryland (b)	10,248	$4.7	458.6	26	241,707	$112	464.2	26	251,955	$116.9	464.0	29
Massachusetts (a)	10,921	$7.2	659.3	14	242,554	$136	560.3	11	253,475	$143.1	564.6	11
Michigan (b)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Minnesota	17,304	$13.1	758.9	10	147,326	$84	569.9	8	164,630	$97.1	589.8	8
Mississippi	37,354	$17.6	472.2	24	563,075	$146	260.0	41	600,429	$164.0	273.2	42
Missouri	13,369	$12.6	943.4	5	156,353	$82	523.6	16	169,722	$94.5	556.7	14
Montana	NA	NA	NA	NA	51,706	$16	318.0	38	51,706	$16.4	318.0	39
Nebraska	6,205	$1.9	306.2	32	107,416	$41	381.7	37	113,621	$42.9	377.6	38
Nevada	19,024	$9.2	483.6	23	40,171	$21	525.3	15	59,195	$30.3	511.9	23
New Hampshire	5,690	$4.2	743.0	11	66,388	$43	654.2	3	72,078	$47.7	661.2	4
New Jersey (b)	9,855	$18.0	1,826.5	2	688,005	$331	481.7	23	697,860	$349.4	500.7	24
New Mexico (a, c)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
New York (b)	137,500	$134.2	976.0	4	1,541,200	$798	517.5	18	1,678,700	$931.7	555.0	15
North Carolina	40,351	$24.4	604.7	18	383,134	$231	601.9	7	423,485	$255.0	602.2	7
North Dakota	3,300	$1.2	358.8	30	69,869	$19	267.7	40	73,169	$19.9	271.8	43
Ohio	NA	NA	NA	NA	142,508	$69	486.7	22	142,508	$69.4	486.7	27
Oklahoma	11,019	$6.7	608.0	17	55,212	$22	403.9	34	66,231	$29.0	437.9	34
Oregon	263	$0.2	681.8	13	95,413	$51	536.5	14	95,676	$51.4	536.9	17
Pennsylvania (a, c)	NA	NA	NA	NA	832,328	$452	543.5	12	832,328	$452.4	543.5	16
Rhode Island (c)	NA	NA	NA	NA	31,215	$26	838.3	2	31,215	$26.2	838.3	3
South Carolina	14,411	$4.1	284.5	33	133,390	$55	409.3	32	147,801	$58.7	397.2	36
South Dakota	19,453	$4.7	239.5	35	74,542	$14	190.1	44	93,995	$18.8	200.3	46
Tennessee	5,523	$3.5	633.7	15	244,474	$125	510.5	20	249,997	$128.3	513.2	21
Texas (b)	74,283	$28.3	381.0	29	517,097	$199	383.9	36	591,380	$226.8	383.5	37
Utah	17,309	$10.3	595.1	19	57,685	$23	405.7	33	74,994	$33.7	449.4	32
Vermont	NA	NA	NA	NA	NA	$8	NA	NA	NA	$7.7	NA	NA
Virginia (b)	12,296	$9.0	731.9	12	461,876	$280	605.8	6	474,172	$288.8	609.1	6
Washington	15,329	$9.0	588.5	20	524,656	$134	255.8	42	539,985	$143.2	265.2	45
West Virginia (b)	NA	NA	NA	NA	69,313	$36	517.9	17	69,313	$35.9	517.9	19
Wisconsin	31,234	$19.4	621.1	16	40,968	$26	624.9	5	72,202	$45.0	623.3	5
Wyoming	270	$0.8	2,867.4	1	16,521	$8	460.6	27	16,791	$8.4	499.3	25
Total	**715,098**	**452.6**	**632.9**		**9,984,066**	**4,652**	**$466.69**		**11,164,697**	**5,318**	**$476.31**	
Average (Mean)	**20,431**	**12.9**	**702.5**	**35**	**226,911**	**104**	**$480.15**	**44**	**242,711**	**113**	**$495.60**	**46**
Median	**11,871**	**7.2**	**604.7**		**101,649**	**50**	**$484.17**		**115,507**	**59**	**$506.27**	
Minimum	**263**	**0.2**	**239.5**		**16,521**	**8**	**$190.05**		**16,791**	**8**	**$200.28**	
Maximum	**137,500**	**134.2**	**2,867.4**		**1,541,200**	**798**	**$845.18**		**1,678,700**	**932**	**$951.54**	

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.
(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 36: SMHA Mental Health-Controlled Expenditures per Inpatient Day, All Forensic Patients in State Psychiatric Hospitals Receiving Mental Health Services, by State, FY 2005 (in Millions)

	Forensic Patients			Sexually Violent Predators						
State	Patient Days	Expenditures	Per Patient Day	Patient Days	Expenditures	Per Patient Day	Total Forensic/ SVP Patient Days	Expenditures	Per Patient	Rank
Alabama	41,422	$11.2	$270.39	NA	$0	NA	41,422	$11	$270.39	37
Alaska	2,763	$2.3	$839.70	NA	$0	NA	2,763	$2	$839.70	1
Arizona	46,769	$23.4	$500.33	25,508	$10	$376.35	72,277	$33	$456.58	16
Arkansas (a)	27,740	$4.8	$171.76	NA	$0	NA	27,740	$5	$171.76	41
California (b)	1,270,185	$577.4	$454.58	201,133	$91	$454.43	1,471,318	$669	$454.56	18
Colorado	88,574	$40.9	895.2	6	82,235	$39	468.8	25	94,106	$49.2
Connecticut (c)	$76.0	$461.72	NA	NA	NA	88,574	$41	$461.72	15	$91.6
Delaware (a, c)	93,676		$811.31	NA	$0	NA	93,676	$76	$811.31	2
District of Columbia (b)	10,191	$5.4	$532.00	NA	$0	NA	10,191	$5	$532.00	9
Florida	75,796	$30.0	$395.24	1,460	$1	$409.57	77,256	$31	$395.51	24
Georgia	348,308	$105.0	$301.51	188,321	$22	$115.61	536,629	$127	$236.27	40
Hawaii	162,611	$27.4	$168.21	NA	$0	NA	162,611	$27	$168.21	42
Idaho	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Illinois	2,904	$1.4	$495.14	1,417	$1	$593.80	4,321	$2	$527.49	10
Indiana	190,649	$107.7	$564.91	78,475	$17	$221.73	269,124	$125	$464.84	13
Iowa	69,032	$30.4	$439.92	NA	$0	NA	69,032	$30	$439.92	19
Kansas	3,295	$1.7	$512.81	17,202	$4	$209.59	20,497	$5	$258.33	38
Kentucky	38,949	$15.7	$403.09	44,530	$11	$235.80	83,479	$26	$313.85	31
Louisiana	26,888	$10.8	$401.67	NA	$0	NA	26,888	$11	$401.67	22
Maine (a)	172,802	$74.8	$432.87	NA	$0	NA	172,802	$75	$432.87	20
Maryland (b)	NA	$0.0	NA	NA	$0	NA	NA		NA	NA
Massachusetts (a)	213,160	$98.9	$463.97	NA	$0	NA	213,160	$99	$463.97	14
Michigan (b)	91,156	$50.9	$558.38	NA	$0	NA	91,156	$51	$558.38	7
Minnesota	NA	NA	NA	NA	NA	NA	NA	$0	NA	NA
Mississippi	91,902	$47.3	$514.94	101,326	$30	$300.76	193,228	$78	$402.63	21
Missouri	11,678	$3.3	$285.44	NA	$0	NA	11,678	$3	$285.44	33
Montana	258,265	$89.3	$345.74	36,201	$10	$277.63	294,466	$99	$337.37	27
Nebraska	15,834	$5.0	$318.04	NA	NA	NA	15,834	$5	$318.04	28
Nevada	44,778	$12.3	$274.69	26,645	$8	$288.98	71,423	$20	$280.02	34
New Hampshire	17,756	$5.6	$315.39	NA	$0	NA	17,756	$6	$315.39	30
New Jersey (b)	NA	$0.0	NA	NA	$0	NA	NA	$0	NA	NA
New Mexico (a, c)	145,290	$71.9	$494.87	114,975	$10	$88.71	260,265	$82	$315.45	29
New York (b)	25,035	NA	NA	NA	$0	NA	25,035	$0	NA	NA
North Carolina	244,600	$141.2	$577.27	NA	$0	NA	244,600	$141	$577.27	5
North Dakota	8,107	$6.0	$735.40	NA	$0	NA	8,107	$6	$735.40	4
Ohio	NA	$0.0	NA	11,059	$1	$106.14	11,059	$1	$106.14	43
Oklahoma	235,059	$127.4	$541.87	NA	$0	NA	235,059	$127	$541.87	8
Oregon	58,591	$16.3	$278.20	NA	$0	NA	58,591	$16	$278.20	35
Pennsylvania (a, c)	170,318	$52.4	$307.64	NA	$0	NA	170,318	$52	$307.64	32
Rhode Island (c)	69,014	$39.5	$572.83	NA	$0	NA	69,014	$40	$572.83	6
South Carolina	NA	NA	NA	NA	$0	NA	NA	$0	NA	NA
South Dakota	73,157	$19.7	$269.28	25,296	$4	$154.17	98,453	$24	$239.71	39
Tennessee	NA	$0.0	NA	NA	$0	NA	NA	$0	NA	NA
Texas (b)	73,972	$35.4	$478.56	NA	$0	NA	73,972	$35	$478.56	12
Utah	225,287	$88.2	$391.50	NA	$0	NA	225,287	$88	$391.50	25
Vermont	30,059	$12.0	$399.21	NA	$0	NA	30,059	$12	$399.21	23
Virginia (b)	16,766	$7.7	$456.28	NA	$0	NA	16,766	$8	$456.28	17
Washington	64,571	$14.7	$227.66	3,879	$4	$1,056.97	68,450	$19	$274.65	36
West Virginia (b)	530,045	$34.1	$64.26	NA	$0	NA	530,045	$34	$64.26	44
Wisconsin	25,187	$12.3	$488.35	NA	$0	NA	25,187	$12	$488.35	11
Wyoming	233,171	$82.2	$352.53	103,585	$34	$325.34	336,756	$116	$344.17	26
Total	**8,579**	**$6.5**	**$762.41**	**NA**	**$0**	**NA**	**8,579**	**$7**	**$762.41**	**3**
Average (Mean)	**5,653,891**	**2,226**	**$393.77**	**981,012**	**257**	**$261.99**	**6,634,903**	**2,483**	**$374.29**	
Median	**128,498**	**47**	**$433.30**	**61,313**	**5**	**$325.97**	**147,442**	**51**	**$407.55**	
Minimum	**69,023**	**20**	**$439.92**	**31,423**	**0**	**$283.31**	**72,277**	**24**	**$400.44**	
Maximum	**2,763**	**0**	**$64.26**	**1,417**	**0**	**$88.71**	**2,763**	**0**	**$64.26**	
	1,270,185	**577**	**$839.70**	**201,133**	**91**	**$1,056.97**	**1,471,318**	**669**	**$839.70**	**44**

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.
(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.
NA= Services provided but exact expenditures are unallocatable.

Table 37: SMHA-Controlled Mental Health Revenues, by Revenue Source and by State, FY 2005 (in Millions)

State	State General Funds	Percent	State Medicaid Match	Federal Medicaid	Total Medicaid	Percent	Medicare	Percent	CMHS MHBG	Percent	Other Federal	Percent	Local Gov	Percent	1st/3rd Party and Other	Percent	Total SMHA Revenues	FY 2005 per Capita
Alabama	157.9	58%	26.8	65.2	$92.0	34%	$9.3	3%	$6.7	2%	$2.6	1%	$0.0	0%	$21.2	2%	$273.7	$60.31
Alaska	31.4	18%	54.5	80.1	$134.6	78%	$2.6	1%	$0.8	0%	$3.2	2%	$0.0	0%	$0.9	1%	$173.5	$269.64
Arizona	134.0	16%	178.1	484.3	$662.4	78%	$0.1	0%	$7.7	1%	$4.1	0%	$0.0	0%	$45.2	5%	$853.5	$143.90
Arkansas (a)	60.5	61%	0.0	25.8	$25.8	26%	$1.5	2%	$3.5	4%	$1.7	2%	$0.0	0%	$5.7	6%	$98.6	$35.60
California (b)	1,632.6	38%	904.3	904.3	$1,808.6	42%	$38.7	1%	$54.5	1%	$6.0	0%	$0.0	0%	$730.0	17%	$4,270.4	$118.65
Colorado	146.5	43%	88.2	88.2	$176.3	51%	$8.0	2%	$5.2	2%	$5.3	2%	$0.0	0%	$2.4	1%	$343.8	$74.28
Connecticut (c)	528.0	91%	11.7	11.7	$23.4	4%	$6.0	1%	$5.2	1%	$10.6	2%	$0.0	0%	$6.4	1%	$579.6	$165.91
Delaware (a, c)	61.8	79%	6.8	8.1	$14.9	19%	$0.2	0%	$0.6	1%	$0.3	0%	$0.0	0%	$0.0	0%	$77.7	$92.73
District of Columbia (b)	193.1	83%	0.0	32.8	$32.8	14%	$2.5	1%	$0.8	0%	$4.5	2%	$0.0	0%	$0.0	0%	$233.8	$404.40
Florida	464.9	72%	46.8	72.6	$119.4	18%	$0.0	0%	$28.8	4%	$34.0	5%	$0.0	0%	$0.0	0%	$647.2	$36.56
Georgia	357.4	80%	49.7	5.6	$55.3	12%	$8.4	2%	$13.1	3%	$9.8	2%	$0.0	0%	$0.0	0%	$444.0	$48.98
Hawaii	184.7	95%	0.0	3.9	$3.9	2%	$0.3	0%	$1.7	1%	$2.9	1%	$0.0	0%	$0.5	0%	$194.1	$157.83
Idaho	37.4	64%	1.8	7.6	$9.4	16%	$0.0	0%	$1.8	3%	$8.7	15%	$0.0	0%	$0.9	2%	$58.3	$40.90
Illinois	591.7	58%	203.0	198.1	$401.1	39%	$4.3	0%	$16.9	2%	$5.9	1%	$0.0	0%	$1.8	0%	$1,021.7	$80.15
Indiana	105.2	20%	146.4	247.0	$393.4	76%	$0.6	0%	$7.6	1%	$10.3	2%	$0.0	0%	$1.5	0%	$518.7	$82.79
Iowa	78.2	33%	35.8	63.0	$98.8	41%	$0.0	0%	$3.7	2%	$6.5	3%	$52.7	22%	$0.0	0%	$239.8	$80.89
Kansas	92.0	36%	29.3	126.5	$155.8	61%	$0.0	0%	$2.7	1%	$3.2	1%	$0.0	0%	$0.0	0%	$253.7	$92.81
Kentucky	127.3	61%	17.5	42.6	$60.0	29%	$9.9	5%	$5.7	3%	$3.1	1%	$0.0	0%	$2.4	1%	$208.4	$50.22
Louisiana	110.7	43%	30.6	75.0	$105.6	41%	$0.3	0%	$5.2	2%	$5.2	2%	$0.0	0%	$31.5	12%	$258.5	$57.59
Maine (a)	49.3	27%	91.1	32.7	$123.8	69%	$1.1	1%	$1.8	1%	$4.3	2%	$0.0	0%	$0.0	0%	$180.3	$137.15
Maryland (b)	582.8	75%	0.0	181.0	$181.0	23%	$0.0	0%	$8.1	1%	$4.6	1%	$0.0	0%	$0.0	0%	$776.5	$139.75
Massachusetts (a)	672.8	82%	0.0	129.3	$129.3	16%	$4.8	1%	$8.5	1%	$4.3	1%	$0.0	0%	$4.1	0%	$823.8	$128.13
Michigan (b)	333.3	34%	246.4	354.5	$600.9	62%	$4.0	0%	$10.4	1%	$0.5	0%	$21.8	2%	$2.6	0%	$973.5	$96.40
Minnesota	276.6	41%	146.4	157.2	$303.6	45%	$3.7	1%	$6.3	1%	$19.1	3%	$32.6	5%	$27.4	4%	$669.3	$130.60
Mississippi	129.6	42%	36.0	120.9	$156.9	51%	$0.0	0%	$4.1	1%	$3.7	1%	$0.0	0%	$11.6	4%	$305.9	$105.68
Missouri	281.9	48%	42.2	224.0	$266.2	46%	$12.9	2%	$7.1	1%	$11.2	2%	$0.0	0%	$3.3	1%	$582.6	$100.75
Montana	38.5	31%	22.1	62.9	$85.0	68%	$0.0	0%	$1.0	1%	$0.4	0%	$0.0	0%	$0.0	0%	$124.8	$134.03
Nebraska	101.9	86%	0.0	9.9	$9.9	8%	$0.9	NA	$2.1	2%	$2.3	2%	$1.5	1%	$0.0	0%	$118.5	$67.65
Nevada	104.9	70%	10.2	12.5	$22.7	15%	$3.7	2%	$3.1	2%	$9.8	7%	$0.0	0%	$6.3	4%	$150.5	$62.62
New Hampshire	44.8	29%	45.5	45.5	$91.0	59%	$6.6	4%	$1.5	1%	$5.2	3%	$0.0	0%	$5.7	4%	$154.9	$118.65
New Jersey (b)	784.2	64%	115.1	115.1	$230.2	19%	$48.8	4%	$11.1	1%	$2.2	0%	$55.2	5%	$84.1	7%	$1,215.8	$139.84
New Mexico (a, c)	39.5	83%	1.1	3.5	$4.6	10%	$0.2	0%	$0.9	2%	$0.2	0%	$0.0	0%	$2.3	5%	$47.7	$24.91
New York (b)	1,058.4	28%	1,033.5	1,048.6	$2,082.1	56%	$240.8	6%	$28.9	1%	$73.0	2%	$69.2	2%	$195.0	5%	$3,747.4	$194.28
North Carolina	316.4	31%	203.5	413.7	$617.1	60%	$28.2	3%	$9.7	1%	$2.6	0%	$35.6	3%	$18.1	2%	$1,027.8	$119.82
North Dakota	22.2	47%	1.1	9.1	$10.2	22%	$1.3	3%	$0.8	2%	$4.4	9%	$0.0	0%	$7.9	17%	$46.8	$74.39
Ohio	433.0	54%	87.1	241.9	$329.0	41%	$13.9	2%	$15.3	2%	$10.3	1%	$0.0	0%	$2.1	0%	$803.5	$70.09
Oklahoma	121.1	77%	10.7	8.9	$19.6	12%	$3.8	2%	$4.9	3%	$3.5	2%	$0.0	0%	$4.7	3%	$157.6	$44.76
Oregon	122.6	28%	116.0	183.3	$299.3	69%	$0.0	0%	$4.4	1%	$1.5	0%	$0.0	NA	$6.7	2%	$434.6	$119.48
Pennsylvania (a, c)	1,613.8	64%	112.5	597.6	$710.1	28%	$8.0	0%	$17.4	1%	$154.2	6%	$0.0	0%	$37.4	1%	$2,540.8	$204.88
Rhode Island (c)	13.6	13%	38.4	48.0	$86.3	84%	$0.0	0%	$1.4	1%	$1.1	1%	$0.0	0%	$0.0	0%	$102.4	$95.55
South Carolina	106.9	38%	33.0	122.4	$155.4	55%	$0.8	0%	$5.9	2%	$2.8	1%	$3.0	1%	$10.1	4%	$284.9	$67.63
South Dakota	31.9	58%	6.6	12.6	$19.2	35%	$2.1	4%	$0.8	1%	$0.9	2%	$0.0	0%	$0.3	0%	$55.2	$71.47
Tennessee	144.2	28%	101.1	254.5	$355.6	68%	$9.1	2%	$8.1	2%	$2.0	0%	$0.0	0%	$3.0	1%	$522.0	$87.91
Texas (b)	523.9	63%	73.8	112.5	$186.3	22%	$18.5	2%	$33.0	4%	$19.2	2%	$19.3	2%	$32.0	4%	$832.2	$36.47
Utah	60.6	38%	0.0	83.2	$83.2	52%	$1.5	1%	$2.6	2%	$2.9	2%	$7.9	5%	$1.2	1%	$159.9	$64.34
Vermont	19.6	18%	34.2	51.5	$85.7	79%	$0.4	0%	$0.8	1%	$2.3	2%	$0.0	0%	$0.2	0%	$109.0	$175.16
Virginia (b)	352.9	64%	77.8	77.8	$155.6	28%	$9.1	2%	$9.7	2%	$2.3	0%	$0.0	0%	$20.6	4%	$550.2	$74.14
Washington	54.1	9%	251.9	253.2	$505.1	86%	$11.2	2%	$8.1	1%	$1.3	0%	$0.0	0%	$5.3	1%	$585.2	$93.92
West Virginia (b)	50.1	42%	11.0	33.1	$44.1	37%	$2.9	2%	$2.6	2%	$18.4	15%	$0.0	0%	$0.8	1%	$118.9	$65.56
Wisconsin	305.8	53%	56.7	78.7	$135.5	23%	$5.7	1%	$6.8	1%	$0.2	0%	$113.6	20%	$12.1	2%	$579.7	$104.90
Wyoming	43.2	83%	3.3	4.4	$7.7	15%	$0.0	0%	$0.4	1%	$0.4	1%	$0.0	0%	$0.0	0%	$51.8	$102.45
Total	**$13,929.6**	**47%**	**$4,839.5**	**$7,626.4**	**$12,465.9**	**42%**	**$536.7**	**1.8%**	**$400.1**	**1.4%**	**$499.0**	**1.7%**	**$412.4**	**1.4%**	**$1,339.4**	**4.5%**	**$29,583**	**$100.17**
Average (Mean)	**$273.1**		**$94.9**	**$149.5**	**$244.4**		**$10.5**		**$7.8**		**$9.8**		**$8.1**		**$26.3**	**0%**	**$580**	
Median	**$127.3**		**$36.0**	**$77.8**	**$123.8**		**$2.6**		**$5.2**		**$3.7**		**$0.0**		**$1.1**	**0%**	**$285**	**$92.81**

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.
(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 38: SMHA-Controlled Mental Health Revenues to Community Programs, by Revenue Source and by State, FY 2005 (in Millions)

State	State General Funds	Percent	State Medicaid Match	Federal Medicaid	Total Medicaid	Percent	Medicare	Percent	CMHS MHBG	Percent	Other Federal	Percent	Local Gov	Percent	1st/3rd Party and Other	Percent	Total SMHA Revenues	FY 2005 per Capita
Alabama	49.6	36%	22.7	55.1	$77.8	57%	$0.0	0%	$6.6	5%	$2.5	2%	$0.0	0%	$0.4	0%	$136.9	$30.16
Alaska	22.2	15%	50.5	74.8	$125.3	84%	$0.0	0%	$0.8	1%	$1.1	1%	$0.0	0%	$0.0	0%	$149.4	$232.10
Arizona	104.2	14%	164.7	453.8	$618.5	80%	$0.0	0%	$7.3	1%	$1.8	0%	$0.0	0%	$38.6	5%	$770.4	$129.89
Arkansas (a)	32.5	88%	0.0	0.0	$0.0	0%	$0.0	0%	$3.4	9%	$1.1	3%	$0.0	0%	$0.0	0%	$37.0	$13.35
California (b)	931.8	27%	895.1	895.1	$1,790.2	52%	$38.7	1%	$51.1	1%	$6.0	0%	$0.0	0%	$656.4	19%	$3,474.2	$96.53
Colorado	72.7	29%	82.4	82.4	$164.8	66%	$0.0	0%	$4.8	2%	$4.8	2%	$0.0	0%	$0.8	0%	$247.9	$53.57
Connecticut (c)	310.4	89%	8.9	8.9	$17.8	5%	$1.5	0%	$5.2	1%	$9.4	3%	$0.0	0%	$2.9	1%	$347.2	$99.39
Delaware (a, c)	23.8	62%	6.8	6.8	$13.5	35%	$0.2	0%	$0.6	2%	$0.3	1%	$0.0	0%	$0.0	0%	$38.3	$45.74
District of Columbia (b)	105.7	80%	0.0	23.9	$23.9	18%	$0.0	0%	$0.8	1%	$1.9	1%	$0.0	0%	$0.0	0%	$132.3	$228.82
Florida	277.2	80%	8.5	8.5	$16.9	5%	$0.0	0%	$28.2	8%	$25.6	7%	$0.0	0%	$0.0	0%	$347.9	$19.66
Georgia	163.6	68%	49.7	5.6	$55.3	23%	$0.0	0%	$13.1	5%	$9.8	4%	$0.0	0%	$0.0	0%	$241.8	$26.67
Hawaii	130.9	95%	0.0	3.9	$3.9	3%	$0.3	0%	$1.7	1%	$0.6	0%	$0.0	0%	$0.5	0%	$138.0	$112.21
Idaho	17.6	59%	1.3	1.8	$3.2	11%	$0.0	0%	$1.7	6%	$6.9	23%	$0.0	0%	$0.4	1%	$29.8	$20.90
Illinois	300.5	42%	197.3	192.1	$389.4	55%	$0.0	0%	$16.1	2%	$5.3	1%	$0.0	0%	$0.0	0%	$711.3	$55.80
Indiana	53.4	15%	104.2	172.2	$276.4	80%	$0.0	0%	$7.2	2%	$7.7	2%	$0.0	0%	$0.0	0%	$344.7	$55.02
Iowa	46.4	23%	34.5	60.3	$94.8	48%	$0.0	0%	$3.5	2%	$4.2	2%	$49.7	25%	$0.0	0%	$198.6	$66.98
Kansas	49.9	27%	29.3	99.9	$129.2	70%	$0.0	0%	$2.7	1%	$3.2	2%	$0.0	0%	$0.0	0%	$185.0	$67.68
Kentucky	59.9	63%	7.0	18.9	$25.8	27%	$0.0	0%	$5.5	6%	$2.7	3%	NA		$1.3	1%	$95.3	$22.97
Louisiana	67.2	68%	4.0	9.8	$13.8	14%	$0.3	0%	$3.5	4%	$0.0	0%	$0.0	0%	$14.6	15%	$99.4	$22.15
Maine (a)	48.4	39%	73.7	0.0	$73.7	59%	$0.0	0%	$1.8	1%	$0.3	0%	$0.0	0%	$0.0	0%	$124.2	$94.48
Maryland (b)	311.7	63%	0.0	170.4	$170.4	34%	$0.0	0%	$8.1	2%	$4.4	1%	$0.0	0%	$0.0	0%	$494.6	$89.02
Massachusetts (a)	534.0	79%	0.0	120.6	$120.6	18%	$4.1	1%	$8.1	1%	$4.1	1%	$0.0	0%	$3.5	1%	$674.4	$104.90
Michigan (b)	147.6	20%	240.1	340.8	$580.9	78%	$0.0	0%	$10.1	1%	$0.2	0%	$10.2	1%	$0.0	0%	$749.0	$74.17
Minnesota	141.6	30%	137.5	148.4	$285.9	60%	$0.0	0%	$5.2	1%	$18.8	4%	$8.9	2%	$15.2	3%	$475.6	$92.80
Mississippi	8.8	7%	25.7	86.4	$112.1	88%	$0.0	0%	$3.9	3%	$2.8	2%	$0.0	0%	$0.0	0%	$127.6	$44.09
Missouri	60.0	30%	42.2	66.7	$108.9	55%	$12.4	6%	$6.9	3%	$9.6	5%	$0.0	0%	$0.0	0%	$197.8	$34.20
Montana	13.8	14%	22.1	60.7	$82.8	85%	$0.0	0%	$1.0	1%	$0.4	0%	$0.0	0%	$0.0	0%	$97.9	$105.12
Nebraska	43.5	87%	0.0	4.0	$4.0	8%	$0.0	0%	$2.0	4%	$0.0	0%	$0.6	1%	$0.0	0%	$50.1	$28.59
Nevada	75.2	68%	7.7	9.4	$17.1	15%	$0.4	0%	$3.0	3%	$9.4	8%	$0.0	0%	$6.2	6%	$111.3	$46.31
New Hampshire	4.1	5%	36.8	36.8	$73.6	85%	$2.7	3%	$1.5	2%	$5.0	6%	$0.0	0%	$0.0	0%	$86.9	$66.59
New Jersey (b)	425.2	55%	99.2	99.2	$198.4	26%	$26.6	3%	$10.7	1%	$1.5	0%	$31.0	4%	$76.4	10%	$769.8	$88.55
New Mexico (a, c)	20.1	95%	0.0	0.0	$0.0	0%	$0.0	0%	$0.9	4%	$0.2	1%	$0.0	0%	$0.0	0%	$21.2	$11.07
New York (b)	467.0	22%	569.8	569.8	$1,139.6	54%	$175.5	8%	$27.6	1%	$73.0	3%	$44.4	2%	$178.8	8%	$2,105.9	$109.18
North Carolina	100.5	14%	189.9	387.6	$577.4	80%	$0.0	0%	$9.7	1%	$2.4	0%	$33.5	5%	$0.0	0%	$723.5	$84.35
North Dakota	9.8	38%	0.0	6.8	$6.8	27%	$0.0	0%	$0.8	3%	$4.4	17%	$0.0	0%	$3.8	15%	$25.7	$40.82
Ohio	219.8	38%	86.8	240.5	$327.3	57%	$0.0	0%	$14.5	3%	$10.3	2%	$0.0	0%	$0.0	0%	$572.0	$49.90
Oklahoma	76.7	75%	8.8	5.0	$13.8	14%	$2.0	2%	$4.6	5%	$2.3	2%	$0.0	0%	$2.5	2%	$101.9	$28.94
Oregon	40.7	13%	105.1	167.6	$272.7	86%	$0.0	0%	$4.4	1%	$0.4	0%	$0.0	0%	$0.1	0%	$318.4	$87.54
Pennsylvania (a, c)	1,191.3	59%	84.7	564.9	$649.6	32%	$0.0	0%	$17.4	1%	$154.2	8%	$0.0	0%	$19.6	1%	$2,032.1	$163.86
Rhode Island (c)	12.4	17%	26.7	33.4	$60.2	81%	$0.0	0%	$1.4	2%	$0.5	1%	$0.0	0%	$0.0	0%	$74.4	$69.48
South Carolina	43.4	25%	30.4	82.9	$113.3	64%	$0.0	0%	$5.9	3%	$2.8	2%	$3.0	2%	$7.5	4%	$175.9	$41.75
South Dakota	7.6	38%	4.0	6.7	$10.7	54%	$0.0	0%	$0.8	4%	$0.8	4%	$0.0	0%	$0.1	0%	$19.9	$25.84
Tennessee	38.4	11%	67.7	229.5	$297.2	86%	$0.0	0%	$7.7	2%	$1.8	1%	$0.0	0%	$0.1	0%	$345.2	$58.14
Texas (b)	252.6	51%	61.9	95.0	$156.9	32%	$0.0	0%	$31.1	6%	$17.3	4%	$19.3	4%	$17.0	3%	$494.2	$21.66
Utah	26.1	23%	0.0	74.0	$74.0	65%	$0.0	0%	$2.4	2%	$2.7	2%	$7.9	7%	$0.0	0%	$113.1	$45.51
Vermont	4.3	5%	33.0	50.4	$83.4	92%	$0.0	0%	$0.8	1%	$2.1	2%	$0.0	0%	$0.0	0%	$90.6	$145.59
Virginia (b)	112.4	50%	50.5	50.5	$101.0	45%	$0.0	0%	$9.7	4%	$0.8	0%	$0.0	0%	$0.0	0%	$223.9	$30.17
Washington	30.1	8%	177.8	179.0	$356.8	90%	$0.0	0%	$7.7	2%	$0.8	0%	$0.0	0%	$0.0	0%	$395.4	$63.46
West Virginia (b)	24.5	35%	11.0	32.4	$43.4	61%	$0.0	0%	$2.6	4%	$0.2	0%	$0.0	0%	$0.0	0%	$70.7	$38.99
Wisconsin	176.4	42%	50.6	70.3	$120.8	29%	$0.0	0%	$6.8	2%	$0.0	0%	$113.6	27%	$0.0	0%	$417.6	$75.57
Wyoming	18.2	68%	3.2	4.4	$7.7	29%	$0.0	0%	$0.4	2%	$0.4	2%	$0.0	0%	$0.0	0%	$26.7	$52.79
Total	**$7,505.6**	**37%**	**$3,913.6**	**$6,167.8**	**$10,081.4**	**50%**	**$264.8**	**1.3%**	**$383.5**	**1.9%**	**$428.9**	**2.1%**	**$322.1**	**1.6%**	**$1,046.8**	**3.8%**	**$20,033**	**$67.84**
Average (Mean)	**$147.2**		**$76.7**	**$120.9**	**$197.7**		**$5.2**		**$7.5**		**$8.4**		**$6.4**		**$20.5**	**0.0%**	**$393**	
Median	**$59.9**		**$30.4**	**$60.7**	**$94.8**		**$0.0**		**$4.8**		**$2.5**		**$0.0**		**$0.0**	**0.0%**	**$185**	**$55.80**

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.
(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 39: SMHA-Controlled Mental Health Medicaid Revenues as a Percentage of Total State Medicaid Spending, by State, FY 2005

State	State Medicaid Match	Federal Medicaid	Total SMHA Mental Health Medicaid	Percent	Total State Medicaid Expenditures
Alabama	26,800,000	65,200,000	92,000,000	2.3%	$4,062,000,000
Alaska	54,526,100	80,065,300	134,591,400	13.1%	$1,027,000,000
Arizona	178,100,000	484,300,000	662,400,000	14.9%	$4,443,000,000
Arkansas (a)	0	25,778,175	25,778,175	0.9%	$3,007,000,000
California (b)	904,300,000	904,300,000	1,808,600,000	5.5%	$32,907,000,000
Colorado	88,174,156	88,174,156	176,348,312	7.0%	$2,508,000,000
Connecticut (c)	11,700,000	11,700,000	23,400,000	0.6%	$3,716,000,000
Delaware (a, c)	6,754,621	8,114,421	14,869,041	1.6%	$917,000,000
District of Columbia (b)	0	32,838,143	32,838,143	2.6%	$1,276,605,955
Florida	46,842,518	72,561,761	119,404,279	0.9%	$13,890,000,000
Georgia	49,716,516	5,603,124	55,319,640	0.9%	$6,470,000,000
Hawaii	0	3,900,000	3,900,000	0.4%	$912,000,000
Idaho	1,787,300	7,602,000	9,389,300	0.9%	$1,053,000,000
Illinois	203,000,000	198,100,000	401,100,000	3.4%	$11,834,000,000
Indiana	146,412,871	247,028,240	393,441,111	8.7%	$4,510,000,000
Iowa	35,761,240	62,993,584	98,754,824	4.2%	$2,334,000,000
Kansas	29,300,000	126,500,000	155,800,000	7.2%	$2,162,000,000
Kentucky	17,478,800	42,551,500	60,030,300	1.4%	$4,249,000,000
Louisiana	30,600,000	75,000,000	105,600,000	2.1%	$5,066,000,000
Maine (a)	91,100,000	32,700,000	123,800,000	5.9%	$2,099,000,000
Maryland (b)	0	181,000,000	181,000,000	3.5%	$5,167,000,000
Massachusetts (a)	0	129,300,000	129,300,000	2.2%	$5,998,000,000
Michigan (b)	246,400,000	354,500,000	600,900,000	6.9%	$8,687,000,000
Minnesota	146,362,857	157,247,177	303,610,034	5.7%	$5,312,000,000
Mississippi	35,992,617	120,886,796	156,879,413	4.3%	$3,637,000,000
Missouri	42,218,067	223,963,205	266,181,272	4.1%	$6,561,000,000
Montana	22,055,823	62,908,814	84,964,637	12.4%	$683,000,000
Nebraska	0	9,900,000	9,900,000	0.7%	$1,431,000,000
Nevada	10,200,000	12,500,000	22,700,000	2.0%	$1,143,000,000
New Hampshire	45,511,433	45,511,433	91,022,866	7.5%	$1,219,000,000
New Jersey (b)	115,097,000	115,097,000	230,194,000	3.0%	$7,568,000,000
New Mexico (a, c)	1,100,000	3,500,000	4,600,000	0.2%	$2,401,000,000
New York (b)	1,033,500,000	1,048,600,000	2,082,100,000	7.1%	$29,355,000,000
North Carolina	203,455,582	413,674,823	617,130,405	7.3%	$8,489,000,000
North Dakota	1,101,680	9,139,075	10,240,755	2.0%	$513,000,000
Ohio	87,108,088	241,908,079	329,016,167	2.6%	$12,564,000,000
Oklahoma	10,700,000	8,900,000	19,600,000	0.7%	$2,735,000,000
Oregon	115,988,082	183,320,297	299,308,379	9.4%	$3,192,000,000
Pennsylvania (a, c)	112,487,483	597,605,376	710,092,859	4.3%	$16,638,000,000
Rhode Island (c)	38,377,310	47,950,949	86,328,259	5.2%	$1,662,000,000
South Carolina	33,000,000	122,400,000	155,400,000	3.6%	$4,318,000,000
South Dakota	6,621,998	12,612,632	19,234,630	3.1%	$628,000,000
Tennessee	101,100,000	254,500,000	355,600,000	4.1%	$8,570,000,000
Texas (b)	73,800,000	112,500,000	186,300,000	1.1%	$17,713,000,000
Utah	0	83,233,100	83,233,100	6.0%	$1,393,000,000
Vermont	34,200,000	51,500,000	85,700,000	10.1%	$849,000,000
Virginia (b)	77,800,000	77,800,000	155,600,000	3.6%	$4,309,000,000
Washington	251,904,979	253,179,755	505,084,734	8.2%	$6,161,000,000
West Virginia (b)	11,000,000	33,100,000	44,100,000	2.1%	$2,088,000,000
Wisconsin	56,728,729	78,723,945	135,452,674	3.1%	$4,384,000,000
Wyoming	3,293,651	4,429,351	7,723,002	1.8%	$427,000,000
Total	**$4,839,459,501**	**$7,626,402,210**	**$12,465,861,711**	**4.4%**	**$284,237,605,955**
Average (Mean)	**$94,891,363**	**$149,537,298**	**$244,428,661**	**4.4%**	**$5,573,286,391**
Median	**$35,992,617**	**$77,800,000**	**$123,800,000**	**3.5%**	**$3,716,000,000**
Number of States Reporting	**51**		**51**		**51**

Note: Total state government Medicaid data from NASBO Fiscal Survey of the States, FY 2005; DC data from CMS

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.

(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 40: FY 2001 to FY 2005 SMHA-Controlled Mental Health Expenditures (in Millions)

State	State Psychiatric Hospital Inpatient					Community Mental Health					Total SMHA-Con trolled				
	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Alabama	$103.6	$107.4	$105.0	$112.5	$125.3	$142.6	$152.7	$161.9	$146.3	$140.6	$253.3	$267.9	$273.6	$265.6	$273.7
Alaska	$17.1	$17.2	$18.0	$18.7	$19.3	$31.2	$21.7	$32.1	$158.5	$149.4	$51.4	$54.9	$53.6	$182.7	$173.5
Arizona	$46.4	$55.8	$61.5	$63.1	$62.6	$415.4	$485.4	$626.5	$700.1	$791.4	$472.3	$553.2	$702.3	$776.0	$867.3
Arkansas (a)	$23.2	$25.3	$25.6	$26.6	$28.2	$49.2	$48.4	$50.2	$58.6	$63.5	$75.7	$76.4	$80.5	$90.5	$98.6
California (b)	$569.5	$625.9	$631.1	$699.7	$764.4	$2,546.4	$2,997.2	$3,199.3	$3,327.6	$3,474.1	$3,147.8	$3,656.3	$3,861.7	$4,060.3	$4,270.2
Colorado	$83.6	$92.0	$79.5	$72.1	$90.1	$197.6	$207.7	$218.3	$241.8	$252.4	$282.6	$301.2	$299.5	$315.6	$343.8
Connecticut (c)	$133.5	$140.1	$138.7	$146.2	$167.6	$267.3	$294.4	$334.6	$333.8	$327.7	$439.5	$478.2	$525.0	$531.7	$549.2
Delaware (a, c)	$47.4	$44.6	$36.5	$37.2	$39.0	$24.6	$24.7	$28.7	$31.6	$34.1	$73.5	$69.3	$66.2	$70.2	$74.8
District of Columbia (b)	$103.3	$79.5	$77.5	$80.8	$80.3	$123.3	$122.4	$128.5	$119.0	$132.3	$226.6	$231.8	$231.5	$225.3	$233.8
Florida	$252.0	$390.5	$275.4	$275.1	$287.2	$316.0	$336.2	$357.5	$336.6	$347.9	$578.3	$736.3	$643.9	$623.1	$647.2
Georgia	$173.6	$180.2	$189.0	$192.9	$202.2	$184.9	$206.6	$226.5	$240.5	$241.8	$380.6	$399.1	$429.6	$448.7	$444.0
Hawaii	$33.8	$36.6	$42.9	$50.0	$52.7	$152.5	$140.3	$96.3	$110.1	$131.2	$213.6	$194.3	$152.1	$180.3	$192.6
Idaho	$22.0	$19.9	$19.1	$18.8	$22.9	$37.4	$28.8	$24.6	$32.6	$30.9	$60.5	$53.5	$45.9	$54.9	$53.9
Illinois	$306.7	$280.4	$256.8	$255.5	$292.3	$465.7	$566.3	$555.8	$595.5	$711.3	$789.9	$865.2	$835.1	$869.5	$1,021.7
Indiana	$146.9	$148.5	$143.7	$159.8	$170.8	$261.2	$274.6	$301.1	$339.4	$344.7	$411.9	$427.3	$448.3	$502.5	$518.7
Iowa	$36.1	$37.7	$29.0	$30.1	$27.3	$115.7	$118.7	$183.5	$190.2	$204.3	$152.4	$157.0	$217.0	$224.9	$235.6
Kansas	$57.4	$58.1	$58.4	$62.9	$68.7	$102.0	$130.9	$145.2	$163.3	$185.0	$161.8	$189.0	$203.6	$226.2	$253.7
Kentucky	$100.7	$102.6	$99.2	$99.1	$104.0	$92.5	$101.3	$102.5	$97.8	$95.3	$196.9	$207.1	$210.0	$205.0	$208.4
Louisiana	$116.2	$130.1	$122.8	$122.7	$135.0	$80.7	$76.4	$96.8	$103.4	$106.3	$200.9	$214.8	$229.8	$236.6	$258.5
Maine (a)	$41.3	$49.4	$51.5	$52.5	$51.9	$89.6	$96.5	$111.7	$114.4	$124.2	$137.5	$152.5	$166.5	$171.6	$180.3
Maryland (b)	$203.5	$216.6	$221.8	$218.3	$215.8	$444.4	$491.6	$549.5	$578.0	$526.2	$677.8	$739.5	$805.0	$828.5	$776.5
Massachusetts (a)	$122.7	$125.9	$121.9	$107.4	$112.7	$538.4	$542.8	$540.3	$539.2	$552.3	$682.2	$689.6	$682.8	$666.8	$685.6
Michigan (b)	$295.2	$281.0	$253.6	$235.2	$217.2	$540.1	$626.8	$725.1	$676.3	$749.0	$844.4	$915.8	$985.5	$919.6	$973.5
Minnesota	$154.8	$157.7	$174.0	$166.0	$174.9	$359.9	$415.9	$452.2	$470.0	$490.9	$518.0	$576.6	$629.4	$639.0	$669.3
Mississippi	$147.2	$143.8	$150.4	$152.8	$167.4	$96.7	$109.0	$114.6	$119.9	$135.5	$246.8	$255.5	$267.8	$275.7	$305.9
Missouri	$169.5	$162.2	$181.4	$192.6	$193.8	$151.4	$216.9	$191.2	$194.8	$209.5	$336.2	$390.9	$382.8	$397.8	$414.0
Montana	$19.4	$18.0	$18.3	$20.1	$21.5	$88.4	$98.2	$92.1	$94.1	$99.4	$111.7	$119.4	$112.8	$117.6	$124.8
Nebraska	$54.9	$55.9	$62.5	$62.2	$62.9	$30.1	$37.4	$36.2	$36.7	$40.0	$86.6	$95.7	$100.9	$101.4	$106.1
Nevada	$43.5	$39.2	$39.4	$30.5	$35.9	$75.6	$88.3	$98.1	$93.5	$111.3	$120.2	$128.7	$140.1	$126.6	$150.5
New Hampshire	$41.5	$44.0	$45.5	$46.3	$47.7	$96.4	$99.6	$101.2	$102.0	$103.3	$140.5	$147.2	$150.8	$152.2	$154.9
New Jersey (b)	$297.0	$337.7	$364.5	$404.0	$431.5	$452.8	$674.6	$705.9	$741.8	$769.8	$763.1	$1,025.5	$1,083.9	$1,159.5	$1,215.8
New Mexico (a, c)	$21.9	$21.5	$22.1	$18.4	$21.7	$36.8	$31.4	$31.6	$34.2	$24.7	$59.0	$53.0	$53.7	$52.5	$46.4
New York (b)	$992.6	$1,052.8	$1,045.5	$1,056.4	$1,072.9	$2,210.2	$2,327.6	$2,479.4	$2,619.2	$2,733.6	$3,331.7	$3,526.8	$3,681.4	$3,840.9	$3,977.5
North Carolina	$300.1	$284.0	$273.5	$253.7	$261.0	$139.5	$121.9	$141.7	$724.9	$749.9	$442.7	$408.4	$417.3	$994.2	$1,027.8
North Dakota	$22.4	$23.8	$23.1	$19.2	$18.7	$26.8	$27.4	$27.7	$26.7	$28.0	$49.9	$51.3	$50.8	$45.9	$46.8
Ohio	$193.8	$188.3	$185.4	$189.9	$196.7	$469.7	$481.7	$494.8	$514.6	$531.5	$692.3	$698.7	$708.9	$733.5	$757.7
Oklahoma	$40.7	$44.1	$43.9	$42.3	$45.3	$87.5	$90.9	$86.0	$88.4	$101.9	$136.1	$142.4	$137.5	$139.2	$157.3
Oregon	$81.0	$89.9	$79.5	$96.0	$103.8	$115.8	$115.1	$117.1	$118.4	$318.4	$201.9	$209.5	$201.0	$218.4	$434.6
Pennsylvania (a, c)	$399.1	$398.7	$399.3	$408.7	$491.9	$1,447.1	$1,638.5	$1,993.6	$1,887.0	$2,032.6	$1,859.8	$2,052.8	$2,410.5	$2,312.5	$2,541.3
Rhode Island (c)	$23.7	$23.0	$23.9	$24.4	$26.2	$66.7	$69.4	$69.5	$74.0	$74.4	$92.5	$94.4	$95.3	$100.1	$102.4
South Carolina	$108.8	$101.5	$86.0	$80.1	$82.3	$174.2	$164.5	$173.8	$183.0	$187.7	$299.4	$283.0	$276.1	$280.1	$285.2
South Dakota	$30.6	$31.2	$32.5	$33.4	$34.9	$14.3	$17.6	$17.6	$19.1	$20.2	$45.7	$49.4	$50.1	$53.3	$55.1
Tennessee	$126.8	$137.8	$148.5	$155.3	$163.7	$257.7	$338.4	$346.8	$350.5	$345.2	$395.2	$486.5	$508.0	$518.7	$522.0
Texas (b)	$306.2	$325.6	$351.0	$330.6	$315.0	$462.4	$479.5	$479.5	$475.4	$503.6	$797.0	$833.0	$858.2	$821.0	$832.2
Utah	$41.3	$41.1	$40.1	$42.9	$45.7	$116.9	$118.1	$125.1	$131.2	$113.1	$159.3	$159.2	$166.4	$175.3	$159.9
Vermont	$9.6	$10.5	$12.3	$12.8	$15.3	$67.9	$76.1	$79.4	$87.1	$90.6	$79.7	$89.2	$94.3	$103.1	$109.0
Virginia (b)	$277.7	$275.9	$290.1	$293.5	$307.6	$162.8	$179.8	$189.6	$202.4	$223.9	$466.6	$479.6	$495.6	$509.8	$531.5
Washington	$167.9	$173.1	$171.7	$170.9	$177.3	$345.7	$368.6	$368.0	$392.2	$395.4	$525.6	$554.5	$552.8	$575.3	$585.5
West Virginia (b)	$36.9	$44.5	$48.1	$50.1	$48.2	$48.5	$38.8	$39.5	$58.4	$70.7	$87.1	$83.9	$88.2	$108.5	$118.9
Wisconsin	$109.7	$160.2	$170.5	$151.1	$160.9	$293.5	$331.1	$325.7	$369.6	$417.6	$405.4	$492.7	$497.8	$522.3	$579.7
Wyoming	$13.1	$13.6	$15.1	$16.6	$14.9	$16.2	$24.4	$35.6	$34.2	$34.2	$30.1	$38.4	$51.4	$51.5	$50.0
Total**	**$7,267**	**$7,645**	**$7,557**	**$7,658**	**$8,077**	**$15,130**	**$16,873**	**$18,210**	**$19,478**	**$20,673**	**$22,991**	**$25,156**	**$26,413**	**$27,802**	**$29,397**
Mediian	**$103**	**$102**	**$86**	**$96**	**$104**	**$140**	**$131**	**$145**	**$163**	**$188**	**$247**	**$256**	**$268**	**$266**	**$285**
Average	**$142**	**$150**	**$148**	**$150**	**$158**	**$297**	**$331**	**$357**	**$382**	**$405**	**$451**	**$493**	**$518**	**$545**	**$576**
State Reporting	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**

**Total percent changes are calculated based only on states reporting data for both years being compared.

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.

(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 41: FY 2001 to FY 2005 Percent Change in SMHA-Controlled Mental Health Expenditures

State	Average Annual FY 2001 to FY 2005			FY 2004 to FY 2005		
	Hospital	Community	Total	Hospital	Community	Total
Alabama	4.9%	-0.3%	2.0%	11.4%	-3.9%	3.0%
Alaska	3.1%	48.0%	35.5%	3.7%	-5.8%	-5.0%
Arizona	7.8%	17.5%	16.4%	-0.8%	13.0%	11.8%
Arkansas (a)	5.0%	6.6%	6.8%	6.3%	8.3%	9.0%
California (b)	7.6%	8.1%	7.9%	9.2%	4.4%	5.2%
Colorado	1.9%	6.3%	5.0%	25.0%	4.4%	8.9%
Connecticut (c)	5.9%	5.2%	5.7%	14.6%	-1.8%	3.3%
Delaware (a, c)	-4.8%	8.5%	0.4%	4.8%	8.1%	6.6%
District of Columbia (b)	-6.1%	1.8%	0.8%	-0.7%	11.2%	3.8%
Florida	3.3%	2.4%	2.9%	4.4%	3.3%	3.9%
Georgia	3.9%	6.9%	3.9%	4.8%	0.5%	-1.0%
Hawaii	11.7%	-3.7%	-2.6%	5.4%	19.2%	6.8%
Idaho	1.0%	-4.7%	-2.9%	22.1%	-5.2%	-1.9%
Illinois	-1.2%	11.2%	6.6%	14.4%	19.4%	17.5%
Indiana	3.9%	7.2%	5.9%	6.9%	1.6%	3.2%
Iowa	-6.7%	15.3%	11.5%	-9.1%	7.4%	4.7%
Kansas	4.6%	16.1%	11.9%	9.2%	13.3%	12.2%
Kentucky	0.8%	0.8%	1.4%	4.9%	-2.5%	1.7%
Louisiana	3.8%	7.1%	6.5%	10.0%	2.8%	9.3%
Maine (a)	5.9%	8.5%	7.0%	-1.1%	8.6%	5.1%
Maryland (b)	1.5%	4.3%	3.5%	-1.1%	-9.0%	-6.3%
Massachusetts (a)	-2.1%	0.6%	0.1%	4.9%	2.4%	2.8%
Michigan (b)	-7.4%	8.5%	3.6%	-7.7%	10.7%	5.9%
Minnesota	3.1%	8.1%	6.6%	5.4%	4.5%	4.7%
Mississippi	3.3%	8.8%	5.5%	9.5%	13.0%	11.0%
Missouri	3.4%	8.5%	5.3%	0.6%	7.5%	4.1%
Montana	2.6%	3.0%	2.8%	7.1%	5.6%	6.2%
Nebraska	3.5%	7.4%	5.2%	1.1%	9.0%	4.6%
Nevada	-4.7%	10.1%	5.8%	17.7%	19.1%	18.9%
New Hampshire	3.5%	1.8%	2.5%	3.0%	1.3%	1.8%
New Jersey (b)	9.8%	14.2%	12.4%	6.8%	3.8%	4.9%
New Mexico (a, c)	-0.2%	-9.5%	-5.8%	18.2%	-27.7%	-11.7%
New York (b)	2.0%	5.5%	4.5%	1.6%	4.4%	3.6%
North Carolina	-3.4%	52.3%	23.4%	2.9%	3.5%	3.4%
North Dakota	-4.4%	1.1%	-1.6%	-2.4%	5.0%	1.9%
Ohio	0.4%	3.1%	2.3%	3.6%	3.3%	3.3%
Oklahoma	2.7%	3.9%	3.7%	7.1%	15.3%	13.0%
Oregon	6.4%	28.8%	21.1%	8.1%	168.9%	99.0%
Pennsylvania (a, c)	5.4%	8.9%	8.1%	20.4%	7.7%	9.9%
Rhode Island (c)	2.5%	2.8%	2.6%	7.0%	0.6%	2.2%
South Carolina	-6.7%	1.9%	-1.2%	2.7%	2.6%	1.8%
South Dakota	3.3%	9.0%	4.8%	4.4%	5.5%	3.4%
Tennessee	6.6%	7.6%	7.2%	5.4%	-1.5%	0.6%
Texas (b)	0.7%	2.2%	1.1%	-4.7%	5.9%	1.4%
Utah	2.6%	-0.8%	0.1%	6.5%	-13.8%	-8.8%
Vermont	12.4%	7.5%	8.2%	19.5%	4.0%	5.7%
Virginia (b)	2.6%	8.3%	3.3%	4.8%	10.6%	4.3%
Washington	1.4%	3.4%	2.7%	3.7%	0.8%	1.8%
West Virginia (b)	6.9%	9.9%	8.1%	-3.8%	21.1%	9.6%
Wisconsin	10.0%	9.2%	9.4%	6.5%	13.0%	11.0%
Wyoming	3.4%	20.6%	13.5%	-9.9%	0.0%	-3.1%
Total**	**3.6%**	**11.0%**	**8.5%**	**5.5%**	**6.1%**	**5.7%**
Median	**3.1%**	**7.2%**	**5.0%**	**4.9%**	**4.4%**	**4.1%**
Average	**2.5%**	**8.2%**	**5.9%**	**5.8%**	**7.9%**	**6.2%**
States Reporting	**51**	**51**	**51**	**51**	**51**	**51**
States Increasing	**40**	**46**	**46**	**41**	**42**	**44**
States Decreasing	**11**	**5**	**5**	**10**	**9**	**7**

**Total percent changes are calculated based only on states reporting data for both years being compared.

(a) Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

(b) SMHA-controlled expenditures include funds for mental health services in jails or prisons.

(c) Children's mental health expenditures are not included in SMHA-controlled expenditures.

IX. The SMHA and its Relationship With Other State Government Agencies

This section discusses the SMHA's relationship with other state government agencies and highlights some interagency collaboration the SMHA is engaged in. In recent years, SMHAs have advanced the importance of interagency collaboration by taking steps to better understand the role of other state agencies in delivering mental health services and supports. The PNFC found that the provision of mental health services and essential supports (such as housing and vocational rehabilitation) are being provided by a broad array of state government agencies. The level of coordination among these agencies, however, does not deter the Commission's conclusion that the provision of mental health services is highly fragmented, leaving clients to navigate through a complicated maze to receive high quality of care.

provide $2.3 billion in funding for state psychiatric hospitals (26 percent of state psychiatric hospital funding).

Since then, SMHAs have taken the challenge through a number of activities to break silos, address the fragmentation issue, and better understand the overall state delivery of mental health care. Through analysis of Medicaid-paid claims files, linking of SMHA data with other state agencies, and participation in special projects that strengthen interagency collaboration, the relationship between the SMHA and other state agencies seems to be moving towards the direction essential to designing an effective and efficient service delivery system.

The succeeding paragraphs illustrate the extent to which SMHAs implement these various initiatives.

9.1 Analysis of Medicaid-Paid Claims Files

Forty-four states reported they have access to Medicaid-paid claims files. In 30 states, the SMHA analyzes mental health services paid for by Medicaid. A few methods facilitate the conduct of analysis. In

12 states (Colorado, Iowa, Illinois, Louisiana, Maine, Michigan, Nebraska, New York, Pennsylvania, South Carolina, Tennessee, and Wisconsin), the SMHA utilizes a central data warehouse run by a separate agency that combines SMHA data with Medicaid data. In 22 states, the SMHA uses a direct link to a paid claims contractor database. Medicaid-paid claims data were reported not linked to mental health data in only 10 SMHAs.

Of the states that link Medicaid-paid claims data, 14 perform the linking on a monthly basis, and 7 link data on an ad hoc basis. There were several reasons cited by SMHAs for linking Medicaid and mental health data:

- Analysis of mental health services (36 states)
- Linking for administrative purposes (28 states)
- Linking for policy analysis (29 states)
- Linking to identify fraud and abuse (11 states)

To further sustain the effort to understand mental health expenditures of other state agencies, 14 SMHAs are working with their state Medicaid agency to combine data systems. Seven states are considering the use of the Federal Centers for Medicare and Medicaid Systems' (CMS) Medicaid Information Technology Architecture (MITA) for the integrated system. For example, Oklahoma has been developing a new information system around the MITA standards, while in Indiana, Maryland, Missouri, Ohio, and Rhode Island, the SMHA and Medicaid agency are exploring potential MITA-related collaborations to their data systems.

9.2 Linking SMHA Data With Other State Agency Data

In addition to linking mental health client data with Medicaid, many SMHAs reported efforts undertaken to integrate or match mental health client-level data with other state government agencies client databases (see Table 42). The most frequently linked data are for substance abuse services (often in states where the SMHA is responsible for both mental health and substance abuse services). While many states link their client-level data with many other state government agencies (such as criminal justice, health, employment, and child welfare), this procedure is not routine and instead usually happens only for designated special projects. So far, only Medicaid and substance abuse (alcohol/drug abuse) client files are regularly integrated or matched with mental health records in more than 10 states.

9.3 Participation in Special Projects That Strengthen Collaborative Relationships With Other State Agencies

In 2004, the NRI, under contract with CMHS, carried out an initiative of identifying mental health services and essential supports delivered by many of the major state government agencies other than the SMHA. These major state government agencies are corrections, Medicaid, housing, vocational rehabilitation, substance abuse, education, juvenile justice, early intervention, and child welfare.

This is the first initiative funded by CMHS for a group of states to engage other state agencies in identifying and gathering mental health expenditures, count of clients, and revenue sources. The project was implemented in two phases in which a total of 20 states volunteered to participate. Although not all states were able to generate data for this project (for varying reasons), it allowed the states to start a dialogue with these agencies. Overall, the state experiences from the project sent a strong message supporting the importance of continuing the effort of understanding the state mental health service delivery system.

The underlying lesson that can be derived from all these interagency activities is that information from other state agencies providing significant levels of mental health services will, in the future, become crucial in accurately understanding the overall state government expenditures on mental health. For example, the interagency database linking will help inform the mental health NOMS, such as the employment and criminal justice NOMS. Therefore, as more States build state data warehouses, routinely link client-level data across systems, and participate in various interagency projects, the SMHA and other state agencies can effectively serve persons with mental illness through a well-coordinated system of care.

Table 42: Other State Agencies SMHAs Link Data With

State	Update Frequency		Purpose			Agency Responsible		
	Regularly	Special Projects	Analysis of Mental Health Services	Admin Purposes	Policy Analysis	SMHA	OSA	Other
Alcohol and drug abuse	19	9	22	22	20	21	8	13
Criminal justice	5	16	14	13	10	13	5	2
Health	5	14	12	10	6	11	2	2
Employment/vocational rehabilitation	4	11	12	8	7	12	3	1
Child welfare	5	12	12	12	11	12	3	6
Juvenile justice	0	9	7	6	3	9	2	0
Education	1	4	4	4	3	3	1	0

Glossary

ACT	Assertive Community Treatment
ALR	Assisted living residence
AMHA	American Mental Health Alliance
ASAM	American Society of Addiction Medicine
ASI	Addiction Severity Index
ASL	American Sign Language
ASO	Administrative service organization
CAPES	Crisis and Psychiatric Emergency Services
CBT	Cognitive behavioral therapy
CMHC	Community mental health center
CMS	Centers for Medicare and Medicaid Systems
CNS	Comprehensive neuroscience
CRA	Case work, referral, and advocacy
CSR	Community staffing resources
DACTS	Dartmouth Assertive Community Treatment Scale
DBHRT	Disaster Behavioral Health Response Team
DCS	Department of Child Services (IN)
DMHAS	Department of Mental Health and Addiction Services (CT)
DSAMH	Division of Substance Abuse and Mental Health (DE)
DSM	Diagnostic and Statistical Manual of Mental Disorders
EBP	Evidence-based practice
EHR	Electronic health record
EPSTD	Early Periodic Screening Diagnosis Testing
ER	Emergency room
FTE	Full-time employee
GBMI	Guilty but Mentally Ill
G-CAL	Georgia Crisis and Access Line
HMO	Health management organization
ICF-MI	Intermediate-care facility, mentally ill
IOM	Institute of Medicine
IPS	Individual Placement Support
LMHA	Local mental health agency
MAR	Medication administration recording
MCO	Managed care organization
MICA	Mental illness and chemical abuse addition

MITA	Medicaid Information Technology Architecture
MR/DD	Mental retardation/developmental disability
MST	Multisystemic therapy
NASMHPD	National Association of State Mental Health Program Directors
NGRI	Not Guilty by Reason of Insanity
NOM	National Outcome Measure
NTAC	National Technical Assistance Center
OBS	Organic brain syndrome
OMH	Office of Mental Health (LA)
PHR	Personal health record
PNFC	President's New Freedom Commission
PORT	Patient Outcome Research Team
QA	Quality assurance
RDM	Resiliency and disease management
RHIO	Regional Health Information Organization
SAGA	State Administered General Assistance
SED	Serious emotional disorder
SMHA	State mental health agency
SMI	Serious mental illness
SNF	Skilled nursing facility
SPMI	Severely and persistently mentally ill
SPS	NRI's SMHA Profiling System
TBI	Traumatic brain injury
TMAP	Texas Medication Algorithm Project
VNA	Visiting nurse agency
WRAP	Wellness and Recovery Action Plans

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Appendix to

Funding and Characteristics of

State Mental Health Agencies, 2007

HHS Pub. No. (SMA) 09-4424

Tables of Content

Alabama 2007 1
Alaska 2007 5
Arizona 2007 10
Arkansas 2007 14
California 2007 18
Colorado 2007 23
Connecticut 2007 27
Connecticut Children's Services 2007 32
Delaware 2007 36
District Of Columbia 2007 41
Florida 2007 45
Georgia 2007 49
Hawaii 2007 53
Idaho 2007 58
Illinois 2007 61
Indiana 2007 65
Iowa 2007 70
Kansas 2007 74
Kentucky 2007 78
Louisiana 2007 82
Maine 2007 87
Maryland 2007 92
Massachusetts 2007 96
Michigan 2007 100
Minnesota 2007 104
Mississippi 2007 109
Missouri 2007 110
Montana 2007 114
Nebraska 2007 118
Nevada 2007 120
New Hampshire 2007 124
New Jersey 2007 128
New Mexico 2007 133
New York 2007 138

North Carolina 2007 142
North Dakota 2007 147
Ohio 2007 151
Oklahoma 2007 155
Oregon 2007 160
Pennsylvania 2007 165
Rhode Island 2007 170
South Carolina 2007 174
South Dakota 2007 178
Tennessee 2007 182
Texas 2007 186
Utah 2007 191
Vermont 2007 196
Virginia 2007 201
Washington 2007 205
West Virginia 2007 209
Wisconsin 2007 213
Wyoming 2007 217

ALABAMA 2007

Department of Mental Health and Mental Retardation 100 N. Union Street Montgomery, AL 36130 http://www.mh.alabama.gov	*The Alabama Department of Mental Health/Mental Retardation (DMH/MR) is responsible for mental illness, mental retardation, and substance abuse services. The Department is responsible for operating state psychiatric facilities, establishing standards for community services, and is empowered to contract for services.*

Statistics:

State Population (2006):	*4,599,030*
Number of Persons Served (2007):	*102,025*
Utilization Rate for Adults:	*22 per 1,000*
Utilization Rate for Children:	*22 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$273.70 million
Revenue From Medicaid	$92 million
Expenditures for Community Mental Health Services (51% of Total Mental Health Agency Revenues)	$140.6 million
Per Capita State Mental Health Expenditures	$60.31

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	Responsibility for services is shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Responsibility for services is shared with another agency
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in a different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Located in a different state department
State Health Department	Located in a different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	0	26	26
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary mechanism in delivering mental health services:
SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	13
Consumer-Operated Services	Parts of the state	5

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
In-Home Intervention	Available statewide	25

Workforce development initiatives:
The SMHA has initiatives to improve the quality of the mental health workforce.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 31 percent.

Mental health parity laws:
The state does not mandate mental health insurance benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Health	Yes	Yes
Education	No	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Multiple needs child legislation.

Telemedicine:
The SMHA promotes the use of telemedicine; piloted use of telemedicine for psychiatry and pediatric interface.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

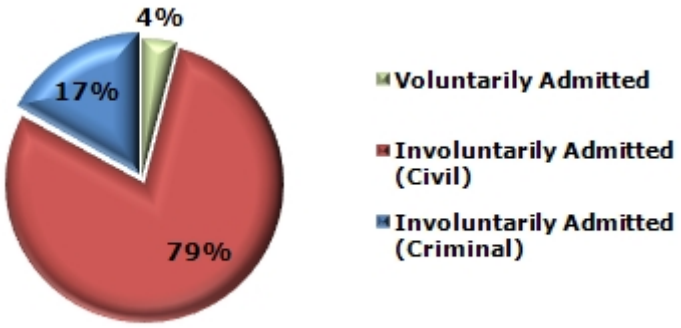
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are six SMHA-operated state psychiatric hospitals and one nursing home.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 13 and for adults was 1,137 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric, state psychiatric hospital, and private psychiatric hospital beds in the last 5 years.

Services for Armed Forces veterans and National Guard members:

The SMHA is working with the state National Guard to assure the provision of services to meet the mental health needs of veterans and National Guard members. There is a State of Alabama Returning Veterans Committee with representatives from the State Office of Veteran Affairs.

ALASKA 2007

Division of Behavioral Health Services Department of Human Services DBH, 3601 C Street Suite 878 Anchorage, AK 99645	*The Department of Health and Social Services (DHSS), Division of Behavioral Health (DBH) is responsible for the State's public mental health system and substance disorder programs. Alaska's public mental health system consists of three components: community mental health programs, Alaska Psychiatric Institute, and Designated Evaluation and Treatment services. DBH administers the statewide system of community mental health programs for delivery of residential and community-based treatment and recovery services; manages Alaska Psychiatric Institute (API), the state's only public psychiatric hospital; administers grants to the state's network of local community mental health programs; and coordinates with other government, tribal, and private providers of mental health services to ensure the provision of comprehensive mental health services to Alaska residents. DBH works closely with the Alaska Mental Health Board (AMHB), the state's mental health planning council, on system planning and evaluation.*

Statistics:

State Population (2006):	*670,053*
Number of Persons Served (2007):	*24,675*
Utilization Rate for Adults:	*25 per 1,000*
Utilization Rate for Children:	*69.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures	Dollars
Total Mental Health Agency-Controlled Revenues	$173.6 million
Revenue From Medicaid	$134.6 million
Expenditure for Community Mental Health Services (86% of Total SMHA Revenues)	$149.4 million
Per Capita State Mental Health Spending	$269.6

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Part of the SMHA
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Responsibility shared with another agency
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
State Housing Department	Same umbrella department as the SMHA
State Health Department	Same umbrella department as the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	68	68

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (Act)		1
Supported Employment	Pilot program; Parts of the state	4
Medication Algorithms (Schizophrenia)	Statewide	
Medication Algorithms (Bipolar Disorders)	Statewide	
Family Psychoeducation	Parts of the state	
Integrated MH/Substance Abuse Services	Statewide	
Self-Management	Pilot program	2
Supported Housing	Statewide	4
Consumer-Operated Services	Pilot program	3
Multisystemic Therapy (Conduct Disorder)	Pilot program	
Therapeutic Foster Care	Statewide	1
Functional Family Therapy	Pilot program	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Treatment, Trauma Treatment	Available in parts of state	1

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce, Alaska Mental Health Trust Authority workforce initiative.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 48 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Writing waiver	SMHA has lead responsibility
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has lead responsibility

Mental health parity laws:
The state does not mandate mental health insurance benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Corrections	No	Yes
Health	No	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine; rural program and state hospital collaborate.

Electronic Health Records (EHR):
The SMHA is in the process of installing an EHR in the single state psychiatric hospital. The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state uses a single EHR system for all community mental health providers. Seven local providers use a variety of EHR systems, which interface with the state EHR database.

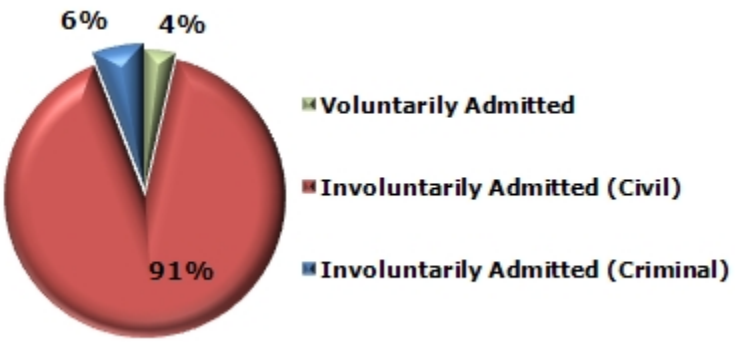
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 13 and for adults was 51 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Note: Percentage may not total 100 because of rounding.

Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in state psychiatric hospital beds in the last 5 years.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. Alerts to community mental health agencies on determination of benefits for services related to Traumatic Brain Injury (TBI) training to the Veterans Administration used Department of Defense standards for screening/treatment of TBI.

ARIZONA 2007

Division of Behavioral Health Services Department of Health Services 150 N 18th Ave, Suite 240 Phoenix, AZ 85007 http://www.azdhs.gov/bhhs	*The organizational structure for Arizona's system of care is divided into six geographical regions (GSAs), designed to promote a service system that is responsible to and reflective of the unique needs of a specific area of the state and its population. The direct local administration of the system is accomplished by nonprofit and for-profit organizations known as Regional Behavioral Health Authorities (RBHAs). In addition, four Arizona Indian Tribes contract with the state for behavioral health services. These are the Pascua Yaqui Tribe and Gila River Indian Community, who operate as TRBHAs, the Colorado River Indian Tribe, contracted to provide Subvention (state only) funded services, and the Navajo Nation, previously a TRBHA, but now operating as a case management provider.*

Statistics:

State Population (2006):	*6,166,318*
Number of Persons Served (2007):	*143,964*
Utilization Rate for Adults:	*22 per 1,000*
Utilization Rate for Children:	*26.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$867.3 million
Revenue From Medicaid	$662.4 million
Expenditures for Community Mental Health Services (91.2% of Total Mental Health Agency Revenues)	$791.4 million
Per Capita State Mental Health Expenditures	$146.22

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	No responsibility
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Part of SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	463	463

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation
Assertive Community Treatment (Act)	Parts of the state
Supported Employment	Statewide
Medication Algorithms (Schizophrenia)	Statewide
Integrated MH/Substance Abuse Services	Statewide
Self-Management	Parts of the state
Supported Housing	Statewide
Consumer-Operated Services	Statewide
Multisystemic Therapy (Conduct Disorder)	Pilot program
Therapeutic Foster Care	Statewide
Functional Family Therapy	Parts of the state

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Teen Screen	Available in parts of state	3
Employment/Psychiatric Rehabilitation	Available statewide	

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of the mental health workforce. The SMHA sponsors/conducts multiple training and TA initiatives: the Behavioral Health/Higher Education Partnership to improve quality, recruitment, and retention; Behavioral Health Loan Repayment Program, modeled on National Health Service Corps, established in statute in 2005.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver.

State's share of the Medicaid match is 29 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA has no responsibility
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has lead responsibility

Mental health parity laws:
The state mandates mental health insurance benefits. These benefits include any mental health service, but not substance abuse services. The following diagnoses are included: limited parity covering number of visits and lifetime maximums but not copays, coinsurance, deductibles. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	No
Corrections	No	Yes
Education	No	Yes
Juvenile Justice	No	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine. Telemedicine network is extensive and has been in place for many years. Northern Arizona network was selected as one of the top five nationally.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity.

ARKANSAS 2007

Division of Behavioral Health Services Department of Human Services 305 S. Palm Street Little Rock, AR 72205 http://www.arkansas.gov/dhs/dmhs	*The Division of Behavioral Health Services (DBHS) is Arkansas' Single State Agency for both mental health and substance abuse treatment/prevention services. DBHS discharges its responsibility for the provision of public mental health services by operating the Arkansas State Hospital (ASH) and the Arkansas Health Center skilled nursing facility, by contracting with 15 local, private, nonprofit Community Mental Health Centers (CMHCs), and by certifying 3 private nonprofit specialty community mental health clinics.*

Statistics:

State Population (2006):	*2,810,872*
Number of Persons Served (2007):	*69,228*
Utilization Rate for Adults:	*23 per 1,000*
Utilization Rate for Children:	*30.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$98.6 million
Revenue From Medicaid	$25.8 million
Expenditures for Community Mental Health Services (64% of Total Mental Health Agency Revenues)	$63 million
Per Capita State Mental Health Expenditures	$35.6

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	15	15
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary mechanism in delivering mental health services:
SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	4
Supported Employment	Parts of the state	6
Family Psychoeducation	Parts of the state	4
Integrated Mental Health/Substance Abuse Services	Parts of the state	4
Self-Management	Parts of the state	5
Supported Housing	Parts of the state	6
Therapeutic Foster Care	Parts of the state	8
Functional Family Therapy	Parts of the state	2

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Mental Health Consultation Child Care Program	Available in parts of state	
Peer-Led Support Groups at ASH	Available in parts of state	1

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce. CoSig grant is funding training of mental health and substance abuse provider staff.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care.
State's share of the Medicaid match is 26 percent.

Mental health parity laws:
The state mandates mental health insurance benefits.
The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Health	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals. The SMHA has some EHR components implemented in community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 30 and for adults was 167 receiving state psychiatric inpatient care.

Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric beds in the last 5 years.

CALIFORNIA 2007

California Department of Mental Health 1600 9th Street, Room 151 Sacramento, CA 95814 (800) 896-4042 http://www.dmh.ca.gov	*The California Department of Mental Health is an independent agency responsible for providing mental health services. The primary public providers of mental health services are California's 58 county mental health agencies and 2 city agencies (Berkeley and Tri-City), the majority run by county governments.*

Statistics:

State Population (2006):	*36,457,549*
Number of Persons Served (2006):	*658,314*
Utilization Rate for Adults:	*17 per 1,000*
Utilization Rate for Children:	*22.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$4.3 billion
Revenue From Medicaid	$1.8 billion
Expenditure for Community Mental Health Services (81% of Total SMHA Revenues)	$3.5 billion
Per Capita State Mental Health Spending	$118.65

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Part of the SMHA
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Different state department
Housing Agency	Different state department
Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total Unduplicated
State Psychiatric Hospitals	5	0	5
Community Mental Health Providers	0	2,484	2,484
Private Psychiatric Hospitals	NA	41	41
General Hospitals With Separate Psychiatric Units	0	54	54
Nursing Homes and Other ICF-MI and SNF Providers	0	83	83

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation
Assertive Community Treatment (ACT)	Parts of the state
Supported Employment	Parts of the state
Family Psychoeducation	Parts of the state
Integrated Mental Health/Substance Abuse Services	Parts of the state
Self-Management	Parts of the state
Supported Housing	Parts of the state
Consumer-Operated Services	Parts of the state
Multisystemic Therapy (Conduct Disorder)	Parts of the state
Therapeutic Foster Care	Parts of the state

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation
Aggression Replacement	Parts of the state
Child/Adolescents Wraparound	Parts of the state
Adult Self-Help Centers	Parts of the state
Adult Wellness and Recovery Centers	Parts of the state
Adult Tribal Integration	Parts of the state
Older Adult Integrated MH Primary Care	Parts of the state

Workforce development initiatives:

The SMHA has initiatives to improve the quality of the mental health workforce. DMH is proposing a comprehensive approach that includes: partially funding psychiatric residency programs; adding a mental health specialty to existing physician assistant programs; establishing a statewide loan assumption program; establishing a statewide client and family member technical assistance center; establishing regional partnership staffing support; establishing learning at a distance; developing leaders for the public health system; developing client entry-level employment preparation programs; establishing mental health career pathway programs; and establishing stipend programs for graduate-level clinical psychologists, social workers, marriage and family therapists, and psychiatric mental health nurse practitioners.

Managed behavioral healthcare:

Mental health services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. The state's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA has lead responsibility
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	No	Yes
Corrections	Yes	No
Health	No	Yes
Housing	No	Yes
Education	No	Yes
Juvenile Justice	No	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: California allows for 12 months of voluntary placement through the county's child welfare system that meets the needs of this type of parent/family crisis. Assembly Bill (AB) 3632 ensures that special education children who require mental health services may receive these services from county mental health programs.

Telemedicine:
The SMHA promotes the use of telemedicine. Some California county mental health programs use telemedicine through California Department of Mental Health funding.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals. The SMHA encourages and supports the development of county and provider EHR systems in community mental health programs. California counties and providers have implemented some EHR components in community mental health programs. The SMHA has some EHR components implemented in community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospital:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are five SMHA-operated state psychiatric hospitals.

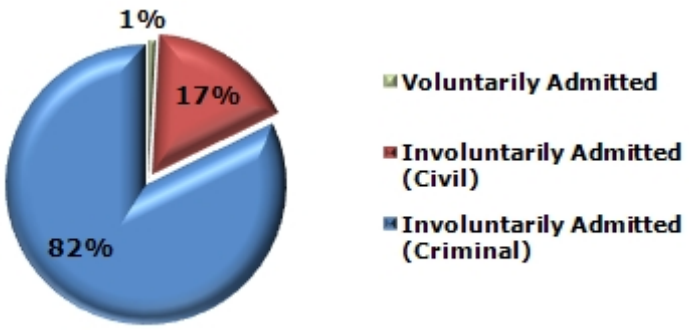
SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children		Yes	Yes
Forensic	Yes	Yes	Yes

Note: Blank space indicates the state did not report data for this category.

Average daily census in FY 2006 for youth was 120 and for adults was 4,172 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:
The commitment status of patients in state hospital on the last day of the year shows that 0.8 percent were voluntarily admitted, 17.0 percent were involuntarily civilly committed, while 82.2 percent were involuntarily criminally committed.



Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric, state psychiatric hospital, and private psychiatric hospital beds in the last year.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard and the Federal Departments of Veterans Affairs and Defense to assure the provision of services to meet the mental health needs of veterans and National Guard members.

COLORADO 2007

3824 W. Princeton Circle Denver, CO 80236	*Colorado's public mental health system comprises community-based mental health programs overseen by the Division of Mental Health, the two state mental health Institutes (both of which are organizationally part of the Office of Behavioral Health and Housing within the Department of Human Services), and the Medicaid-funded community-based mental health programs overseen by the Department of Health Care Policy and Financing (HCPF).*

Statistics:

Statistics Population (2006):	*4,753,377*
Number of Persons Served (2007):	*75,198*
Utilization Rate for Adults:	*13 per 1,000*
Utilization Rate for Children:	*24.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$343.8 million
Revenue From Medicaid	$176.3 million
Expenditures for Community Mental Health Services (73% of Total Mental Health Agency Revenues)	$252.4 million
Per Capita State Mental Health Expenditures	$74.28

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No responsibility
State Mental Hospitals	Shared with another agency
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in a different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Located in the same umbrella department as the SMHA
State Health Department	Located in a different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	23	23

Primary mechanism in delivering mental health services:
SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	8
Supported Employment	Parts of the state	8
Family Psychoeducation	Parts of the state	4
Integrated MH/Substance Abuse Services	Parts of the state	9
Self-Management	Parts of the state	6
Supported Housing	Parts of the state	12
Consumer-Operated Services	Parts of the state	
Multisystemic Therapy (Conduct Disorder)	Parts of the state	4
Therapeutic Foster Care	Parts of the state	0
Functional Family Therapy	Parts of the state	8

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Wraparound Services	Available in parts of state	4
Dialectical Behavioral Therapy	Available in parts of state	5
Specific Substance Abuse/Mental Illness Treatment	Available in parts of state	5

Workforce development initiatives:
The SMHA is developing initiatives to improve the quality of the mental health workforce with an emphasis on cultural competency and rural and frontier issues.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has no responsibility
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA has no responsibility
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The state mandates mental health insurance benefits.
Only benefits for specific mental health diagnoses are included. The following diagnoses are included: biologically based mental illness (e.g., schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific OCOD diagnoses, panic disorder).
The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	No	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	No	Yes
Child Welfare	No	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Child Mental Health Tx Act (1116).

Telemedicine:
The SMHA promotes the use of telemedicine.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals. The SMHA has some EHR components implemented in community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:

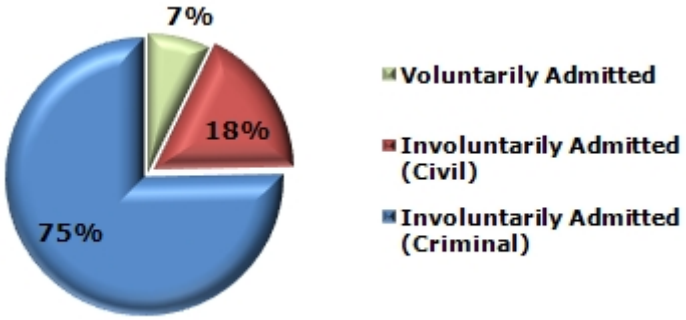
The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding and/or delivery of community-based mental health services. There are two SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 33 and for adults was 486 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric beds in the last year.

Services for Armed Forces veterans and National Guard members:

The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members.

Colorado has established youth and family mental health services for veterans in the Colorado Springs area. Connections are made to Vet centers, the state Veterans Administration (VA) hospital, and other outpatient VA-funded providers.

CONNECTICUT 2007

Department of Mental Health and Addiction Services 410 Capitol Avenue Hartford, CT 06134 http://www.ct.networkofcare.org	*The Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) are responsible for Connecticut's public mental health system. Although mental health services for children and adults are administered separately in Connecticut, the two departments work closely to ensure the provision of quality mental health services, and continue to plan and implement effective transitional services for youth moving from DCF to the adult system of care. DMHAS, through a network of l5 community-based Local Mental Health Authorities, provides a full range of treatment and recovery-support services to adults (age 18 and older). DMHAS is also responsible for adult forensic services in the state. DCF is an integrated child protective service agency and is legislatively mandated to provide mental health, prevention, juvenile justice, substance abuse, and child welfare services in Connecticut.*

Statistics:

State Population (2006):	*3,504,809*
Number of Persons Served (2007):	*79,221*
Utilization Rate for Adults:	*19 per 1,000*
Utilization Rate for Children:	*33.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$549.2 million
Revenue From Medicaid	$23.4 million
Expenditures for Community Mental Health Services (60% of Total Mental Health Agency Revenues)	$328 million
Per Capita State Mental Health Expenditures	$157.21

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	No responsibility
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in a different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Located in a different state department
State Health Department	Located in a different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	9	115	124
Private Psychiatric Hospitals	NA	1	1
General Hospitals With Separate Psychiatric Units	0	11	11
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	28
Supported Employment	Parts of the state	8
Medication Algorithms (Schizophrenia)	Parts of the state	
Family Psychoeducation	Parts of the state	
Integrated MH/Substance Abuse Services	Parts of the state	22
Self-Management	Parts of the state	
Supported Housing	Statewide	98
Consumer-Operated Services	Statewide	4
Multisystemic Therapy (Conduct Disorder)	Parts of the state	
Therapeutic Foster Care	Statewide	
Functional Family Therapy	Statewide	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation
Risking Connections	Available in parts of state
Trauma Adaptive Recovery Group Ed and Training	Available in parts of state
Cognitive Behavioral Intervention and Treatment	Available in parts of state
Wellness and Recovery Action Plans (WRAP)	Available in parts of state

Workforce development initiatives:

The SMHA has initiatives to improve the quality of the mental health workforce. Mental Health Transformation State Incentive Grant (MHT SIG) funding being used to address multiple initiatives focusing on workforce development.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. State's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has no responsibility
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA has no responsibility
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has lead responsibility

Mental health parity laws:
The state mandates mental health insurance benefits.
These benefits include any mental health and substance abuse service.
The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Housing	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: variety of services including voluntary services available to assist families in resolving problems and remaining intact.

Telemedicine:
The SMHA promotes the use of telemedicine. Telemedicine project was launched in 2007 and is currently awaiting additional resources for its continuation. Telemedicine pilot program is designed to reach out to monolingual clients as well as providing access in geographically remote areas.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs.

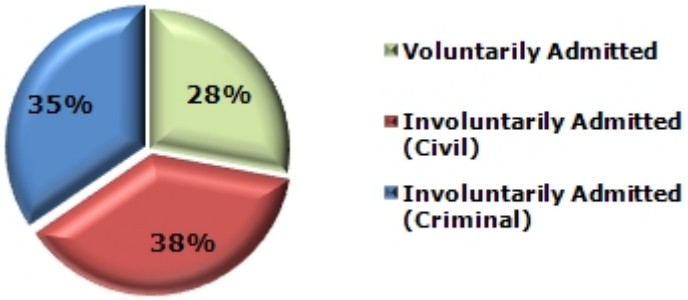
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are four SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly		Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 31 and adults was 572 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Note: Percentage may not total 100 because of rounding.

Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. National Guard: DMHAS provides behavioral health counseling services to guard/reserve personnel and their families through a 200-plus statewide network of licensed clinicians. VA: As a member of Connecticut's State Coordination Committee serving deployed personnel, DMHAS works in close partnership with VA Healthcare and Vet Center system.

CONNECTICUT Children's Services 2007

Department of Children and Families 505 Hudson Street Hartford, CT 06106	*The Department of Children and Families (DCF) is an integrated child protective service agency and is legislatively mandated to provide mental health, prevention, juvenile justice, substance abuse, and child welfare services in Connecticut. Although mental health services for children and adults are administered separately in Connecticut, DCF works closely with the Department of Mental Health and Addiction Services (DMHAS) to oversee Connecticut's public mental health system. Primary goals are to ensure the provision of quality mental health services, and to continue to plan and implement effective transitional services for youth moving from DCF to the adult system of care.*

Statistics:

State Population (2006):	*3,504,809*
Child Population (2006):	*818,286*
Number of Persons Served (2007):	*27,330*
Utilization Rate for Children:	*30.0 per 1,000*

Responsibilities of DCF in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	DCF
Elderly Mental Health Services	No responsibility
Adult Forensic Mental Health Services	No responsibility
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	DCF
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	DCF
State Mental Hospitals	DCF
Community Mental Health Program	Shared with another agency and DCF

Location of other state agencies in relation to the DCF:

Agency	Location
State Medicaid Agency	Located in a different state department
Substance Abuse Agency	Part of DCF
State Housing Department	Located in a different state department
State Health Department	Located in a different state department

The number of mental health providers DCF operates or funds:

Mental Health Providers	DCF-Operated	DCF-Funded	Total
State Psychiatric Hospitals	1	1	1
Community Mental Health Providers	0	133	133
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

DCF funds community-based service providers across the state. DCF also operates and funds the state psychiatric hospital and two residential treatment facilities.

Evidence-based services:

Evidence-Based Practice	Implementation
Multisystemic Therapy	Parts of the state
Functional Family Therapy	Statewide
Multidimensional Family Therapy	Statewide
Trauma-Focused Cognitive Behavior Therapy	Parts of the state
Dialectical Behavior Therapy	Statewide
Cognitive Behavior Therapy	Parts of the state
Intensive In-Home Child and Adolescent Psychiatric Services	Statewide
Family-Based Recovery	Parts of the state
Therapeutic Foster Care	Statewide

Emerging evidence-based and innovative practices:

Emerging EBPs and Innovative Practices	Availability
Risking Connections	Available in parts of state
Trauma Adaptive Recovery Group Education and Training	Available in parts of state
Sanctuary Model	Available in parts of state

Workforce development initiatives:

The DCF has initiatives to improve the quality of mental health workforce, generally through training of current workforce, resident programs, and liaison with colleges/universities.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (115) waiver.

DCF's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	Shared with another agency
Writing waiver	Shared with another agency
Contracting	Shared with another agency
Monitoring	Shared with another agency
Evaluating	Shared with another agency
SMHA serves as managed care agent	Shared with another agency

Mental health parity laws:
The state mandates mental health insurance benefits.
These benefits include any mental health and substance abuse service.
The mandate includes parity with physical health service benefits.

Interagency collaboration:
The DCF has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	No	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to child welfare or juvenile justice systems) in order for them to obtain mental health services. Description of the policies/laws: A variety of services including voluntary services are available to assist families in resolving problems and remaining intact.

Telemedicine:
The SMHA promotes the use of telemedicine. Telemedicine project was launched in 2007 and is currently awaiting additional resources for its continuation. Telemedicine pilot program is designed to reach out to monolingual clients as well as providing access in geographically remote areas.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals. Many community-based service providers have implemented or are in the process of implementing EHRs.

State psychiatric hospitals:

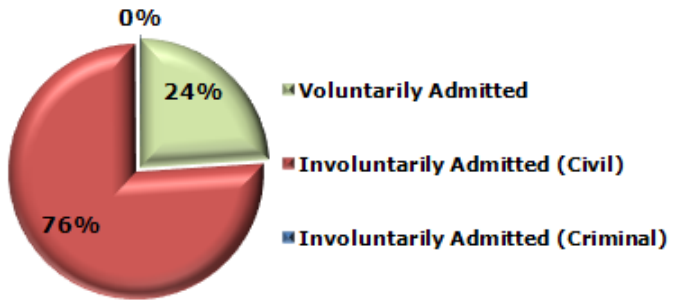
The responsibility for the operation of the state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one DCF-operated state psychiatric hospital.

DCF uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly		Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2007 for youth was 71.2.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state has experienced a decline in psychiatric inpatient bed capacity.

DELAWARE 2007

Division of Substance Abuse and Mental Health Delaware Health and Social Services 1901 N. Dupont HWY New Castle, DE 19720	*The Delaware Health and Social Services/Division of Substance Abuse and Mental Health (DSAMH) has responsibility and administrative oversight for the Community Mental Health Services Block Grant (CMHSBG). The Division of Substance Abuse and Mental Health is responsible for meeting the treatment, rehabilitation, and support needs of adults, age 18 years and older, with serious mental illness (SMI). The division seeks to provide these services to consumers if they are unable to obtain community support through other state agencies. A portion of the CMHSBG award is allocated to the Department of Services for Children, Youth and Their Families/Division of Child Mental Health Services (DCMHS). The Division of Child Mental Health Services plans for, undertakes, and monitors mental health activities funded under the Block Grant for individuals less than 18 years of age.*

Statistics:

State Population (2006):	*853,476*
Number of Persons Served (2007):	*9,756*
Utilization Rate for Adults:	*9 per 1,000*
Utilization Rate for Children:	*12.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$74.8 million
Revenue From Medicaid	$14.9 million
Expenditures for Community Mental Health Services (46% of Total Mental Health Agency Revenues)	$34.1 million
Per Capita State Mental Health Expenditures	$89.19

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	No responsibility
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Responsibility for services is shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	Responsibility for services is shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Same umbrella department as the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	4	17	21
Private Psychiatric Hospitals	NA	3	3
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly operates local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	4
Supported Employment	Statewide	4
Family Psychoeducation	Parts of the state	
Integrated MH/Substance Abuse Services	Parts of the state	
Self-Management		4
Supported Housing	Statewide	
Consumer-Operated Services	Parts of the state	
Multisystemic Therapy (Conduct Disorder)	Pilot program	
Therapeutic Foster Care	Parts of the state	50

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce. DSAMH's training office provides continuing education for professional examination including the Delaware Board of Nursing, Delaware Certification Board, National Association for Alcoholism and Drug Abuse Counselors, and National Board of Certified Counselors.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. State's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA jointly responsible with Medicaid agency
Contracting	SMHA jointly responsible with Medicaid agency
Monitoring	SMHA jointly responsible with Medicaid agency
Evaluating	SMHA jointly responsible with Medicaid agency
SMHA serves as managed care agent	SMHA jointly responsible with Medicaid agency

Mental health parity laws:

The state mandates mental health insurance benefits.
These benefits include any mental health and substance abuse service. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	No	Yes
Health	Yes	Yes
Housing	No	Yes
Education	No	No
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: State does not require custody relinquishment in order to receive MH/SA services. Works extremely hard to keep the family system together. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Electronic Health Records (EHR):
The SMHA is in the process of installing an EHR in state hospitals and community mental health programs. Local providers use a variety of EHR systems.

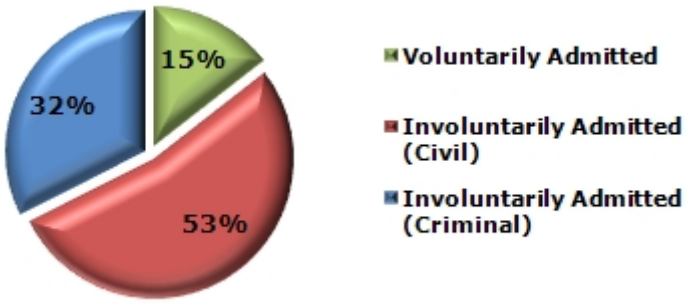
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes		
Adolescents	Yes		
Adults		Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for adults was 242 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. Front Door Teams have been established at the CMHC system. These teams were established to create an "open door" to mental health services. Individuals served on these teams, including veterans, are assisted with immediate mental health service supports. Connections are made to Vet centers, the state Veterans Administration (VA) hospital, and other outpatient VA-funded providers.

DISTRICT OF COLUMBIA 2007

Department of Mental Health 64 New York Avenue, NE 4th Floor Washington, DC 20002	*The Department of Mental Health (DMH) is a Cabinet-level agency whose Director reports to the Office of the Mayor of the District of Columbia. The primary mission of DMH is to address the mental health services and support needs of District residents. To accomplish this mission, DMH is structured with a meaningful separation between its authority role (policymaker for the mental health system) and its provider components, the D.C. Community Services Agency (public provider of core, specialty, and other services) and Saint Elizabeth's Hospital (public provider of a variety of inpatient services).*

Statistics:

State Population (2006):	*581,530*
Number of Persons Served (2007):	*13,201*
Utilization Rate for Adults:	*per 1,000*
Utilization Rate for Children:	*26.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	233.8 million
Revenue From Medicaid	32.8 million
Expenditures for Community Mental Health Services (57% of Total Mental Health Agency Revenues)	132.3 million
Per Capita State Mental Health Expenditures	$404.40

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Different state department
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	1	49	50

Primary mechanism in delivering mental health services:
SMHA directly operates local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	5
Supported Employment	Statewide	6
Medication Algorithms (Schizophrenia)	Pilot program	0
Integrated MH/Substance Abuse Services	Pilot program	
Supported Housing	Statewide	1
Consumer-Operated Services	Parts of the state	0
Multisystemic Therapy (Conduct Disorder)	Statewide	1

Note: Blank space indicates the state did not report data for this category.

Managed behavioral healthcare:
Mental health services are being delivered via managed care.
State's share of the Medicaid match is 30 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility

Mental health parity laws:
The mandate does not include parity with physical health service benefits. The SMHA does not mandate mental health insurance benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid		Yes
Housing	Yes	Yes

Note: Blank space indicates the state did not report data for this category.

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA does not promote the use of telemedicine.

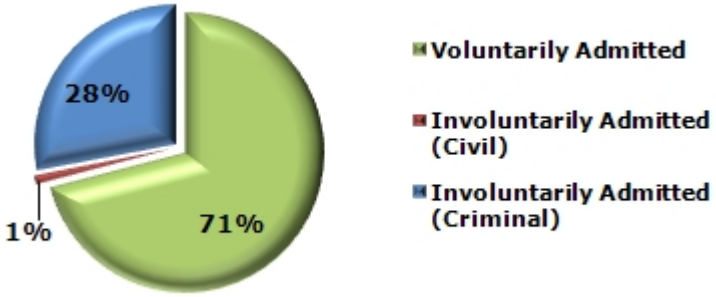
Electronic Health Records (EHR):
The SMHA is in the process of installing an EHR in state hospitals. The SMHA has implemented all EHR components in community mental health programs. The state uses a single EHR system for all community mental health providers. Local providers do not use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic		Yes	Yes

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

There have been declines in state psychiatric hospital beds in the last 5 years. The state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:

The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; developing a grant for service department for veterans that will focus on jail diversion

FLORIDA 2007

Department of Children and Families Mental Health 1317 Winewood Boulevard Tallahassee, FL 32399 http://www.dcf.state.fl.us/mentalhealth	*The Department of Children and Families is the state agency that administers Florida's mental health program and is the state mental health authority. The Department is under the management of a Secretary who reports directly to the Governor. The Assistant Secretary for Substance Abuse and Mental Health facilitates the integration of substance abuse and mental health services and establishes policy direction. The Directors for Mental Health and Substance Abuse report directly to the Assistant Secretary. Operational authority for mental health services is statutorily delegated to five regional offices and 20 circuits. Each circuit has a Substance Abuse and Mental Health Program Office (SAMH).*

Statistics:

State Population (2006):	*18,089,888*
Number of Persons Served (2007):	*262,917*
Utilization Rate for Adults:	*12 per 1,000*
Utilization Rate for Children:	*23.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$647.2 million
Revenue From Medicaid	$119.4 million
Expenditures for Community Mental Health Services (54% of Total Mental Health Agency Revenues)	$347.9 million
Per Capita State Mental Health Expenditures	$36.56

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in a different state department
Substance Abuse Agency	Located in the same umbrella department as the SMHA
State Housing Department	Located in a different state department
State Health Department	Located in a different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	3	4	7
Community Mental Health Providers	0	341	341
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	12
Supported Employment	Statewide	35
Medication Algorithms (Schizophrenia)	Parts of the state	
Medication Algorithms (Bipolar Disorders)	Parts of the state	
Family Psychoeducation	Parts of the state	10
Integrated MH/Substance Abuse Services	Parts of the state	
Self-Management	Parts of the state	38
Supported Housing	Statewide	
Consumer-Operated Services	Parts of the state	32
Therapeutic Foster Care	Statewide	18
Functional Family Therapy	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. State's share of the Medicaid match is 41percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA jointly responsible with Medicaid agency
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The state does not mandate mental health insurance benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	No	Yes
Health	No	Yes
Housing	No	Yes
Education	No	Yes
Juvenile Justice	No	Yes
Child Welfare	No	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Child welfare policy.

Telemedicine:
The SMHA promotes the use of telemedicine—one program pilot.

Electronic Health Records (EHR):
The SMHA has no EHR activities or plans for state hospitals and community mental health programs.

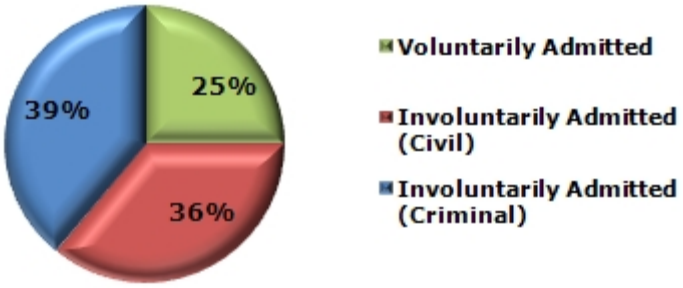
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are three SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Long-Term Inpatient (more than 90 days)
Adults	Yes
Elderly	Yes
Forensic	Yes

The average daily census in FY 2006 for youth was 63 and for adults was 2,541 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
Recently the SMHA applied jointly with FVA and received a Federal technical assistance grant to work together around the more effective provision of mental health services to veterans and their families.

GEORGIA 2007

Division of Mental Health, Developmental Disabilities, and Addictive Diseases Department of Human Resources Two Peachtree Street Suite 23-492 Atlanta, GA 30303	*The Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD) develops and administers services for adults, children, and families in all 159 counties of the State. The DMHDDAD operates within the Department of Human Resources (DHR), together with the Division of Aging, the Division of Public Health, the Department of Family and Children Services, and others. The DMHDDAD provides statewide direction, planning, coordination, consultation, technical assistance, and management support to publicly operated or funded mental health, substance abuse, and developmental disability programs in Georgia. Mental health services are primarily administered through contracts and letters of agreement with public and private providers.*

Statistics:

State Population (2006):	*9,363,941*
Number of Persons Served (2007):	*147,648*
Utilization Rate for Adults:	*16 per 1,000*
Utilization Rate for Children:	*15 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$444 million
Revenue From Medicaid	$55.3 million
Expenditures for Community Mental Health Services (54% of Total Mental Health Agency Revenues)	$241.8 million
Per Capita State Mental Health Expenditures	$48.98

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Part of SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in a different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Located in a different state department
State Health Department	Located in the same umbrella department as the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	7	0	7
Community Mental Health Providers	0	147	147
Private Psychiatric Hospitals	NA	2	2
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation
Assertive Community Treatment (ACT)	Parts of the state
Supported Employment	Statewide
Family Psychoeducation	Statewide
Integrated MH/Substance Abuse Services	Statewide
Self-Management	Statewide
Supported Housing	Statewide
Consumer-Operated Services	Statewide
Therapeutic Foster Care	Parts of the state

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
System of Care Models	Available in parts of state	5
Peer Support	Available in parts of state	51
IFI	Available statewide	
Psychosocial Rehabilitation	Available statewide	

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce. Certified peer specialist certification program; partnership with Medical College of Georgia to develop a recovery-based training curriculum for psychiatric residents; provided intensive supervision for motivational interviewing for persons with co-occurring disorders; offering a financial incentive program for employees.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. State's share of the Medicaid match is 62 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Contracting	SMHA has no responsibility
Monitoring	SMHA has no responsibility
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Parents can access all services, including residential services, without relinquishment of custody.

Telemedicine:
The SMHA promotes the use of telemedicine. The SMHA has developed codes that allow for billing for telemedicine. Pilot projects are in development to link jails with psychiatrists through telemedicine and to link deaf consumers with practitioners and interpreters.

Electronic Health Records (EHR):
The SMHA has no EHR activities or plans for community mental health programs. The SMHA is in the process of installing an EHR in state hospitals. The SMHA has some EHR components implemented in state hospitals.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are seven SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	
Adolescents	Yes	Yes	
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 59 and for adults was 1,169 receiving state psychiatric inpatient care.

Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric and state psychiatric hospital beds during the last year.

HAWAII 2007

2800 Woodland Drive Suite 120 Honolulu, HI 96822 http://www.hawaii.gov/health	*The State's Mental Health System is located in the Department of Health (DOH), Behavioral Health Administration (BHA). Four Divisions comprise the BHA: the Adult Mental Health Division (AMHD), the Child and Adolescent Mental Health Division (CAMHD), the Alcohol and Drug Abuse Division (ADAD), and the Developmental Disabilities Division (DDD). CAMHD, ADAD, and DDD contract for all services provided, and the AMHD both provides services through the CMHCs and contracts for services through approximately thirty-five (35) Purchase of Service (POS) providers.*

Statistics:

State Population (2006):	*1,285,498*
Number of Persons Served (2007):	*17,147*
Utilization Rate for Adults:	*14 per 1,000*
Utilization Rate for Children:	*10 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$192.6 million
Revenue From Medicaid	$3.9 million
Expenditures for Community Mental Health Services (68% of Total Mental Health Agency Revenues)	$131.2 million
Per Capita State Mental Health Expenditures	$156.67

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in a different state department
Substance Abuse Agency	Located in the same umbrella department as the SMHA
State Health Department	Located in the same umbrella department as the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	1	2
Community Mental Health Providers	17	62	79
Private Psychiatric Hospitals	NA	1	1
General Hospitals With Separate Psychiatric Units	0	1	1
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism used in delivering community mental health services:
SMHA directly operates and funds community-based programs.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	3
Supported Employment	Statewide	
Medication Algorithms (Schizophrenia)	Pilot program	
Family Psychoeducation	Statewide	
Integrated MH/Substance Abuse Services	Statewide	9
Self-Management	Statewide	
Supported Housing	Statewide	
Consumer-Operated Services	Parts of the state	
Multisystemic Therapy (Conduct Disorder)	Parts of the state	
Therapeutic Foster Care	Statewide	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Dialectical Behavior Therapy	Available in parts of state	
Child Welfare League/NTAC Seclusion and Restraint	Available in parts of state	6
Transition to Independence Process	Available in parts of state	1
Culture Enhancements to IMR	Available in parts of state	1
Consumer Assessment	Available statewide	1
Culture Enhancements to Family Psychoeducation	Available in parts of state	1

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce: transition of youth and older adult populations (AMHD); maintain a Practice Development office; Evidence-Based Services Committee and Training Committee with numerous initiatives and a comprehensive plan; fund university-based training programs in nursing, psychiatry, psychology, social work, and research and evaluation (CAMHD).

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver.

State's share of the Medicaid match is 58 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA jointly responsible with Medicaid agency (Children's Division), SMHA has no responsibility (Adult Division)
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has lead responsibility (Children's Division), SMHA jointly responsible with Medicaid agency (Adult Division)

Mental health parity laws:
The State mandates mental health insurance benefits.
These benefits include any mental health and substance abuse service. The following diagnoses are included: DSM diagnoses except for epilepsy, senility, mental retardation, and developmental disabilities (CAMHD). The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections		Yes (Adult Division)
Health	Yes (Adult Division)	Yes
Housing	Yes (Adult Division)	Yes (Adult Division)
Education	Yes (Children's Division)	Yes
Juvenile Justice	Yes (Children's Division)	Yes (Children's Division)
Child Welfare	Yes (Children's Division)	Yes (Children's Division)

Note: Blank space indicates the state did not report data for this category.

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Provide mental health services regardless of custody status, no rejection policy. Actively attempt to keep youth with families, provide services to prevent relinquishment (CAMHD).

Telemedicine:
The SMHA promotes the use of telemedicine with neighbor islands (AMHD).

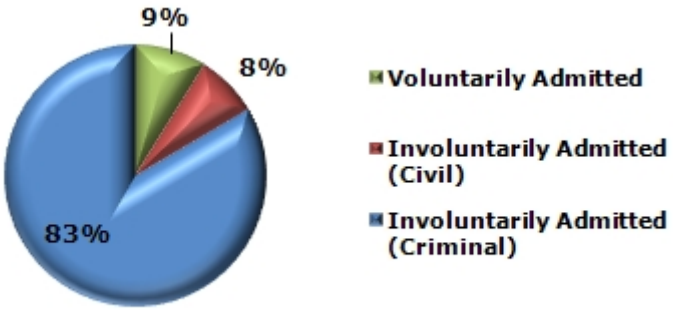
Electronic Health Records (EHR):
The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults		Yes	Yes
Forensic	Yes	Yes	Yes

State psychiatric hospital patient legal status:



Services for Armed Forces veterans and National Guard members:

The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; served equally consistent with eligibility criteria (AMHD).

IDAHO 2007

Division of Behavioral Health Idaho Department of Health and Welfare 450 West State Street, 3rd Floor Boise, ID 83702 http://www.healthandwelfare.idaho.gov	*Idaho's public Community Mental Health Services are administered by the Department of Health and Welfare in the newly formed Division of Behavioral Health Services. Services are delivered through seven geographically defined regional programs. Regional community mental health centers provide adult and children's mental health service. State-level programs provide statewide coordination and technical assistance to regional service programs.*

Statistics:

State Population (2006):	*1,466,465*
Number of Persons Served (2007):	*23,417*
Utilization Rate for Adults:	*14 per 1,000*
Utilization Rate for Children:	*22 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$53.9 million
Revenue From Medicaid	$9.4 million
Expenditures for Community Mental Health Services (57% of Total Mental Health Agency Revenues)	$30.9 million
Per Capita State Mental Health Expenditures	$37.81

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Responsibility for services is shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Responsibility for services is shared with another agency
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
State Housing Department	Different state department
State Health Department	Same umbrella department as the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	7	0	7
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable

Primary mechanism in delivering mental health services:
SMHA directly operates community-based programs.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	7
Supported Employment	Parts of the state	
Supported Housing	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation
Forensic Assertive Community Treatment (FACT)	Available statewide

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce: university partnership in Children's Mental Health.

Managed behavioral healthcare:
Only substance abuse services are being delivered via managed care. State's share of the Medicaid match is 30 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA has no responsibility
Contracting	SMHA jointly responsible with Medicaid agency
Monitoring	SMHA jointly responsible with Medicaid agency
Evaluating	SMHA jointly responsible with Medicaid agency
SMHA serves as managed care agent	SMHA has lead responsibility

Mental health parity laws:
The state does not mandate mental health insurance benefits.

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: The Children's Mental Health Services Act is a voluntary act that prevents relinquishment of custody. Custody relinquishment on emergency is still provided for but encourages the move to voluntary.

Telemedicine:
The SMHA promotes the use of telemedicine. 2006, Service Plan Component; Region 2, Latah County; Telemedicine 2007; Clearwater Economic Development Association; Region 2, Telemedicine.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is in the process of installing an EHR in state hospitals.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are two SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adolescents		Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes

Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric beds in the last 5 years.

ILLINOIS 2007

Illinois Department of Human Services Division of Mental Health 160 N. La Salle Street 10th Floor Chicago, IL 60601 http://www.dhs.state.il.us	*The Illinois Department of Human Services Division of Mental Health (DMH) administers community health and prevention programs; oversees programs for persons with developmental disabilities, mental health and substance abuse problems; and provides rehabilitation services and helps low-income persons with financial support, employment and training services, child care and other family services. The DMH is organized into five Comprehensive Community Service Regions (CCSR). Through these Regions, the DMH operates 9 state hospitals and contracts with 162 community mental health providers across the state.*

Statistics:

State Population (2006):	*12,831,970*
Number of Persons Served (2007):	*179,580*
Utilization Rate for Adults:	*15 per 1,000*
Utilization Rate for Children:	*12 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$1 billion
Revenue From Medicaid	$401.1 million
Expenditures for Community Mental Health Services (70% of Total Mental Health Agency Revenues)	$711.3 million
Per Capita State Mental Health Expenditures	$80.15

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in a different state department
Substance Abuse Agency	Located in the same umbrella department as the SMHA
State Housing Department	Located in a different state department
State Health Department	Located in a different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	10	0	10
Community Mental Health Providers	0	151	151
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	28	28
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds, but does not operate local community-based agencies

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	50
Supported Employment	Pilot program	11
Medication Algorithms (Schizophrenia)	Parts of the state	
Medication Algorithms (Bipolar Disorders)	Parts of the state	
Integrated MH/Substance Abuse Services	Pilot program	3
Self-Management	Parts of the state	
Consumer-Operated Services	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce.

Managed behavioral healthcare:

Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency

Mental health parity laws:
The state mandates mental health insurance benefits.
These benefits include any mental health and substance abuse service. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	No	Yes
Corrections	Yes	Yes
Health		Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	No	Yes

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine. Pilot will be initiated in rural areas of the state focusing on delivery of service to children and adolescents. The Governor also just signed a bill requiring the state Medicaid agency to reimburse for delivery of telepsychiatry services.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals.

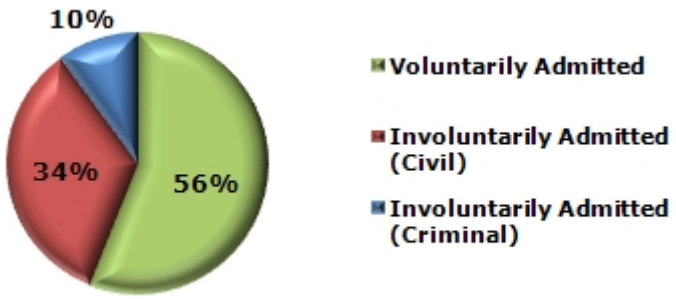
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are 10 SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adolescents	Yes		
Adults	Yes	Yes	Yes
Forensic		Yes	Yes

The average daily census in FY 2006 for youth was 18 and for adults was 1,422 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric beds in the last year.

INDIANA 2007

Division of Mental Health and Addiction Family and Social Services Administration 402 W. Washington Street, Room W353 Indianapolis, IN 46204 http://www.in.gov/fssa/servicemental/	*The Indiana mental health system provides services in all 92 counties of the state. The Hoosier Assurance Plan, adopted in 1994, is the basis on which the Division of Mental Health and Addiction (DMHA) relates to and funds the Indiana mental health service system. It guides the management of public funds earmarked for mental health services, assuring that priority will be given to individuals in greatest need. Under this plan, DMHA acts as a purchasing agent, contracting with qualified managed care providers offering an array of individualized mental health and addiction care. The Division has statutory authority for 6 state-operated facilities, and contracts with 30 private community mental health centers and a network of addiction providers. The Hoosier Assurance Plan eliminated the traditional geographic service areas, resulting in consumers having choice of two or more services providers in many areas of the state.*

Statistics:

State Population (2006):	*6,313,520*
Number of Persons Served (2007):	*87,641*
Utilization Rate for Adults:	*12 per 1,000*
Utilization Rate for Children:	*19 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$518.7 million
Revenue From Medicaid	$393.4 million
Expenditures for Community Mental Health Services (66% of Total Mental Health Agency Revenues)	$344.7 million
Per Capita State Mental Health Expenditures	$82.79

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Responsibility for services is shared with another agency
Adult Forensic Mental Health Services	Responsibility for services is shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Responsibility for services is shared with another agency
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	0	30	30

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	30
Supported Employment	Parts of the state	28
Integrated MH/Substance Abuse Services	Parts of the state	6
Self-Management	Parts of the state	8
Multisystemic Therapy (Conduct Disorder)	Parts of the state	
Therapeutic Foster Care	Parts of the state	
Functional Family Therapy	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Child and Family Wraparound Teams	Available in parts of state	50
Cognitive Behavior Therapy	Available in parts of state	
Psychosocial Rehabilitation (Clubhouses)	Available in parts of state	14

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:

The SMHA has initiatives to improve the quality of the mental health workforce. DMHA, through the Mental Health Commission, has proposed licensure for addiction counselors. Indiana does not currently have any state licensure for addiction treatment providers. The Indiana Family Social Service Agency (FSSA), under which DMHA is housed, funded a study through Indiana University's School of Public and Environmental Affairs. This comprehensive study and focus group activity was charged with developing recommendations for improving Indiana's health delivery system. Special attention was paid to workforce issues, including those specific to mental health and addiction. Recommendations from the report will inform legislative and policy decisions in the coming year.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.
State's share of the Medicaid match is 37 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA has no responsibility
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The state mandates mental health insurance benefits that provide mental health parity if the carrier provides mental health benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: State law was passed to ensure parents would not be forced to relinquish custody in order to receive services. However, there was no funding connected to the law.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are six SMHA-operated state psychiatric hospitals.

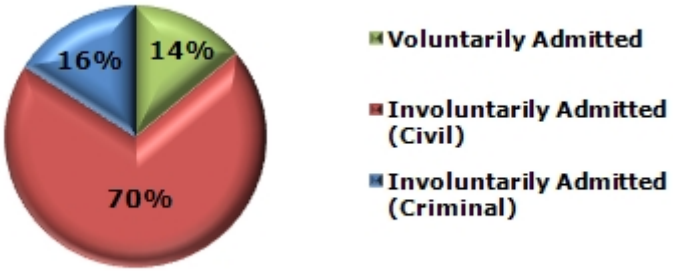
The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 94 and for adults was 1,021 receiving state psychiatric inpatient care.

Telemedicine:
The SMHA does not promote the use by telemedicine.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in private psychiatric hospital beds in the last year.

IOWA 2007

Division of Mental Health and Disability Services Department of Human Services 1305 E. Walnut Hoover Building 5th Floor Des Moines, IA 50319	*The Department of Human Services, Division of Mental Health and Disability Services is the State Mental Health Authority for Iowa. The system of community-based services for adults with a mental illness is uniquely decentralized and remains largely under the control of county governments. The responsibility of mental health services for children and adolescents is centralized at that state level with a number of state agencies, including the state mental health authority and state child welfare, Juvenile Justice, the Department of Education, the Department of Public Health, and county governments providing and managing various service programs.*

Statistics:

State Population (2006):	*2,982,085*
Number of Persons Served (2007):	*81,803*
Utilization Rate for Adults:	*22 per 1,000*
Utilization Rate for Children:	*45 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$235.5 million
Revenue From Medicaid	$98.8 million
Expenditures for Community Mental Health Services (87% of Total Mental Health Agency Revenues)	$204.3 million
Per Capita State Mental Health Expenditures	$79.44

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Responsibility for services is shared with another agency
Adult Forensic Mental Health Services	No responsibility
Brain Impaired Services (including Traumatic Brain Injuries)	Responsibility for services is shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Responsibility for services is shared with another agency
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of umbrella agency
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in the same umbrella department as the SMHA
Substance Abuse Agency	Located in a different state department
State Housing Department	Located in a different state department
State Health Department	Located in a different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	0	4	4
Community Mental Health Providers	0	62	62

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation
Assertive Community Treatment (ACT)	Parts of the state
Supported Employment	Parts of the state
Integrated MH/Substance Abuse Services	Parts of the state
Supported Housing	Parts of the state

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce; self-employment initiatives.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.
State's share of the Medicaid match was unreported.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA jointly responsible with Medicaid agency
Evaluating	SMHA jointly responsible with Medicaid agency
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included. The mandate does not include parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Housing	Yes	
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Have a Medicaid Children's mental health waiver that started July 1, 2005; longer necessary for parents to relinquish custody for PMIC admissions.

Telemedicine:
The SMHA promotes the use of telemedicine.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in community mental health programs. The state is in the process of installing an EHR in state hospitals. The state does not use a single EHR system for all community mental health providers.

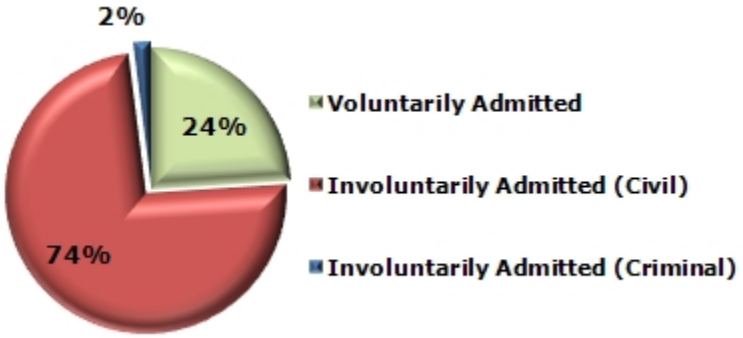
State psychiatric hospital:
There are four state-operated state psychiatric hospitals within the same umbrella agency as the SMHA, which is responsible for funding and/or delivery of community-based mental health services.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	
Adolescents	Yes	
Adults	Yes	
Elderly	Yes	Yes

The average daily census in FY 2006 for youth was 30 and adults was 95 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in private psychiatric hospital beds in the last year.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard to assure the provision of services to meet the mental health needs of veterans and National Guard members.

KANSAS 2007

Disability and Behavioral Health Services Department of Social and Rehabilitation Services 915 SW Harrison 9th Floor Topeka, KS 66612-1570 http://www.srskansas.org/hcp/MHmain.htm	*The mission of the Division of Health Care Policy's Mental Health unit is to promote and ensure high quality mental health care, consisting of a comprehensive array of treatments and supports available to all individuals in Kansas. Kansas has contracted with a newly formed entity, Kansas Health Solutions (KHS), to provide Medicaid-reimbursed mental health services. KHS is a corporation formed by the Association of Community Mental Health Centers (CMHC) and is governed by Federal managed care requirements and monitored by SRS/MH. KHS began operation on July 1, 2007. In order to afford the same accountability for service and addressing unmet need to the non-Medicaid population, SRS/MH has contracted with each CMHC to meet the same requirements articulated in the managed care contract. In Kansas, target populations are adults with severe and persistent mental illness and children with serious emotional disturbance. The Division of Health Care Policy also oversees the operation of three state mental health hospitals.*

Statistics:

State Population (2006):	*2,764,075*
Number of Persons Served (2007):	*103,790*
Utilization Rate for Adults:	*34 per 1,000*
Utilization Rate for Children:	*47 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$253.7 million
Revenue From Medicaid	$155.8 million
Expenditures for Community Mental Health Services (73% of Total Mental Health Agency Revenues)	$185 million
Per Capita State Mental Health Expenditures	$92.81

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	3	0	3
Community Mental Health Providers	0	26	26
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0

NA = not applicable

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Supported Employment	Parts of the state	12
Integrated MH/Substance Abuse Services	Parts of the state	11
Supported Housing	Parts of the state	
Consumer-Operated Services	Statewide	23
Therapeutic Foster Care	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.
State's share of the Medicaid match is 40 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Writing waiver	SMHA jointly responsible with Medicaid agency
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has lead responsibility

Interagency collaboration:

The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	No	Yes
Child Welfare	No	Yes

Custody relinquishment:

The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: SMHA system and child welfare system have policies to eliminate the need for custody relinquishment. These include child welfare family-centered system of care, mental health reform, and mental health initiative 2000.

Telemedicine:

The SMHA promotes the use of telemedicine: supporting the expansion of telemedicine through partner Association of CMHC's and the Mental Health Consortium.

State psychiatric hospitals:

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are three SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)
Children	Yes	Yes
Adolescents	Yes	Yes
Adults	Yes	Yes
Elderly	Yes	Yes

The average daily census in FY 2006 for youth was 25 and for adults was 264 receiving state psychiatric inpatient care.

Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric beds in the last year.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard and the Federal Departments of Veterans Affairs and Defense to assure the provision of services to meet the mental health needs of veterans and National Guard members. All groups listed participate on the veterans and families task force to improve services to all veterans and families

KENTUCKY 2007

KDMHMRS 100 Fair Oaks Lane 4E-A Frankfort, KY 40601	*Department for Mental Health and Mental Retardation Services (KDMHMRS) is identified by Kentucky Revised Statute (KRS) 194.030 as the primary state agency for developing and administering programs for the prevention, detection, and treatment of mental health, mental retardation, and substance abuse disorders. The DMHMRS is a Department within the Cabinet for Health and Family Services. The Commissioner of the Department for Mental Health is responsible directly to an Undersecretary for Health who also oversees the Departments for Public Health and Medicaid Services. Thus, the Secretary of the Cabinet, through the Undersecretary for Health, exercises authority over multiple departments that are directly related to both primary healthcare and behavioral healthcare.*

Statistics:

State Population (2006):	*4,206,074*
Number of Person Served (2007):	*133,692*
Utilization Rate for Adults:	*28 per 1,000*
Utilization Rate for Children:	*48 per 1,000*

Revenue and expenditure:

Revenue and Expenditure (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$208.4 million
Revenue From Medicaid	$60 million
Expenditure for Community Mental Health Services (46% of Total SMHA revenues)	$95.3 million
Per Capita State Mental Health Spending	$50.22

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHAs:

Agency	Location
State Medicaid Agency	Same umbrella department
State Housing Agency	Different state department
State Health Department	Same umbrella department
Substance Abuse Agency	Part of the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	3	1	4
Community Mental Health Providers	0	14	14
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	1	1
Nursing Homes and Other ICF-MI and SNF Providers	2	0	2

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	3
Supported Employment	Parts of the state	3
Medication Algorithms (schizophrenia)	Parts of the state	2
Family Psychoeducation	Parts of the state	9
Integrated Mental Health/Substance Abuse Services	Parts of the state	7
Self-Management	Parts of the state	10
Supported Housing	Parts of the state	9
Consumer-Operated Services		6
Multisystem Therapy (Conduct Disorder)	Pilot program	2
Therapeutic Foster Care	Parts of the state	6
Functional Family Therapy	Parts of the state	1

Note: Blank space indicates the state did not report data for this category.

Managed behavioral healthcare:

Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 30 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has no responsibility
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA has no responsibility
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The State mandates mental health insurance benefits. These benefits include any mental health service, but not substance abuse services. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Juvenile Justice	No	Yes
Child Welfare	No	Yes

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine; funding provided to four CMHCs in the western part of the state for telehealth equipment under the DIVERTS program (to reduce admissions to Western State Hospital).

Electronic Health Records (EHR):
The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

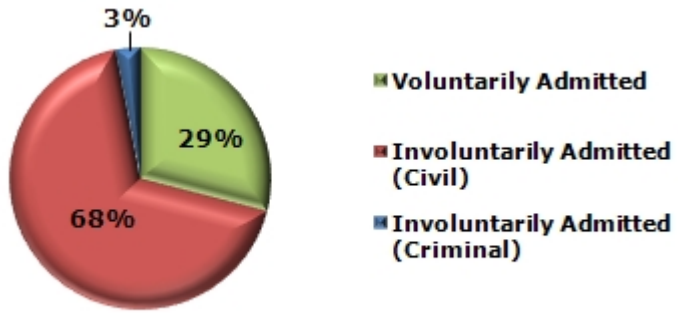
State psychiatric hospital:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are three SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 10 and adults was 489 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state has experienced a decline in psychiatric inpatient bed capacity. There has been decline seen in general hospital specialty unit psychiatric beds in the last 5 years.

LOUISIANA 2007

628 N. 4th Street 4th Floor, POB 4049 Baton Rouge, LA 70821 http://www.dhh.louisiana.gov/offices/?ID=62	*The Office of Mental Health (OMH) operates within the Department of Health and Hospitals (DHH) alongside agencies of the Office of Public Health, the Office of Addictive Disorders, the Office for Citizens with Developmental Disabilities, and the Office of Management and Finance (including the State Medicaid agency). The administration of the Louisiana mental health care system is changing from interrelated geographic areas and regions to a system of independent health care districts or authorities under the general administration of OMH.*

Statistics:

State Population (2006):	*4,287,768*
Number of Persons Served (2007):	*47,341*
Utilization Rate for Adults:	*12 per 1,000*
Utilization Rate for Children:	*7 per 1,000*

Revenue and expenditure:

Revenue and Expenditure (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$258.5 million
Revenue From Medicaid	$105.6 million
Expenditure for Community Mental Health Services (41% of Total SMHA Revenues)	$106.3 million
Per Capita State Mental Health Spending	$57.59

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services*	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Part of the SMHA
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

*SMHA has responsibility for elderly but no formal programs at present.

Location of other state agencies in relation to the SMHAs:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Same umbrella department
State Housing Agency	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	5	5	5
Community Mental Health Providers	40	40	40
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	3	0	3
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly operates local community-based agencies.

Evidence-based services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	10
Supported Employment	Parts of the state	9
Medication Algorithms (Schizophrenia)	Parts of the state	1
Medication Algorithms (Bipolar Disorders)	Parts of the state	1
Family Psychoeducation	Parts of the state	4
Integrated Mental Health/Substance Abuse Services	Parts of the state	10
Self-Management	Parts of the state	4
Supported Housing	Parts of the state	2
Consumer-Operated Services*	Parts of the state	19
Multisystem Therapy (Conduct Disorder)	Parts of the state	2
Therapeutic Foster Care		1
Functional Family Therapy		1

Note: Blank space indicates the state did not report data for this category.

*Consumer Resource Centers

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Number of Programs
Child Adolescent Response Team	6
Early Childhood Supports and Services	10
Louisiana Youth Extension Teams	1
Crisis Intervention Teams	2
School-Based Mental Health Services	9
Family Preservation Services	3
Juvenile Justice Diversion Programs	6

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce; co-occurring training has occurred across the state (Basic and Advanced). Web-based essential learning is being developed, giving staff access to members' courses and including other offices (AHD and OCDD); this project will enhance credentialing and competency-based staff development; Person-Centered training; Mental Health Leadership; Coming Together for recovery.

Managed behavioral healthcare:
Medicaid mental health rehabilitation services are being delivered via managed care. State's share of the Medicaid match is 30 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Writing waiver	SMHA has no responsibility
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has lead responsibility

Mental health parity laws:
The state mandates mental health insurance benefits. These benefits include any mental health service, but not substance abuse services. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	No	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	No	Yes
Juvenile Justice	Yes	Yes
Child Welfare	No	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: A parent does not have to relinquish custody for children to receive mental health services. There are times, however, when a court will place a youth into DHH custody for treatment, etc. (e.g., competency, restoration). The SMHA follows its admission and treatment policy procedures. There were no children in the SMHA system who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs. The SMHA is in the process of installing an EHR in community mental health centers.

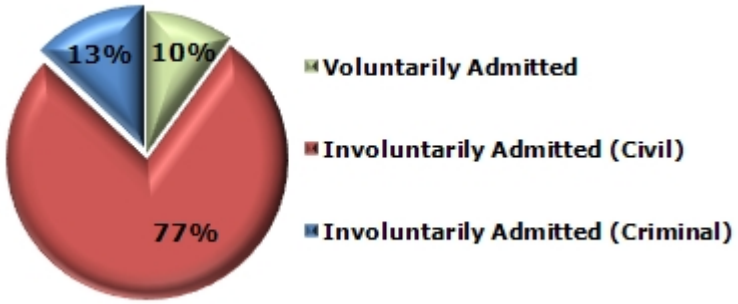
State psychiatric hospital:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are five SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes		
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 49 and adults was 866 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state has experienced a decline in psychiatric inpatient bed capacity. There has been a decline seen in general hospital specialty unit psychiatric beds in the last 5 years.

MAINE 2007

DHHS, 11 SHS Marquadt Building 2nd Floor Augusta, ME 04330 http://www.maine.gov/dhhs/bds/	*The Maine Department of Health and Human Services (DHHS), as the designated State Public Mental Health Authority, is responsible for the integration of mental health with health care in general, and with public health efforts. Within DHHS, the Office of Adult Mental Health Services (OAMHS) performs these functions through coordinated efforts of a central office and three regional offices. A primary responsibility of the Mental Health Authority is to develop and maintain a system of adult community mental health treatments, services, and supports for people age 18 and older. The Office of Adult Mental Health Services reports to the Deputy Commissioner for Integrated Services and collaborates with the Office of Child and Family Services, the Office of Substance Abuse Services, and others. The focal point for children's mental health is the Children's Behavioral Health Services Program within DHHS. Children's Behavioral Health Services supports and serves children, age birth through 5, who have developmental disabilities or demonstrate developmental delays, and children and adolescents, age 0–20, who have treatment needs related to mental illness, mental retardation, autism, developmental disabilities, or emotional and behavioral needs.*

Statistics:

State Population (2006):	*1,321,574*
Number of Persons Served (2007):	*48,696*
Utilization Rate for Adults:	*30 per 1,000*
Utilization Rate for Children:	*62 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$180.3 million
Revenue From Medicaid	$123.8 million
Expenditure for Community Mental Health Services (69% of Total SMHA Revenues)	$124.2 million
Per Capita State Mental Health Spending	$137.15

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Same umbrella department
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	1	117	118
Private Psychiatric Hospitals	NA	2	2
General Hospitals With Separate Psychiatric Units	0	8	8
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly contracts with community-based programs.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	15
Supported Employment	Statewide	
Family Psychoeducation	Parts of the state	1
Integrated MH/Substance Abuse Services	Parts of the state	
Self-Management	Parts of the state	
Supported Housing	Pilot program statewide	
Multisystemic Therapy (Conduct Disorder)	Parts of the state	5
Therapeutic Foster Care	Statewide	12
Functional Family Therapy	Parts of the state	4

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Trauma Informed Services	Parts of the state	1
Children's Assertive Community Tx Approach	Parts of the state	5
Collaborative Problem Solving (Ross Green)	Parts of the state	2

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce; multiple training initiatives at all levels of staffing; continue to update training curricula for direct support workers and community support workers to reflect a recovery perspective and to support evidence-based practices. Piloted a training curriculum for peer support workers and plan to expand the availability of peer support in emergency departments, on warm lines, at peer centers, and other settings across the state. Recently completed a fidelity review of ACT teams and supported employment.

Managed behavioral healthcare:

Neither Mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 37 percent. Contract negotiations are under way with an ASO for behavioral health services for utilization review and prior authorization.

Mental health parity laws:

The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included: psychotic disorders, dissociative disorders, mood disorders, anxiety disorders, personality disorders, paraphilias, ADHD, PDD, tic disorders, eating disorders, and substance abuse disorders. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections		Yes
Health		Yes
Housing		Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Note: Blank space indicates the state did not report data for this category.

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Mental health services are available to all Maine children that meet medical necessity regardless of custody status. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine. Telemedicine has been made available in correctional facilities, psychiatric hospitals, outpatient mental health facilities, and rural settings as well as in all departmental offices to enable mental health services to be more readily available to areas that lack those services.

Electronic Health Records (EHR):
The SMHA is in the process of installing an EHR in state hospitals and community mental health programs. The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are two SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adolescents	No	No	No
Adults	Yes	Yes	Yes
Forensic		Yes	Yes

The average daily census in FY 2006 for adults was 86 receiving state psychiatric inpatient care. The state psychiatric hospitals do not serve youth.

Psychiatric inpatient bed shortages:
There have been declines in general hospital specialty unit psychiatric beds in the last year. The state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the State National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; Military Adjustment Program (MAP) for soldiers and their families both predeployment and upon return from active service.

MARYLAND 2007

Spring Grove Hospital Dix Building 55 Wade Avenue Catonsville, MD 21228 http://www.dhmh.state.md.us/MHA http://www.MAPS-MD.com	*The Mental Hygiene Administration (MHA), the division of the State of Maryland Department of Health and Mental Hygiene is responsible for overseeing the delivery of public mental health services in the state. Maryland operates the majority of its public mental health system under a Medicaid 1115 Waiver. Specialty mental health care is carved out from physical care and is administered by MHA. The system is managed in collaboration with Core Service Agencies (CSAs), entities at the local level that, in collaboration with MHA, develop and manage a coordinated network of Maryland public mental health services. An administrative Services Organization assists MHA and the CSAs in the management of the system.*

Statistics:

State Population (2006):	*5,615,727*
Number of Persons Served (2007):	*92,738*
Utilization Rate for Adults:	*12 per 1,000*
Utilization Rate for Children:	*31 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$776.5 million
Revenue From Medicaid	$181 million
Expenditure for Community Mental Health Services (68% of Total SMHA Revenues)	$526.2 million
Per Capita State Mental Health Spending	$139.7

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of SMHA
Elderly Mental Health Services	Part of SMHA
Adult Forensic Mental Health Services	Part of SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of SMHA

Services Arena	Responsibility
Community Mental Health Program	Part of SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Same umbrella department
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	10		10
Community Mental Health Providers	0	375	375
Private Psychiatric Hospitals	NA	3	3

NA = not applicable

Primary mechanism in delivering mental health services:
SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	7
Supported Employment	Parts of the state	20
Family Psychoeducation	Parts of the state	3
Integrated MH/Substance Abuse Services	Pilot program in part of the state	
Self-Management	Parts of the state	3
Supported Housing	Statewide	83
Consumer-Operated Services	Statewide	
Multisystemic Therapy (Conduct Disorder)	Pilot program	3
Therapeutic Foster Care	Parts of the state	6
Functional Family Therapy	Pilot program	5

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Child Psychiatric Rehabilitation	Statewide	
Seclusion and Restraint	Parts of the state	5
Respite	Parts of the state	84
Adult Partial Capitation	Parts of the state	2
PATCH Project in Senior Housing	Parts of the state	1

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. State's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Writing waiver	SMHA has joint responsibility with Medicaid agency
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has lead responsibility

Mental health parity laws:
The state mandates mental health insurance benefits. These benefits include any mental health service, but not substance abuse services. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Executive order and statute provide for voluntary placement agreement by family with Department of Human Resources (Child Welfare Agency).

Telemedicine:
The SMHA promotes the use of telemedicine. Telemedicine used in several detention centers. Telemedicine case conferencing used among child and adolescent facilities. Program in conjunction with Johns Hopkins Hospital for Adolescent Services with Regional Institutes for Children/Adolescents and Finance Center's adolescent program.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is in the process of installing an EHR in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are 10 SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds. There have been declines in state psychiatric hospital beds in the last year.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; developed a pilot program with the Maryland National Guard, the Maryland Defense Force, the Maryland, Virginia, and the Federal VA Pilot program provides training for the Maryland National Guard Family Readiness Program for recognizing signs of PTSD of returning veterans.

MASSACHUSETTS 2007

25 Staniford Street Boston, MA 02114 http://www.mass.gov	*The Massachusetts Department of Mental Health (DMH) completed a three-phase process to develop a comprehensive Strategic Plan. The overarching goals were to: transform the mental health system; incorporate equity, individual, family and recovery-oriented values into the system redesign; and improve overall quality.*

Statistics:

State Population (2006):	*6,437,193*
Number of Persons Served (2007):	*27,297*
Utilization Rate for Adults:	*5 per 1,000*
Utilization Rate for Children:	*2 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$685.6 million
Revenue From Medicaid	$129.3 million
Expenditure for Community Mental Health Services (81.0% of Total SMHA Revenues)	$552.3 million
Per Capita State Mental Health Spending	$106.64

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Same umbrella department
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	10	0	10
Community Mental Health Providers	6	0	6

Primary mechanism in delivering mental health services:
SMHA directly operates community-based programs.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	15
Supported Employment	Statewide	
Medication Algorithms (Schizophrenia)	Statewide	
Medication Algorithms (Bipolar Disorders)	Statewide	
Family Psychoeducation	Statewide	1
Integrated MH/Substance Abuse Services	Statewide	
Self-Management	Statewide	
Supported Housing	Statewide	
Consumer-Operated Services	Statewide	
Multisystemic Therapy (Conduct Disorder)	Parts of the state	5
Therapeutic Foster Care	Statewide	12
Functional Family Therapy		4

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation
Restraint reduction using NTAC principle and train	Available statewide

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce; consolidated overall responsibility for education and training of mental health workforce into Central Office. Regular trainings are held on various topics and online courses are available and encouraged.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. State's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has joint responsibility with medicaid agency
Writing waiver	SMHA has joint responsibility with medicaid agency
Contracting	SMHA has joint responsibility with medicaid agency
Monitoring	SMHA has joint responsibility with medicaid agency
Evaluating	SMHA has joint responsibility with medicaid agency
SMHA serves as managed care agent	SMHA has joint responsibility with medicaid agency

Mental health parity laws:
The state mandates mental health insurance benefits. Parity is limited to diagnoses enumerated in the legislation (e.g., biological illnesses).
The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	No	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	No	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Child welfare law changes in last few years to allow for voluntary placement without relinquishment of custody.

Telemedicine:
The SMHA promotes the use of telemedicine.

Electronic Health Records (EHR):
The SMHA has some EHR components implemented in state hospitals and community mental health programs.

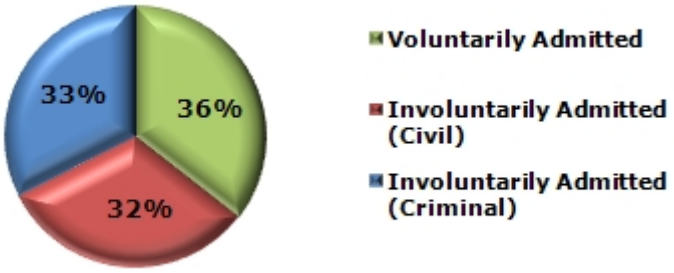
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are 10 SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	
Adolescents	Yes	Yes	
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 53 and for adults was 854 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Note: Percentage may not total 100 because of rounding.

Psychiatric inpatient bed shortages:
There have been declines in state psychiatric hospital beds in the last 5 years. The state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; working with State Department of Veterans Services.

MICHIGAN 2007

320 South Walnut Street Lansing, MI 48913 http://www.Michigan.Gov/MDCH	*In Michigan, Medicaid funds for mental health, substance abuse, and developmental disability services are contracted by the Michigan Department of Community Health (MDCH) with 18 regional Prepaid Inpatient Health Plans (PIHPs), which consist of a single Community Mental Health Services Program (CMHSP) in large counties, or affiliations of CMHSPs in less populous regions. Other public funds for mental health and developmental disabilities are contracted by MDCH with 46 CMHSPs. Other public funds for substance abuse services are contracted by MDCH with 16 regional Substance Abuse Coordinating Agencies.*

Statistics:

State Population (2006):	*10,095,643*
Number of Persons Served (2007):	*207,407*
Utilization Rate for Adults:	*21 per 1,000*
Utilization Rate for Children:	*18 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$973.5 million
Revenue From Medicaid	$600.9 million
Expenditure for Community Mental Health Services (77% of Total SMHA Revenues)	$749 million
Per Capita State Mental Health Spending	$96.4

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Same umbrella department
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	0	46	46

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	88
Supported Employment	Parts of the state	
Medication Algorithms (Schizophrenia)	Pilot program	2
Medication Algorithms (Bipolar Disorders)	Pilot program	
Family Psychoeducation	Statewide	60
Integrated MH/Substance Abuse Services	Statewide	7
Supported Housing	Parts of the state	
Consumer-Operated Services	Statewide	50
Functional Family Therapy	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Wraparound	Statewide	
Peer Support Specialist	Statewide	
Dialectical Behavior Therapy	Statewide	15
Motivational Interviewing	Statewide	32

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce. Improving Practices Leadership Teams: System transformation activities that include assuring systems are based in recovery training initiatives.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.

State's share of the Medicaid match is 43 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Writing waiver	SMHA has lead responsibility
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has lead responsibility

Mental health parity laws:
The SMHA does not mandate mental health insurance benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in community mental health programs. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are six SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic		Yes	Yes

The average daily census in FY 2006 for youth was 67 and for adults was 768 receiving state psychiatric inpatient care.

Psychiatric inpatient bed shortages:
The state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; early identification and coordination.

MINNESOTA 2007

P.O. Box 64981 Saint Paul, MN 55164-0981	*Minnesota is state-supervised, county-administered public mental health. Within this system, three agencies/organizations are responsible for funding and assuring quality mental health services: (1) the state mental health authority (SMHA), part of the Minnesota Department of Human Services; (2) the local mental health authority (the county board of commissioners and its administrative agency, or multicounty mental health authority); and (3) American Indian tribal governments. The adult Mental Health Division (MHD) is a division within the Chemical and Mental Health Services Administration (CandMHSA). The CandMHSA also includes the Children's Mental Health Division (CMHD), the Chemical Health Division, and State Operated Services Networks. Counties receive state grants for adult mental health services and "consolidated" grants for other human services (including children's mental health services).*

Statistics:

State Population (2006):	*5,167,101*
Number of Persons Served (2007):	*85,802*
Utilization Rate for Adults:	*16 per 1,000*
Utilization Rate for Children:	*19 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$669.3 million
Revenue From Medicaid	$303.6 million
Expenditure for Community Mental Health Services (73% of Total SMHA Revenues)	$490.9 million
Per Capita State Mental Health Spending	$130.6

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	No responsibility
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Same umbrella department
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	11	0	11
Community Mental Health Providers	0	600	600
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	16	16
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	26
Supported Employment	Parts of the state	31
Integrated MH/Substance Abuse Services	Parts of the state	55
Self-Management	Statewide	21
Supported Housing	Statewide	20
Consumer-Operated Services	Statewide	16
Multisystemic Therapy (Conduct Disorder)	Parts of the state	21
Therapeutic Foster Care	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Emerging EBPs and Innovative Practices	Availability	Number of Programs
Replication of Hawaii data-based systems	Parts of state	25
Shared care/collaboration models (adult and children) Dialectical Behavioral Therapy (DBT)	Parts of state	4
DBT for persons with borderline personality disorder	Available statewide	

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce; core competencies, training monthly, consultation with national experts.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. State's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has joint responsibility with medicaid agency
Writing waiver	SMHA has joint responsibility with medicaid agency
Contracting	SMHA has joint responsibility with medicaid agency
Monitoring	SMHA has joint responsibility with medicaid agency
Evaluating	SMHA has joint responsibility with medicaid agency
SMHA serves as managed care agent	SMHA has joint responsibility with medicaid agency

Mental health parity laws:
The state mandates mental health insurance benefits. These benefits include any mental health and substance abuse service. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	No	Yes
Health	No	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	No	Yes
Child Welfare	No	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Specific language passed in 2003 prohibits relinquishing custody to obtain mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

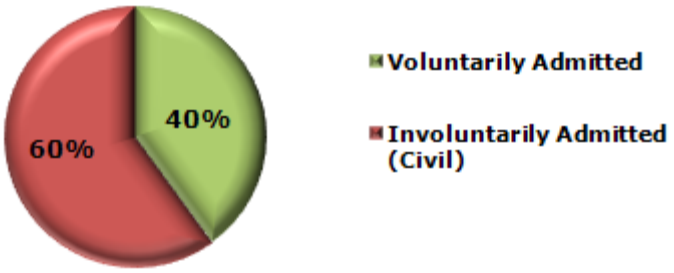
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are 11 state-operated psychiatric hospitals including a forensic hospital.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	
Forensic		Yes	Yes

The average daily census in FY 2006 for youth was 81 and for adults was 340 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:
The commitment status of patients in state hospital on the last day of the year shows that 40 percent were voluntarily admitted while 60 percent were involuntarily civilly committed.



Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric and state psychiatric hospital beds in the last year.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard to assure the provision of services to meet the mental health needs of veterans and National Guard members.

MISSISSIPPI 2007

239 North Lamar Street Suite 1101 Jackson, MS 39201	*The Mississippi Department of Mental Health is under separate governance by the State Board of Mental Health, which oversees mental health, mental retardation/developmental disabilities, and substance abuse services, as well as limited services for persons with Alzheimer's disease/other dementia.*

Statistics:

State Population (2006):	*2,910,540*
Number of Persons Served (2007):	*92,003*
Utilization Rate for Adults:	*29 per 1,000*
Utilization Rate for Children:	*40 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$305.9 million
Revenue From Medicaid	$156.9 million
Expenditure for Community Mental Health Services (44% of Total SMHA Revenues)	$135.5 million
Per Capita State Mental Health Spending	$105.68

Workforce development initiatives:

The SMHA does not have initiatives to improve the quality of the mental health workforce.

Managed behavioral healthcare:

State's share of the Medicaid match is 24 percent.

Electronic Health Records (EHR):

The SMHA is in the process of installing an EHR in community mental health programs. The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers do not use a variety of EHR systems.

MISSOURI 2007

1706 East Elm Street Jefferson City, MO 65102 DMH and Network of Care	*The Department of Mental Health (DMH) is the Missouri agency authorized to develop and implement the public mental health delivery system. The DMH has three operating divisions: Division of Comprehensive Psychiatric Services (CPS), Division of Alcohol and Drug Abuse (ADA), and the Division of Mental Retardation and Developmental Disabilities (MRDD). Each of the three Divisions has its own state advisory structure and target populations. There are four regional hospital systems comprised of 11 CPS inpatient facilities. For the provision of community-based services, Missouri's 114 counties and the City of Street Louis are subdivided into 25 mental health service areas, each with an Administrative Agent (AA). AAs are community mental health centers responsible for the assessment and provision of services to persons in their designated area and for providing followup services to persons released from state-operated inpatient services.*

Statistics:

State Population (2006):	*5,842,713*
Number of Persons Served (2007):	*73,808*
Utilization Rate for Adults:	*13 per 1,000*
Utilization Rate for Children:	*12 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$414.0 million
Revenue From Medicaid	$266.2 million
Expenditure for Community Mental Health Services (51% of Total SMHA Revenues)	$193.8 million
Per Capita State Mental Health Spending	$71.59

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	11	0	11
Community Mental Health Providers	0	30	30

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation
Assertive Community Treatment (ACT)	Parts of the state
Supported Employment	Parts of the state
Medication Algorithms (Schizophrenia)	Statewide
Medication Algorithms (Bipolar Disorders)	Statewide
Integrated MH/Substance Abuse Services	Parts of the state
Supported Housing	Parts of the state
Consumer-Operated Services	Parts of the state
Multisystemic Therapy (Conduct Disorder)	Parts of the state
Therapeutic Foster Care	Statewide
Functional Family Therapy	Parts of the state

Emerging evidence-based and innovative practices:

Evidence-Based Practices
Pro-Recovery
Federally Qualified Health Centers (FQHC)/Community Mental Health Centers (CMHC)

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce, such as requesting new budget items and making merit system changes for medical staff.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 38 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA jointly responsible with Medicaid agency
Contracting	
Monitoring	SMHA jointly responsible with Medicaid agency
Evaluating	
SMHA serves as managed care agent	SMHA has no responsibility

Note: Blank space indicates the state did not report data for this category.

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: see block grant.

Telemedicine:
The SMHA promotes the use of telemedicine; to be addressed in Transformation Plan.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs. The SMHA is in the process of installing an EHR in community mental health programs. The SMHA has some EHR components implemented in community mental health programs. The SMHA has implemented all EHR components in community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are 11 SMHA-operated state psychiatric hospitals.

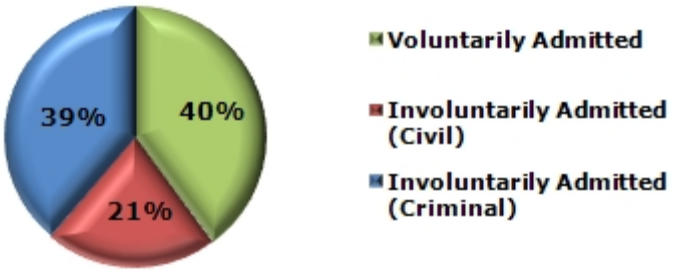
SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	
Adolescents	Yes	
Adults	Yes	Yes
Forensic	Yes	Yes

The average daily census in FY 2007 for youth was 69 and for adults was 1,303 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:

The commitment status of patients in state hospitals on the last day of the year shows that 40 percent were voluntarily admitted, 21 percent were involuntarily civilly committed, while 39 percent were involuntarily criminally committed.



Psychiatric inpatient bed shortages:

The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric beds in the last year.

Services for Armed Forces veterans and National Guard members:

The SMHA is working with the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members.

MONTANA 2007

P.O. Box 202905 Helena, MT 59620	*The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the public mental health system. The adult and children's systems have separate administrative structures within DPHHS. The adult mental health system is administered through the Addictive and Mental Disorders Division. This division also administers three state-run facilities: the Montana State Hospital, the Montana Mental Health Nursing Care Center, and the Montana Chemical Dependency Center. The Health Resources Division administers children's services through the Children's Mental Health Bureau. In addition, HRD is responsible for Medicaid Primary Care services and the Children's Health Insurance Program (CHIP). Medicaid mental health services are provided to adults with severe disabling mental illness (SDMI) through a fee-for-service system. The state also administers the Mental Health Services Plan (MHSP) for adults with SDMI who are not eligible for Medicaid and have a family income that does not exceed 150 percent of the Federal poverty level.*

Statistics:

State Population (2006):	*944,632*
Number of Persons Served (2007):	*26,248*
Utilization Rate for Adults:	*25 per 1,000*
Utilization Rate for Children:	*38 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$124.8 million
Revenue From Medicaid	$85 million
Expenditure for CommunityMental Health Services (80% of Total SMHA Revenues)	$99.4 million
Per Capita State Mental Health Spending	$134.03

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Same umbrella department
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
General Hospitals With Separate Psychiatric Units	0	4	4
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary mechanism in delivering mental health services:

SMHA directly funds, but does not operate local community-based programs.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	6
Supported Employment	Statewide	
Integrated MH/Substance Abuse Services	Parts of the state	
Consumer-Operated Services	Pilot program in parts of the state	
Therapeutic Foster Care	Parts of the state	12

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce such as salary increase for selected professional categories in state-run facilities and pursuit of telepsychiatry pool.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 28 percent.

Mental health parity laws:
The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive compulsive disorder, autism. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Corrections	Yes	Yes

Custody relinquishment:
There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine. Statewide telemedicine/video system used for treatment/assessments and for statewide training for providers.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is in the process of installing an EHR in state hospitals. The SMHA has some EHR components implemented in state hospitals. The state does not use a single EHR system for all community mental health providers.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2007 for adults was 199 receiving state psychiatric inpatient care.

Psychiatric inpatient bed shortages:
The state has experienced a decline in psychiatric inpatient bed capacity. There have been declines in general hospital specialty unit psychiatric beds in the last 5 years.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard to assure the provision of services to meet the mental health needs of veterans and National Guard members; participated in Governor's Task Force to identify mental health needs of returning veterans and National Guard personnel.

NEBRASKA 2007

P.O. Box 98925 Lincoln, NE 68509	*The Division of Behavioral Health is within the Nebraska Department of Health and Human Services. The Division is the chief behavioral health authority for the State. The Nebraska Behavioral Health Services Act defines the term Behavioral Health Disorder as "mental illness or alcoholism, drug abuse, problem gambling, or other addictive disorder." The Division's primary role involves State administration of non-Medicaid public behavioral health services. The Division contracts with the six Regional Behavioral Health Authorities (RBHA) to purchase community mental health and substance abuse services using the state and Federal funds. Each RBHA is governed by a Regional Governing Board consisting of one commissioner from each county assigned to the region. The Division is a direct service provider of mental health services through state psychiatric hospitals, referred to as Regional Centers. The Gamblers Assistance Program (GAP) provides training, education, and treatment services in an effort to reduce problem gambling and gambling-related addictions in Nebraska. The Division contracts with Magellan Behavioral Health for Managed Care Administration Service Organization (ASO) Mental Health and Substance Abuse (MH/SA) services. The act established the Behavioral Health office of Consumer Affairs within the Division. This office helps people who have experienced mental illness, substance abuse, and/or problem gambling to pursue a journey of recovery that will allow him or her to live in the community of his or her choice.*

Statistics:

State Population (2006):	*1,768,331*
Number of Persons Served (2007):	*37,163*
Utilization Rate for Adults:	*25 per 1,000*
Utilization Rate for Children:	*9 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$106.1 million
Revenue From Medicaid	$9.9 million
Expenditure for Community Mental Health Services (38% of Total SMHA Revenues)	$40 million
Per Capita State Mental Health Spending	$60.56

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
State Mental Hospitals	Part of SMHA
Community Mental Health Program	Part of SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Part of SMHA

Primary mechanism in delivering mental health services:
SMHA funds county or city mental health authorities statewide.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.

Custody relinquishment:
There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals. The SMHA is in the process of installing an HER in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services.

NEVADA 2007

4126 Technology Way, Second Floor Carson City, NV 89706 http://www.mhds.nv.gov	*The Division of Mental Health and Developmental Services (MHDS) is responsible for the operation of state-funded outpatient community mental health programs, psychiatric inpatient programs, mental health forensic services, and all developmental services programs and facilities. The Division is responsible for planning, administration, policy setting, monitoring, and budget development of all state-funded mental health and developmental services programs.*

Statistics:

State Population (2006):	*2,495,529*
Number of Persons Served (2007):	*28,513*
Utilization Rate for Adults:	*13 per 1,000*
Utilization Rate for Children:	*7 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$150.5 million
Revenue From Medicaid	$22.7 million
Expenditure for Community Mental Health Services (74% of Total SMHA Revenues)	$111.3 million
Per Capita State Mental Health Spending	$62.6

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	No responsibility
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	19	0	19

Primary mechanism in delivering mental health services:
SMHA directly operates community-based programs.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	3
Supported Employment	Statewide	3
Medication Algorithms (Schizophrenia)	Statewide	3
Integrated MH/Substance Abuse Services	Statewide	3
Supported Housing	Statewide	3
Consumer-Operated Services	Parts of the state	3
Multisystemic Therapy (Conduct Disorder)	Parts of the state	
Therapeutic Foster Care	Statewide	3

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation
Consumer-Assisted Programs	Available statewide

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce; pay for specific disciplines has helped, but created management problems due to salary "compaction."

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. State's share of the Medicaid match is 47 percent.

The Medicaid Managed Care population is limited to the two largest counties in Nevada, which are Clark (Las Vegas) and Washoe (Reno). TANF clients are mandatory for managed care, unless they are SMI or SED, then voluntary. All other Nevada counties are rural and are fee-for-service, regardless of eligibility criteria.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Interagency collaboration:

The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Health	Yes	Yes
Housing	Yes	Yes
Medicaid	Yes	Yes

Custody relinquishment:

The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:

The SMHA promotes the use of telemedicine.

Electronic Health Records (EHR):

The SMHA has implemented all EHR components in state hospitals and community mental health programs. The state uses a single EHR system for all community mental health providers.

State psychiatric hospitals:

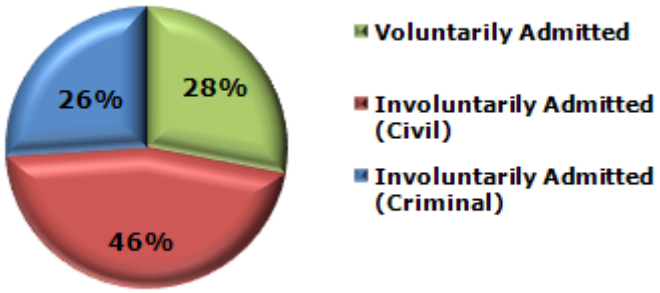
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are two SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)
Adults	Yes

The average daily census in FY 2006 for youth was 11 and for adults was 172 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state is experiencing a shortage of psychiatric beds. Nevada continues to experience a shortage of psychiatric acute care beds and concurrent overcrowding of emergency rooms, particularly in Southern Nevada.

NEW HAMPSHIRE 2007

105 Pleasant Street Concord, NH 03301 http://www.dhhs.state.nh.us	*The New Hampshire Bureau of Behavioral Health (BBH) aligns the overall mission, regional priorities, and funding into a comprehensive service delivery system that supports BBH's mission to promote respect, recovery, and full community inclusion for people who experience a mental illness, an emotional disturbance, and/or a substance abuse or addiction problem. BBH approaches this mission by working collaboratively with people who receive services and by supporting a network of local services that are responsive, effective, and efficient. BBH operates on a biennial budget, and the state plan reflects the biennium. New Hampshire's state-funded comprehensive community mental health system is based on the values of full community integration, consumer choice, family and consumer involvement at all levels, and flexible services provided in natural settings*

Statistics:

State Population (2006):	*1,314,895*
Number of Persons Served (2007):	*46,909*
Utilization Rate for Adults:	*35 per 1,000*
Utilization Rate for Children:	*39 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$154.9 million
Revenue From Medicaid	$91 million
Expenditure for CommunityMental Health Services (67% of Total SMHA Revenues)	$103.3 million
Per Capita State Mental Health Spending	$118.6

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No responsibility
State Mental Hospitals	Shared with another agency
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Same umbrella department
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
Community Mental Health Providers	11	0	11

Primary mechanism in delivering mental health services:
SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Supported Employment	Statewide	10
Integrated MH/Substance Abuse Services	Parts of the state	1
Self-Management	Statewide	10

Emerging evidence-based and innovative practices:

Emerging EBPs and Innovative Practices	Availability	Number of Programs
Trauma-Focused Cognitive Based Therapy	Statewide	10
Intentional Peer Support	Statewide	9
Real Choice Grants		0

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce; provision of training for the statewide implementation and maintenance of evidence-based practices in the CMHCs.

Managed behavioral healthcare:
Mental health services are being delivered via managed care. State's share of the Medicaid match is 50 percent.

Mental health parity laws:
The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included: biologically based mental illness and mandated benefits for other mental illness and substance use disorders. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	No	Yes
Health	No	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Child Protection Act New Hampshire RSA 169C3 NH tries to maintain primary health care provider regardless of whether child is in custody.

Telemedicine:
The SMHA promotes the use of telemedicine; Genesis CMHC using telemedicine to provide psychiatric emergency services to distant locations (rural EDs).

Electronic Health Records (EHR):
The SMHA is in the process of installing an EHR in state hospitals and community mental health programs. The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

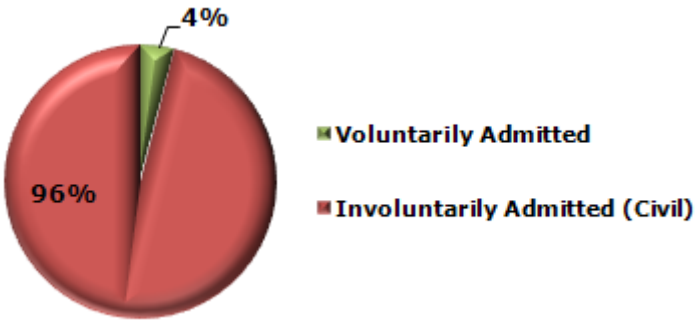
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding and/or delivery of community-based mental health services.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	
Adolescents	Yes	Yes	
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 30 and for adults was 177 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:
The commitment status of patients in the state hospital on the last day of the year shows that 4 percent were voluntarily admitted and 96 percent were involuntarily civilly committed.



Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds in the last year.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard to assure the provision of services to meet the mental health needs of veterans and National Guard members; member of the advisory board of Disaster Behavioral Health Response Team (DBHRT) under the Office of Homeland Security; participate in Operation Welcome Home with the National Guard via contract for services of the CMHCs; also some housing for mentally ill veterans.

NEW JERSEY 2007

Capitol Center P.O. Box 727 3rd Floor Trenton, NJ 08625 http://www.njmentalhealthcres.org	*The New Jersey Department of Human Services, Division of Mental Health Services (DMHS) oversees the state's public system of mental health services, offering a wide range of programs and support services. While the Division itself directly operates five state psychiatric hospitals, services are predominately based in local communities, where private agencies provide a variety of program options.*

Statistics:

State Population (2006):	*8,696,075*
Number of Persons Served (2007):	*334,949*
Utilization Rate for Adults:	*45 per 1,000*
Utilization Rate for Children:	*201 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$1.2 billion
Revenue From Medicaid	$230.2 million
Expenditure for Community Mental Health Services (63% of Total SMHA Revenues)	$769.8 million
Per Capita State Mental Health Spending	$139.84

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Same umbrella department
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	5	0	5
Community Mental Health Providers	0	120	120
Private Psychiatric Hospitals*	NA	6*	6
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

*These are county hospitals ONLY, not private hospitals.

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	31
Supported Employment	Statewide	22
Medication Algorithms (Schizophrenia)	Parts of the state	5
Family Psychoeducation		21
Integrated MH/Substance Abuse Services	Pilot program in parts of the state	5
Self-Management	Pilot program in parts of the state	24
Supported Housing	Statewide	42
Consumer-Operated Services	Statewide	27
Therapeutic Foster Care	Statewide	31

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Jail Diversion/Reentry Programs	Parts of the state	13

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce. The workforce development committee is continuing to provide education and training to staff with the ultimate goal of transitioning daily job and interactions with consumers into the wellness and recovery model/initiative.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility

Mental health parity laws:
The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included. There are two New Jersey statutes that mandate parity of coverage to physical health insurance. One statute was enacted in 1999 and mandates coverage for biologically based mental health diagnoses. Under the statute, biologically based mental health diagnoses are defined as: "a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or patter that substantially limits the functioning of the person with the illness, including but not limited to schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism."

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	No	Yes

Custody relinquishment:
The state does not have laws designed to mandate that parents must relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order to obtain mental health services. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine. Telepsychiatry is utilized in a few screening centers in the southern region and in Somerset and Warren counties in the Northern region of the state. DMHS permits the use of telepsychiatry under regulated circumstances.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals. The SMHA has some EHR components implemented in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers do not use a variety of EHR systems.

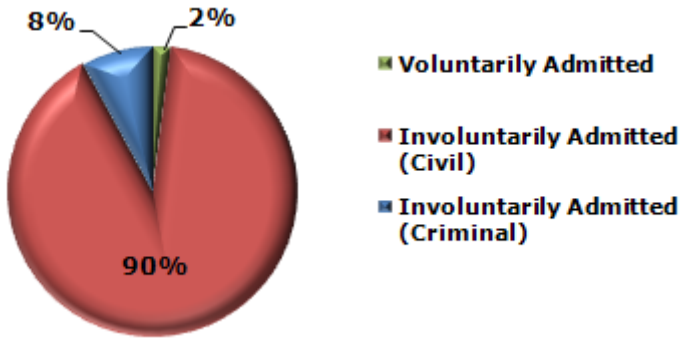
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are five SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2007 for youth was 39 and adults was 2,274 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds; however, DMHS has planned to expand its acute care inpatient short-term care facility beds.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. DMHS has partnered with the Department of Military Affairs and Veterans Administration (DMAVA) to provide reciprocal Web links advertising help lines that offer information, counseling, and support services to veterans previously deployed and returning from war. DMHS and DMAVA will also be engaging in planning discussions to explore partnership opportunities that will increase access to mental health services for veterans. Discussions are scheduled to take place in fall 2007.

NEW MEXICO 2007

1190 Street Francis Drive Santa Fe, NM 87502 http://www.valueoptions.com	*As New Mexico continues its ongoing transformation of the behavioral health system, FY 2007 and FY 2008 will continue to mark some of the most significant systemic changes to date. 2004 legislation created the Behavioral Health Purchasing Collaborative (the Collaborative) and in 2006 the Behavioral Health Planning Council was restructured. This resulted in coordinated management of most state and Federal behavioral health funding and administration of these funds by a single statewide entity. As the single statewide entity contract with Value Options, New Mexico began its third contract year in July 2007. The state has moved forward with internal infrastructure development and critical efforts to rebalance the system of care for both children and adults. The most significant new developments in New Mexico include the creation of a Behavioral Health Strategic Plan setting 10 priorities. This plan emphasizes stronger and more central roles for consumers and family members in planning, policy development, and oversight. Cross-agency teams are key to the state infrastructure for the Collaborative. Local Collaboratives in 13 geographic and 2 Native American areas, as well as the statewide Behavioral Health Planning Council, are the critical tools by which the state seeks advice from consumers and families. A major advancement in both the adult and children's systems is the expanded use of telehealth. Children, their families, and adult consumers in the rural and frontier areas of New Mexico are increasingly less isolated from the services and supports they require due to increased availability of video conferencing for reunification, prerelease staffing, case consultations, psychological evaluations, and medication management. In addition, local collaboratives are using teleconferencing to effectively engage people in rural and frontier areas.*

Statistics:

State Population (2006):	*1,954,599*
Number of Persons Served (2007):	*72,959*
Utilization Rate for Adults:	*30 per 1,000*
Utilization Rate for Children:	*59 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$46.4 million
Revenue From Medicaid	$4.6 million
Expenditure for Community Mental Health Services (53% of Total SMHA Revenues)	$21.7 million
Per Capita State Mental Health Spending	$24.23

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Shared with another agency
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	1	2
Community Mental Health Providers	0	23	23
Private Psychiatric Hospitals	NA	3	3
General Hospitals With Separate Psychiatric Units	0	1	1
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Pilot program in parts of the state	2
Supported Employment	Statewide	1
Integrated MH/Substance Abuse Services	Statewide	4
Supported Housing	Statewide	5
Consumer-Operated Services	Pilot Program	30
Multisystemic Therapy (Conduct Disorder)	Statewide	19
Therapeutic Foster Care	Statewide	15
Function Family Therapy	Statewide	5

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Native American Traditional Healing Practices	2 Reservation 2 Metro	4

Workforce development initiatives:

The SMHA has initiatives to improve the quality of the mental health workforce. The purchasing collaborative has assigned responsibility of workforce development to the newly formed New Mexico Consortium for Behavioral Health Training and Research (NM CBHTR) to assess the severe shortages and to make recommendations. This will be an ongoing initiative. The goals for CBHTR are to develop their infrastructure, funding, and advisory groups from academic institutions, providers, consumers, and families. They are also developing a statewide training and workforce development plan among other specific objectives.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. State's share of the Medicaid match is 25 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	Joint responsibility with Medicaid
Writing waiver	SMHA has no responsibility
Contracting	Joint responsibility with Medicaid
Monitoring	Joint responsibility with Medicaid
Evaluating	Joint responsibility with Medicaid
SMHA serves as managed care agent	SMHA has lead responsibility

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: A parent does not have to relinquish custody in order to get services. There were no children who had their parents' custody relinquished in 2007 to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine. Initiative was established at the University of New Mexico and has been expanded statewide. ValueOptions New Mexico has extended funding to a number of their contractors to ensure this service. There is a state Medicaid plan to use telehealth. The SBIRT Grant has 32 sites that have telemedicine capabilities to do motivational interviewing and counseling.

Electronic Health Records (EHR):
The SMHA has some EHR components implemented in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers do not use a variety of EHR systems.

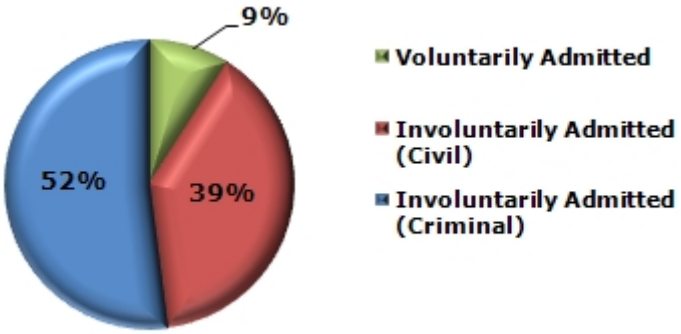
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding and/or delivery of community-based mental health services.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes

The average daily census in FY 2006 for adults was 63 receiving state psychiatric inpatient care. The state has not indicated the average daily census in FY 2007 for youth receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. There is a working group on behavioral health services to military personnel and their families that is reporting to the Governor and conducting a pilot PTSD project in one area of the state. The SMHA initiated a program to train and supervise clinicians to treat PSTD through the technique of Eye Movement Desensitization or EMDR.

NEW YORK 2007

44 Holland Avenue Albany, NY 12229 http://www.omh.state.ny.us	*The Office of Mental Health is responsible for the administration of a large state-operated system of state institutions. The Office is responsible for the regulation and licensing of all mental health facilities and programs in the state other than private practice and Federal facilities.*

Statistics:

State Population (2006):	*19,306,183*
Number of Persons Served (2007):	*615,379*
Utilization Rate for Adults:	*32 per 1,000*
Utilization Rate for Children:	*30 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$4.0 billion
Revenue From Medicaid	$2.1 billion
Expenditure for Community Mental Health Services (69% of Total SMHA Revenues)	$2.7 billion
Per Capita State Mental Health Spending	$206.21

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Part of the SMHA
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Prison part of the SMHA; jails, no responsibility

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Different state department
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	27	0	27
Community Mental Health Providers	160	3,041	3,201
General Hospitals With Separate Psychiatric Units	0	6	6

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	76
Supported Employment	Statewide	147
Medication Algorithms (Schizophrenia)	Parts of the state	
Medication Algorithms (Bipolar Disorders)	Parts of the state	
Family Psychoeducation	Parts of the state	17
Integrated Mental Health/Substance Abuse Services	Parts of the state	
Self-Management	Parts of the state	
Supported Housing	Statewide	421
Consumer-Operated Services	Statewide	
Multisystemic Therapy (Conduct Disorder)	Pilot program	
Therapeutic Foster Care	Parts of the state	
Functional Family Therapy	Parts of the state	0

Note: Blank space indicates the state did not report data for this category.

Emerging evidence based and innovative practices:

Evidence-Based Practices	Implementation	Number of Programs
Single Point of Access	Available statewide	65
Clinic Plus	Available statewide	300
PTSD	Available statewide	
Peer Support/Self-Help	Available statewide	
DBT	Available in parts of state	
“Gatekeeper” At-Risk Identification	Available in parts of state	3
Mental Health/Physical Health Integration	Available in parts of state	7

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce; preventing and managing crisis situations, safety training for mental health workers, safe and therapeutic environment, and other programs tailored to policy and JCHO standards.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 35 percent.

Mental Health Parity Laws:
The state mandates mental health insurance benefits. These benefits include any mental health service, but not substance abuse services. Other small employers have limited mandates. The mandate includes parity with physical health service benefits.

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Available array of residential services based on need, not custody. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine; Grand Rounds satellite training, NYPI science to service consulting, rural counties consulting/training for primary doctors.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is in the process of installing an EHR in community mental health programs. The SMHA has some EHR components implemented in community mental health programs. The SMHA has implemented all EHR components in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

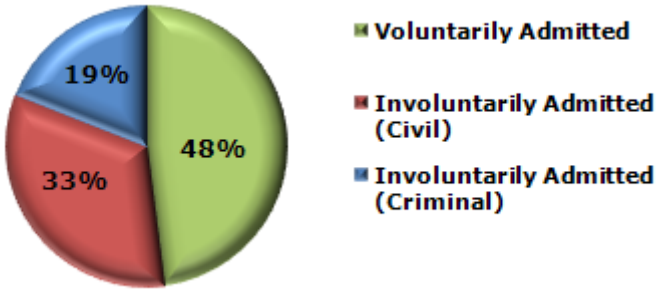
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are 27 SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	
Adolescents	Yes	Yes	
Adults		Yes	Yes
Elderly		Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2007 for youth was 500 and for adults was 4,568 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

There have been declines in general hospital specialty unit psychiatric beds in the last year. The state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:

The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. Ongoing work with VA on mental health needs of returning veterans and families; recent work with National Guard.

NORTH CAROLINA 2007

Albermarle Building, Room 1149 Raleigh, NC 27606 http://www.dhhs.state.nc.us/mhddsas/	*The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MHDDSAS) is the state agency responsible for mental health services. The Division's state facilities consist of four regional psychiatric hospitals, four developmental disabilities centers, three substance abuse treatment centers, a specialty nursing facility for mentally ill consumers, a specialty nursing facility for consumers with developmental disabilities, and two residential facilities for children with serious emotional disturbances.*

Statistics:

State Population (2006):	*8,856,505*
Number of Persons Served (2007):	*246,609*
Utilization Rate for Adults:	*27 per 1,000*
Utilization Rate for Children:	*31 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency Controlled Revenues	$1.0 billion
Revenue From Medicaid	$617.1 million
Expenditure for CommunityMental Health Services (73% of Total SMHA Revenues)	$749.0 million
Per Capita State Mental Health Spending	$119.82

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Part of the SMHA
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	0	26	26
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary mechanism in delivering mental health services:
SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	47
Supported Employment	Parts of the state	40
Family Psychoeducation	Parts of the state	5
Integrated MH/Substance Abuse Services	Parts of the state	10
Self-Management	Parts of the state	9
Supported Housing	Statewide	26
Consumer-Operated Services	Parts of the state	11
Multisystemic Therapy (Conduct Disorder)	Parts of the state	6
Therapeutic Foster Care	Statewide	1
Functional Family Therapy	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Consumer-Run Services	Parts of the state	
Consumer-Run Recovery	Parts of the state	
Geriatric Specialty Teams	Parts of the state	20

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce; joint workforce development initiative between Division and the NC Commission for MH/DD/SAS to identify and recommend strategies that the Division should undertake over the next several years to retain current staff and recruit new workers into this field (due December 2007).

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care in 1 of 24 catchment areas. These behavioral health services are administered through a Medicaid 1915(b) waiver. State's share of the Medicaid match is 36 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA jointly responsible with Medicaid agency
Evaluating	SMHA jointly responsible with Medicaid agency
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The state mandates mental health insurance benefits. Legislation was signed 7/27/07 and will become effective 7/1/08; also provides minimum required benefits of 30 combined inpatient and outpatient days per year and 30 office visits per year for the following illnesses: bipolar disorder, major depressive disorder, obsessive compulsive disorder, paranoid and other psychotic disorders, schizoaffective disorder, schizophrenia, posttraumatic stress disorder, anorexia nervosa and bulimia. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: (1) Services and supports are broad and target populations for these services including those children at risk of out of home placement or DDS custody; (2) Coordination of policy and practice with child welfare occurs; and (3) state CTSP (Comprehensive Treatment Services Program) special provision funding.

Telemedicine:
The SMHA promotes the use of telemedicine; has started to investigate ways to expand this capacity; exploring a partnership with East Carolina University and considering exploring funding sources; drafted a statement of need and will continue to develop same.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is in the process of installing an EHR in state hospitals. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are four SMHA-operated state psychiatric hospitals.

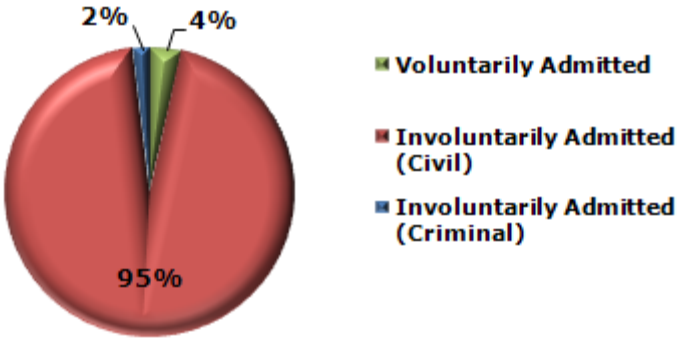
SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 160 and for adults was 977 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:

The commitment status of patients in state hospitals on the last day of the year shows that 4 percent were voluntarily admitted, 95 percent were involuntarily civilly committed, and 2 percent were involuntarily criminally committed.



Note: Percentage may not total 100 because of rounding.

Psychiatric inpatient bed shortages:

The state is experiencing a shortage of psychiatric beds. There have been declines in state psychiatric hospital beds in the last year.

Services for Armed Forces veterans and National Guard members:

The SMHA is working with the state National Guard and the Federal Departments of Veterans Affairs and Defense to assure the provision of services to meet the mental health needs of veterans and National Guard members. There is a link on the Division website to the Web page for the Governor's Focus on Returning Combat Veterans and Their Families (http://www.governorsinstitute.org).

NORTH DAKOTA 2007

ND DHS MHSAS 1237 W. Divide Ave Suite 1C Bismarck, ND 58501-1208 http://www.nd.gov/dhs	*The Division of Mental Health and Substance Abuse Services is a part of the Program and Policy component of the Department of Human Services. It works closely with other public agencies (such as the Department of Public Instruction, the Department of Health, and the Department of Corrections and Rehabilitation), as well as a myriad of private and not-for-profit human service agencies to ensure quality and effective mental health services are provided throughout the state.*

Statistics:

State Population (2006):	*635,687*
Number of Persons Served (2007):	*15,493*
Utilization Rate for Adults:	*25 per 1,000*
Utilization Rate for Children:	*22 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$46.8 million
Revenue From Medicaid	$10.2 million
Expenditure for Community Mental Health Services (60% of Total SMHA Revenues)	$28 million
Per Capita State Mental Health Spending	$74.39

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	No responsibility
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Shared with another agency
State Mental Hospitals	Shared with another agency
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	0	0	0
Community Mental Health Providers	0	0	0
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:
SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Integrated MH/Substance Abuse Services	Pilot program in parts of the state	1
Therapeutic Foster Care	Statewide	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Wraparound	Statewide	1
Mental Health Recovery	Statewide	8

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce; coordination and collaboration with WICHE to identify gaps and strengths of workforce.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 33 percent.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Health	No	Yes
Housing	Yes	Yes
Education	No	Yes
Juvenile Justice	No	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: state statute and program policies.

Telemedicine:
The SMHA promotes the use of telemedicine; telemedicine workgroup looking at feasibility of implementing telemedicine.

Electronic Health Records (EHR):
The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state uses a single EHR system for all community mental health providers.

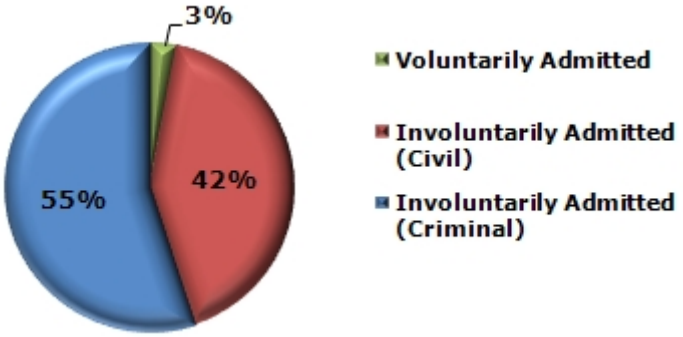
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are no SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for adults was 257 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:
The commitment status of patients in state hospital on the last day of the year shows that 3 percent were voluntarily admitted, 42 percent were involuntarily civilly committed, while 55 percent were involuntarily criminally committed.



Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard to assure the provision of services to meet the mental health needs of veterans and National Guard members; discussions to ensure awareness of potential increase in veterans presenting with psychological issues.

OHIO 2007

30 E. Broad Street Suite 800 Columbus, OH 43215 http://www.networkofcare.org	*The Ohio Department of Mental Health (ODMH) contracts with 50 county and multicounty mental health boards that plan, develop, fund, manage, and evaluate mental health services. Of these boards, 46 also administer substance abuse services. Four board areas have separate boards for drug and alcohol services that contract separately with the Ohio Department of Alcohol Services. The boards are supported by Federal, state, and local funds and are responsible for ensuring that alcohol, drug addiction, and/or mental health services are available to those who need them.*

Statistics:

State Population (2006):	*11,478,006*
Number of Persons Served (2007):	*309,594*
Utilization Rate for Adults:	*23 per 1,000*
Utilization Rate for Children:	*38 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$757.7 million
Revenue From Medicaid	$329 million
Expenditure for Community Mental Health Services (70% of Total SMHA Revenues)	$531.5 million
Per Capita State Mental Health Spending	$66.1

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Different state department
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State psychiatric hospitals	5	0	5
Community Mental Health Providers	27	365	392
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	29
Supported Employment	Parts of the state	10
Medication Algorithms (Schizophrenia)	Parts of the state	
Medication Algorithms (Bipolar Disorders)	Parts of the state	
Family Psychoeducation	Parts of the state	6
Integrated MH/Substance Abuse Services	Parts of the state	43
Self-Management	Pilot program	4
Supported Housing	Parts of the state	50
Consumer-Operated Services	Parts of the state	68
Multisystemic Therapy (Conduct Disorder)	Parts of the state	17
Therapeutic Foster Care	Parts of the state	
Functional Family Therapy	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Emerging EBPs and Innovative Practices	Availability	Number of Programs
Intensive Home Base Treatment	Statewide	45
Integrated Services for MI/MRDD	Parts of state	46
Sequential Intercept Model/CIT Crisis Intervention	Statewide	49
Wellness Management and Recovery	Parts of state	10

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce. These include 31 residency and traineeship grants to college and university departments of psychiatry, psychology, nursing, social work, as well as Health Professional Shortage Area (HPSA) activities. Additionally, eight Coordinating Centers of Excellence promote evidence-based practices through in-service training, consultation, and fidelity assessment. A contract with NetSmart University will support Web-based learning.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care.

Mental health parity laws:
The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	No
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Former governor ordered an action plan to eliminate custody relinquishment as a requirement for mental health care.

Telemedicine:
The SMHA facilitates the use of telemedicine by implementing new certification rules in 2007, which increased the regulatory burden for providers.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is in the process of installing an EHR in state hospitals. The SMHA has some EHR components implemented in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

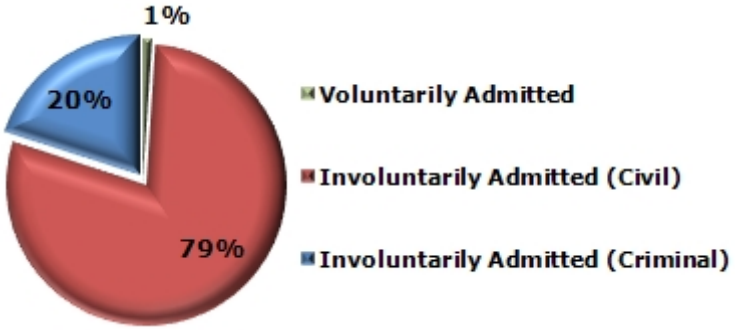
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are five SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2007 for youth was 25 and for adults was 1,022 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
After declining from 1995 to 2005, Ohio's state hospital bed capacity has remained unchanged from 2005 to 2007.

Services for Armed Forces veterans and National Guard members:
In collaboration with the National Guard, the SMHA is working to assure the provision of services to meet the mental health needs of veterans and National Guard members; OhioCares Initiative; returning Home/Ohio Network of Care website shared training conferences specific to needs of returning vets.

OKLAHOMA 2007

1200 NE 13th Street Oklahoma City, OK 73117 http://www.odmhsas.org	*ODMHSAS: A publicly supported community mental health center is located within each of 17 mental health service areas in Oklahoma. Most have satellite offices or other specialized programs within their service areas. These centers provide emergency intervention, assessment, counseling, psychosocial rehabilitation, case management, and community support services designed to assist adult mental health clients in living as independently as possible and to provide therapeutic services for children who are demonstrating symptoms of emotional disturbance. For clients who need inpatient treatment, the Department operates a psychiatric hospital for adults and a facility for children under the age of 18 years. Funding is also provided to support inpatient services through a network of community-based hospitals. There is also a specialty center devoted to forensic services. Additionally, the Department provides funding for social and recreational services for individuals with mental illness who live in residential care facilities, as well as support for certain other community-based services such as assistance for people who are homeless and have a mental illness.*

Statistics:

State Population (2006):	*3,579,212*
Number of Persons Served (2007):	*44,002*
Utilization Rate for Adults:	*14 per 1,000*
Utilization Rate for Children:	*6 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$157.3 million
Revenue From Medicaid	$19.6 million
Expenditure for Community Mental Health Services (65% of Total SMHA Revenues)	$101.9 million
Per Capita State Mental Health Spending	$44.67

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State psychiatric hospitals	4	0	4
Community Mental Health Providers	7	10	17
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	14
Integrated MH/Substance Abuse Services	Statewide	
Supported Housing	Parts of the state	16
Functional Family Therapy	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Emerging EBPs and Innovative Practices	Availability
Systems of Care/Wraparound	Available in parts of state
Psychosocial Rehabilitation	Available statewide
Strengths Based Case Management	Available statewide

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce. Nurse leadership initiatives; training specifically for nurses; children's workforce development; annual conferences/special seminar; cross-training for trauma-informed services; integrated (MH/SA) services initiatives.

Managed behavioral healthcare:

Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 31 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	No responsibility
Writing waiver	No responsibility
Contracting	No responsibility
Monitoring	No responsibility
Evaluating	No responsibility
SMHA serves as managed care agent	No responsibility

Mental health parity laws:

The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included. The following diagnoses are included: severe mental illness. The mandate includes parity with physical health service benefits.

Interagency collaboration:

The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine; using telemedicine between selected sites to facilitate clinical consultation and linkage with court proceedings. ODMHSAS is working with providers and consumers through its IT Steering Committee and Transformation Grant to identify areas of need and support deployment of equipment to support telemedicine. Department and TSIG staff have also met with state university telemedicine project staff to discuss collaborating to expand and extend services in rural areas of the state where child and adult psychiatrists are desperately needed.

Electronic Health Records (EHR):
The SMHA is in the process of installing an EHR in state hospitals and community mental health programs. Local providers use a variety of EHR systems.

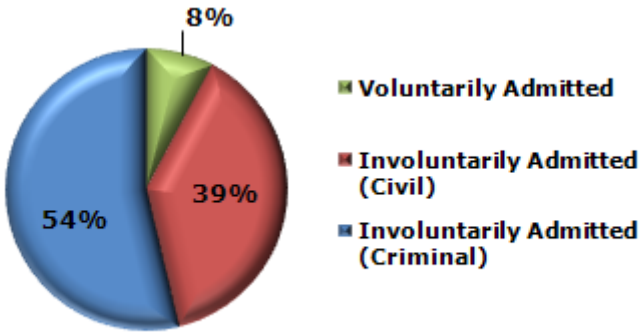
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are four SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 39 and for adults was 315 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Note: Percentage may not total 100 because of rounding.

Psychiatric inpatient bed shortages:

The state is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric, state psychiatric hospital and private psychiatric hospital beds in the last year.

Services for Armed Forces veterans and National Guard members:

The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; formed statewide workgroup to respond to needs of returning veterans. Initiatives include providing mental health and substance abuse education at pre- and post-deployment briefings for military members and their families, including a youth initiative; statewide resource directory; legislation and funding; public relations and antistigma and peer support groups.

Oregon 2007

500 Summer St NE Salem, OR 97301 http://www.oregon.gov	*The Oregon Addictions and Mental Health Division (AMH) is located within the Department of Human Services (DHS). DHS is made up of the following program areas: Children, Adults and Families; Seniors and People with Disabilities; AMH, the Office of Medical Assistance Programs (State Medicaid Agency) and public health related offices. State general funds for nonresidential services are allocated to counties using a "block grant" approach. AMH currently contracts with 31 counties or consortium of counties, one community mental health program and one tribe. Capitated mental health services for persons who are Medicaid-eligible are administered through contracts between AMH and Managed Care Organizations. All other non-capitated services are administered through contracts to the counties and direct contracts to service providers for community hospitals for acute psychiatric care and a small number of residential programs.*

Statistics:

State Population (2006):	*3,700,758*
Number of Persons Served (2007):	*109,758*
Utilization Rate for Adults:	*26 per 1,000*
Utilization Rate for Children:	*43 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenues	$434.6 million
Revenue From Medicaid	$299.3 million
Expenditure for CommunityMental Health Services (73% of Total SMHA Revenues)	$318.4 million
Per Capita State Mental Health Spending	$119.48

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Part of the SMHA
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	114	114
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	13	13
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	19
Supported Employment	Parts of the state	30
Medication Algorithms (Schizophrenia)	Parts of the state	55
Family Psychoeducation	Parts of the state	28
Integrated MH/Substance Abuse Services	Parts of the state	84
Self-Management	Parts of the state	11
Supported Housing	Parts of the state	19
Consumer-Operated Services	Parts of the state	13
Multisystemic Therapy (Conduct Disorder)	Parts of the state	11
Therapeutic Foster Care	Parts of the state	8
Functional Family Therapy	Parts of the state	14

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Parent/Child Interactive Therapy	Parts of the state	1
Supported Education	Parts of the state	
Gatekeeping/Multidisciplinary Team	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:

The SMHA has initiatives to improve the quality of the mental health workforce. Workforce development initiative is Psychiatric Nurse Workforce Development Team.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. State's share of the Medicaid match is 38 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Writing waiver	SMHA jointly responsible with Medicaid agency
Contracting	SMHA jointly responsible with Medicaid agency
Monitoring	SMHA jointly responsible with Medicaid agency
Evaluating	SMHA jointly responsible with Medicaid agency
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:

The state mandates health insurance benefits. These benefits include any mental health and substance abuse service. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	No	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Law allows voluntary placement by parent in agreement with Child Welfare.

Telemedicine:
The SMHA promotes the use of telemedicine for youth and adults in rural areas.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

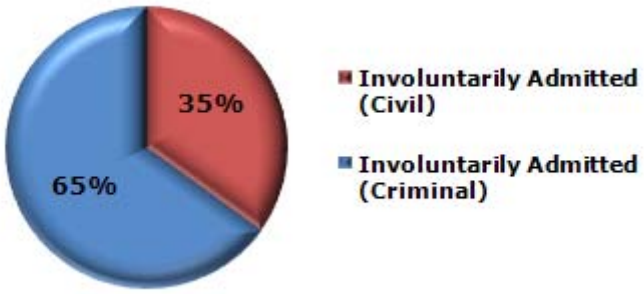
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are two SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults		Yes	Yes
Elderly		Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 15 and for adults was 718 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state is experiencing a shortage of psychiatric beds. There have been declines in state psychiatric hospital beds in the last year.

PENNSYLVANIA 2007

Office of Mental Health and Substance Abuse Services PA Department of Public Welfare PO Box 2675 Admin Building DGS Complex Annex Harrisburg, Pennsylvania 17105-2675	*Office of Mental Health and Substance Abuse Services (OMHSAS) in the Department of Public Welfare has primary responsibility for the planning, policy, program development, and financial oversight of the behavioral health service system in the Commonwealth, which includes mental health treatment services and supports, as well as designated substance abuse services. The primary objective of these services is to support individual movement toward recovery. OMHSAS is the Medicaid State Mental Health Authority for behavioral health services, and the Office of Medical Assistance Programs (OMAP) manages physical health Medicaid. OMHSAS is the state agency responsible for substance abuse services for Medicaid recipients, while the Department of Health manages the non-Medicaid substance abuse services.*

Statistics:

State Population (2006):	*12,440,621*
Number of Persons Served (2007):	*299,037*
Utilization Rate for Adults:	*21 per 1,000*
Utilization Rate for Children:	*33.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$2.5 billion
Revenue From Medicaid	$710.1 million
Expenditures for Community Mental Health Services (80% of Total Mental Health Agency Revenues)	$2 billion
Per Capita State Mental Health Expenditures	$204.92

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Part of the SMHA
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Part of the SMHA
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Part of SMHA
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	8	0	8
Community Mental Health Providers	0	1300	1300
Private Psychiatric Hospitals	NA	31	31
General Hospitals With Separate Psychiatric Units	0	104	104
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	42
Supported Employment	Parts of the state	
Medication Algorithms (Schizophrenia)	Parts of the state	7
Family Psychoeducation	Parts of the state	
Integrated MH/Substance Abuse Services	Parts of the state	
Self-Management	Parts of the state	
Supported Housing	Parts of the state	
Consumer-Operated Services	Parts of the state	
Multisystemic Therapy (Conduct Disorder)	Parts of the state	10
Therapeutic Foster Care		1
Functional Family Therapy	Parts of the state	8

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Fair Weather Lodge	Available in parts of state	19
Compeer	Available in parts of state	13
Consumer-Run Drop-In Centers	Available in parts of state	25

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce. The state funds three universities and a child and family institute that provides free/low cost array of training to all staff within the state. For several years, the state has provided funds to counties for recruitment/retention efforts for direct care staff.

Managed behavioral healthcare:
Mental health and substance abuse services for all categories of assistance are being delivered statewide via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. State's share of the Medicaid match is 100 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Writing waiver	SMHA jointly responsible with Medicaid agency
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The state mandates mental health insurance benefits.
Only benefits for specific mental health diagnoses are included.
The mandate does not include parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Eligibility requirements for medical assistance enable children to receive needed services without parents giving up custody.

Telemedicine:

The SMHA promotes the use of telemedicine. There are several pilot projects that provide mostly child psychiatric consultations and medication management. Telepsychiatry links include schools (nursing office), mental health clinics, and hospitals. One county contracted for after-hour, weekend, and holiday psychiatric consultation to its hospital emergency room. There is a proposed initiative from the Office of Medical Assistance Programs to use telemedicine to provide consultation to rural primary care. Other identified areas of need include high-risk pregnancies and individuals receiving three or more psychiatric medications. Pilots are developed by the managed care vendor.

Electronic Health Records (EHR):

The state does not use a single EHR system for all community mental health providers. Local providers do not use a variety of EHR systems.

State psychiatric hospitals:

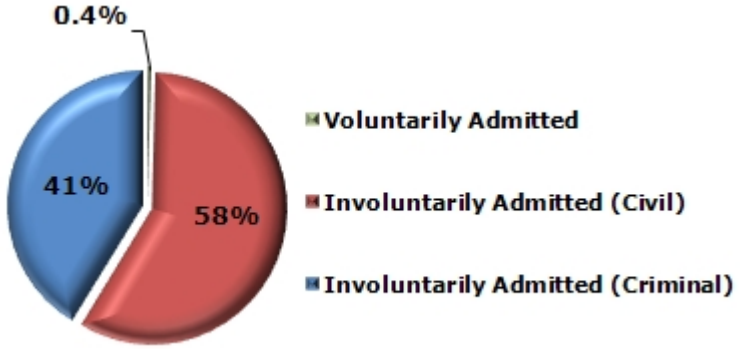
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are seven SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth (18–20) was 19 and for adults was 2,136 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Note: Percentage may not total 100 because of rounding.

Psychiatric inpatient bed shortages:

There have been declines in state psychiatric hospital and private psychiatric hospital beds in the last year. The state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
Since 2005, the SMHA has helped organize and cochair the PA CARES task force. The task force is a collaborative effort of over 20 organizations including the Department of Public Welfare, Department of Health, Pennsylvania Department of Military and Veterans Affairs, county mental health authorities, Pennsylvania colleges and universities, Vocational Rehabilitation, Association for the Blind, clergy, and numerous other organizations in addition to veterans themselves. PA CARES has sponsored or delivered over 30 events aimed at program development, training, education, and public awareness. Members of the Task Force identify resources for mental health, health, drug and alcohol treatment, education, vocational and other resources and work to link those resources with the PA Guardsmen and other PA military.

RHODE ISLAND 2007

14 Harrington Road Cranston, RI 02920 http://www.mhrh.ri.gov	*The Rhode Island Department of Mental Health, Retardation and Hospitals (MHRH) serves hospital patients with chronic, long-term debilitating diseases and medical conditions who generally are uninsured or underinsured; persons with serious and persistent mental illness, emotional difficulty and psychological disorders; people with developmental disabilities that are attributable to a cognitive or physical impairment, or a combination of cognitive and physical impairments; and persons with a problem of substance abuse that is chronic, progressive, and relapsing and results in physical and psychological dependence on chemical substances. The Rhode Island Department of Children, Youth and Families (DCYF) plans, develops, and evaluates a comprehensive and integrated statewide program of services designed to ensure the opportunity for children.*

Statistics:

State Population (2006):	*1,067,610*
Number of Persons Served (2007):	*26,886*
Utilization Rate for Adults:	*24 per 1,000*
Utilization Rate for Children:	*30 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$102.4 million
Revenue From Medicaid	$86.3 million
Expenditures for Community Mental Health Services (73% of Total Mental Health Agency Revenues)	$74.4 million
Per Capita State Mental Health Expenditures	$95.55

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	No responsibility
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Same umbrella department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
Community Mental Health Providers	0	10	10
General Hospitals With Separate Psychiatric Units	1	0	1

Primary mechanism in delivering mental health services:
SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	14
Supported Employment	Statewide	8
Family Psychoeducation		1
Integrated MH/Substance Abuse Services	Statewide	
Supported Housing	Parts of the state	
Consumer-Operated Services	Parts of the state	
Multisystemic Therapy (Conduct Disorder)		7

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of the mental health workforce; does not provide direct service, but monitors it; and in the process, provides technical assistance to direct service provides and train supervisors regarding recovery-oriented treatment planning and integrated assessments of mental health provides.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. State's share of the Medicaid match is 45 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has no responsibility
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA has no responsibility
Evaluating	SMHA jointly responsible with Medicaid agency
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:

The State mandates mental health insurance benefits. These benefits include any mental health and substance abuse service. The following diagnoses are included: all mental illnesses and substance abuse disorders. The mandate includes parity with physical health service benefits.

Interagency collaboration:

The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections		Yes
Child Welfare	Yes	Yes

Note: Blank space indicates the state did not report data for this category.

Custody relinquishment:

There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Electronic Health Records (EHR):

The SMHA is considering the adoption of an EHR in state hospitals. The SMHA is in the process of installing an EHR in community mental health programs. The SMHA has some EHR components implemented in community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding and/or delivery of community-based mental health services.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults		Yes	Yes
Elderly		Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 1 and for adults was 148 receiving state psychiatric inpatient care.

Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds. There have been declines in state psychiatric hospital beds in the last year.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. Volunteers from local CMHCs and EAPs meet and speak with families as required.

SOUTH CAROLINA 2007

http://www.scdmh.org	*The South Carolina Department of Mental Health (DMH) provides assessment, diagnosis, and treatment to its priority populations through a network of 17 community mental health centers (CMHCs) and 3 specialized inpatient facilities. The 17 CMHCs provide services within their respective counties and operate within the policies and guidelines set by DMH. The catchment areas covered by each of the 17 CMHCs range from part of a county to 7 counties.*

Statistics:

State Population (2006):	*4,321,249*
Number of Persons Served (2007):	*88,331*
Utilization Rate for Adults:	*18 per 1,000*
Utilization Rate for Children:	*30 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$285.2 million
Revenue From Medicaid	$155.4 million
Expenditures for Community Mental Health Services (66% of Total Mental Health Agency Revenues)	$187.7 million
Per Capita State Mental Health Expenditures	$67.70

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Part of SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Different state department
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	3	0	3
Community Mental Health Providers	17	0	17
Nursing Homes and Other ICF-MI and SNF Providers	1	2	3

Primary mechanism in delivering mental health services:
SMHA directly operates local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	3
Supported Employment	Statewide	10
Medication Algorithms (Schizophrenia)	Pilot program	
Supported Housing	Statewide	0
Multisystemic Therapy (Conduct Disorder)	Parts of the state	6

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Juvenile Justice Diversion	Parts of state	
Trauma Screening and TF-CBT	Parts of state	10
School-Base MH Services	Statewide	500
Trauma Screening and TF-CBT	Parts of state	
Peer Support Services	Parts of state	11
MH Courts and/or Jail Diversion	Parts of state	
Family Education	Parts of state	

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of mental health workforce. Leadership development; mentoring program (fourth year). Education, training, and research develop and promote numerous opportunities to improve skills of work force.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. State's share of the Medicaid match is 30 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has no responsibility
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA has no responsibility
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The State mandates mental health insurance benefits. These benefits include any mental health and substance abuse service. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	No
Health	Yes	No
Housing	Yes	No
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: State law provides DSS may provide child protective services to children and families of children who are in custody of state. SMHA does not precondition services on custody relinquishment. Clients without Medicaid or other insurance may find specific services (private residential care) difficult to access.

Telemedicine:
The SMHA promotes the use of telemedicine. In application process; collaborating with South Carolina Hospital Association. If approved will contact South Carolina hospital emergency departments to DMH psychiatric staff 24 hours per day, 7 days per week.

Electronic Health Records (EHR):

The SMHA is in the process of installing an EHR in community mental health programs. The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state uses a single EHR system for all community mental health providers. Local providers do not use a variety of EHR systems.

State psychiatric hospitals:

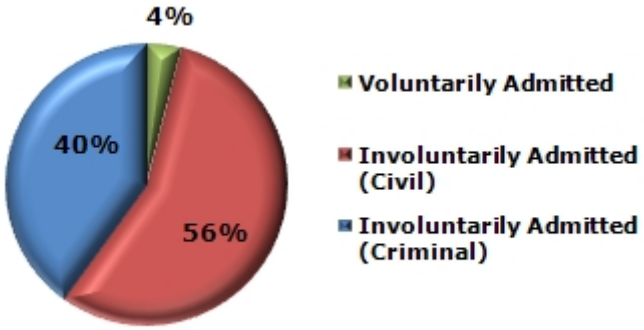
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are three SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 37 and for adults was 604 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds in the last year.

SOUTH DAKOTA 2007

E. Hwy 34 Hillsview Plaza c/o 500 E. Capitol Pierre, SD 57501	*The Division of Mental Health's mission is to ensure children and adults with mental health disorders in communities have the opportunity to choose and receive effective services needed to promote resiliency and recovery. In carrying out this mission, the Division of Mental Health provides a range of services through purchase of service agreements with 11 private, nonprofit communities mental health centers (CMHCs). The principal responsibilities of the Division of Mental Health are to establish policy, develop and administer the implementation of the Community Mental Health Services Block Grant, determine and establish reasonable standards and requirements for the locally operated community mental health centers, and enter into purchase of services agreements for assisting in the operation and programs of the local mental health centers. The Division of Mental Health also has the responsibility for the delivery of mental health services within the state's adult and juvenile correctional facilities.*

Statistics:

State Population (2006):	*781,919*
Number of Persons Served (2007):	*11,918*
Utilization Rate for Adults:	*12 per 1,000*
Utilization Rate for Children:	*24 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$55.2 million
Revenue From Medicaid	$19.2 million
Expenditures for Community Mental Health Services (37% of Total Mental Health Agency Revenues)	$20.2 million
Per Capita State Mental Health Expenditures	$71.38

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	No responsibility
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	No responsibility
Services to Persons With Mental Illness in Prison/Jail	Part of the SMHA
Sex Offender Services	No responsibility
State Mental Hospitals	No responsibility
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Same umbrella department
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	0	0	0
Community Mental Health Providers	0	11	11
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	4
Medication Algorithms (Schizophrenia)	Parts of the state	
Medication Algorithms (Bipolar Disorders)	Parts of the state	
Integrated MH/Substance Abuse Services		1
Supported Housing	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:
The SMHA has initiatives to improve the quality of the mental health workforce such as implementation of Systems of Care and recovery-oriented services and training toward these.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 39 percent.

Mental health parity laws:
The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included. The following diagnoses are included: Axis I. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Corrections		Yes
Housing	No	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Note: Blank space indicates the state did not report data for this category.

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. The state did not indicate how many children had their parents' custody relinquished in 2007 in order to receive mental health services.

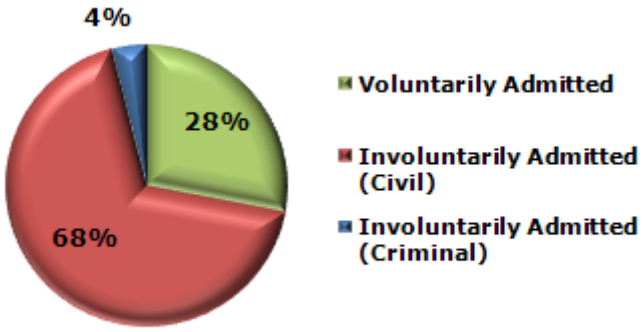
Telemedicine:
The SMHA promotes the use of telemedicine; established telepsychiatry as reimbursable service under State Medicaid; also utilizes telemedicine for psychiatric services in correctional mental health.

Electronic Health Records (EHR):
The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding and/or delivery of community-based mental health services. There are no SMHA-operated state psychiatric hospitals.

The average daily census in FY 2006 for youth was 64 and for adults was 180 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the State National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. Community mental health centers are actively working with the state National Guard to ensure guardsmen and their families receive needed services.

TENNESSEE 2007

E425 Fifth Avenue North Cordell Hull Building 5th Floor Nashville, TN 37243 http://www.state.tn.us/mental	*The Department of Mental health and Developmental Disabilities (DMHDD) contracts with managed care organizations for behavioral health care services under the TennCare Partners Program, a Medicaid waiver program; contracts with community mental health agencies (CMHAs) for Mental Health Safety Net (MHSN) services, a clinical services program for TennCare disenrolled adults with SMI; and contracts with CMHAs and other community entities to provide an array of education, prevention, early intervention and support programs for children and youth and their families and for a variety of recovery programs for adults, persons with co-occurring disorders, and older adults. The Department of Children's Services (DCS) is responsible for provision and oversight of services to children in or at risk of state custody.*

Statistics:

State Population (2006):	*6,038,803*
Number of Persons Served (2007):	*170,727*
Utilization Rate for Adults:	*26 per 1,000*
Utilization Rate for Children:	*36 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$522 million
Revenue From Medicaid	$355.6 million
Expenditures for Community Mental Health Services (66% of Total Mental Health Agency Revenues)	$345.2 million
Per Capita State Mental Health Expenditures	$87.91

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Part of SMHA
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	5	0	5
Community Mental Health Providers	0	48	48
Private Psychiatric Hospitals	NA	2	2

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	2
Supported Employment	Statewide	7
Medication Algorithms (Schizophrenia)	Pilot program	1
Integrated MH/Substance Abuse Services	Parts of the state	10
Self-Management	Parts of the state	1
Supported Housing	Statewide	10
Consumer-Operated Services	Statewide	48
Multisystemic Therapy (Conduct Disorder)	Parts of the state	1
Therapeutic Foster Care	Statewide	4

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Better Attitudes and Skills in Children (BASIC)	Statewide	43
Regional Intervention Program (RIP)	Parts of state	14
Peer Support Centers	Statewide	48
Peer Specialists	Parts of state	32

Workforce development initiatives:
The SMHA has initiatives to improve the quality of the mental health workforce, generally through training of current workforce, resident programs, and liaison with colleges/universities. The department works with the Tennessee Department of Health in the identification of critical shortage areas for mental health professionals across the state. In addition, several DMHDD staff work in conjunction with the Governor's Office of Children's Care Coordination, Tennessee Adolescent Coordination of Treatment (T-ACT) project on workforce development.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. State's share of the Medicaid match is 35 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid
Writing waiver	SMHA has no responsibility
Contracting	SMHA jointly responsible with Medicaid
Monitoring	SMHA jointly responsible with Medicaid
Evaluating	SMHA jointly responsible with Medicaid
SMHA serves as managed care agent	SMHA jointly responsible with Medicaid

Mental health parity laws:
The State mandates mental health insurance benefits. These benefits include any mental health service, but not substance abuse services. The following diagnoses are included: limited parity covering number of visits and lifetime maximums but not copays, coinsurance, deductibles. The mandate includes parity with physical health service benefits.

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine.

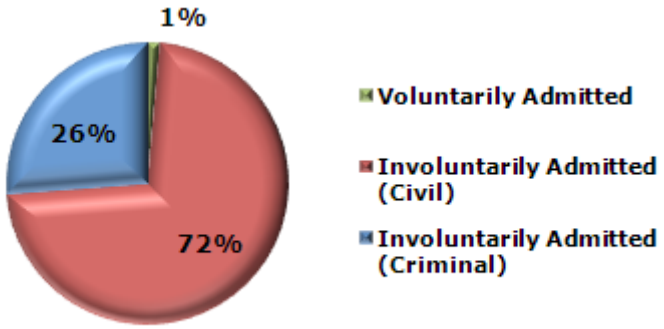
Electronic Health Records (EHR):
The SMHA is in the process of installing an EHR in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are five SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes		
Adolescents	Yes		
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State psychiatric hospital patient legal status:



Note: Percentage may not total 100 because of rounding.

Psychiatric inpatient bed shortages:

There have been declines in state psychiatric hospital beds in the last 5 years. The state is not experiencing a shortage of psychiatric beds.

TEXAS 2007

Department of State Health Services 909 W. 45th Street Mail Code 2018 P.O. Box 149347 Austin, TX 78714-9347 http://www.dshs.state.tx.us/mentalhealth.shtm	*The Department of State Health Service (DSHS) administers substance abuse services and public health services. Community mental health Services for adults and children are administered through 38 Local Mental Health Authorities (LMHAs).*

Statistics:

State Population (2006):	*23,507,783*
Number of Persons Served (2007):	*240,443*
Utilization Rate for Adults:	*11 per 1,000*
Utilization Rate for Children:	*7.0 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$832.2 million
Revenue From Medicaid	$186.3 million
Expenditures for Community Mental Health Services (66% of Total Mental Health Agency Revenues)	$503.6 million
Per Capita State Mental Health Expenditures	$36.47

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	No responsibility
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Part of SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	9	3	12
Community Mental Health Providers	0	38	38
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	17
Supported Employment	Statewide	38
Medication Algorithms (Schizophrenia)	Statewide	38
Medication Algorithms (Bipolar Disorders)	Statewide	38
Family Psychoeducation	Statewide	0
Integrated MH/Substance Abuse Services	Statewide	38
Self-Management	Statewide	38
Supported Housing	Statewide	38
Consumer-Operated Services	Parts of the state	10
Multisystemic Therapy (Conduct Disorder)	Parts of the state	2

Workforce development initiatives:

The SMHA has initiatives to improve the quality of the mental health workforce. DSHS has a Training and Technical Assistance Unit that develops and provides training to build the professional capacity of individuals and organizations in the field to deliver quality services more successfully and increase staff effectiveness. The Training and Technical Assistance Unit is responsible for the development of new trainings and technical assistance protocols based on assessments and input from providers, stakeholders, and staff in other units.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.
State's share of the Medicaid match is 39 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA jointly responsible with Medicaid agency
Contracting	SMHA jointly responsible with Medicaid agency
Monitoring	SMHA jointly responsible with Medicaid agency
Evaluating	SMHA jointly responsible with Medicaid agency
SMHA serves as managed care agent	SMHA jointly responsible with Medicaid agency

Mental health parity laws:
The State mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included.

The following diagnoses are included: Certain health plans regulated by the Texas Department of Insurance are required to provide coverage for the treatment of bipolar disorder, schizophrenia, schizoaffective disorder, major depressive disorder, obsessive compulsive disorder, pervasive developmental disorder, paranoia, psychosid, and childhood depression. Texas law requires that group insurance coverage for mental illness provide up to 45 days of inpatient and 60 days of outpatient treatment; see: http://www.tdi.tx.us/pbs/consumer/cb005.html.

The mandate does not include parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	Yes	Yes
Juvenile Justice	Yes	Yes

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. There were 300 children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:

The SMHA promotes the use of telemedicine. Texas has long allowed physician-to-physician consultations via telemedicine and the State Mental Health Authority has allowed Local Mental Health Authorities to utilize telemedicine as a means of delivering telemedicine services for several years.

Electronic Health Records (EHR):

The SMHA is in the process of installing an EHR in community mental health programs. The SMHA has implemented all EHR components in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:

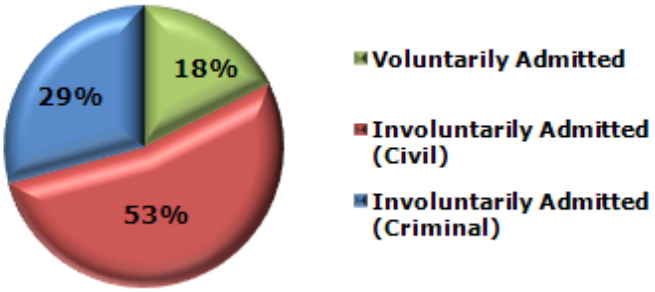
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are nine SMHA-operated state psychiatric hospitals.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 356 and adults were 1,885 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. Some initial coordination and planning activities have taken place with DVA. Discussions are focused on information sharing and coordination.

UTAH 2007

Division of Substance Abuse and Mental Health Department of Human Services 120 North 200 West Salt Lake City, UT 84103	*Utah's Division of Substance Abuse and Mental Health is authorized under Utah State statute Section 62A-15-103 to be the substance abuse and mental health authority for the state. As the mental health authority, the Division is charged with maintenance and oversight of the State Hospital and the responsibility to contract with local mental health authorities who administer public mental health care through community mental health centers. The Division is one of eight divisions and offices under the Department of Human Services, but falls under the policy direction of the governor-appointed Board of Substance Abuse and Mental Health. Under Utah State Statute Section 17-43-301 local mental health authorities are responsible for the provision of mental health services to their citizens. A local mental health authority is generally the governing body of a county. Several of Utah's rural and frontier counties have joined together to provide mental health services through a single community mental health center. Utah has 11 community mental health centers with 4 of the centers organized as private nonprofit corporations and seven organized under interlocal agreements.*

Statistics:

State Population (2006):	*2,550,063*
Number of Persons Served (2007):	*38,658*
Utilization Rate for Adults:	*14 per 1,000*
Utilization Rate for Children:	*17 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$159.9 million
Revenue From Medicaid	$106.8 million
Expenditures for Community Mental Health Services (71% of Total Mental Health Agency Revenues)	$113.1 million
Per Capita State Mental Health Expenditures	$64.34

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in a different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Located in a different state department
State Health Department	Located in a different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1		1
Community Mental Health Providers	0	13	13
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	3
Supported Employment	Statewide	7
Medication Algorithms (Schizophrenia)	Parts of the state	
Medication Algorithms (Bipolar Disorders)	Parts of the state	
Family Psychoeducation	Statewide	11
Integrated MH/Substance Abuse Services	Parts of the state	2
Self-Management	Parts of the state	11
Supported Housing	Parts of the state	8
Consumer-Operated Services	Parts of the state	3
Multisystemic Therapy (Conduct Disorder)	Parts of the state	1
Therapeutic Foster Care		1
Functional Family Therapy	Parts of the state	2

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
School-Based	Available in parts of state	6
Consumer-Run Services	Available in parts of state	
Trauma-Based Care	Available in parts of state	
Wellness Clinics	Available in parts of state	4
Person-Centered Planning	Available in parts of state	13

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce.

Managed behavioral healthcare:

Mental health services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.

State's share of the Medicaid match is 63 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has no responsibility
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA has lead responsibility
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The state mandates mental health insurance benefits.
The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Health	Yes	No
Education	Yes	Yes
Juvenile Justice	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine; assisting all rural centers to purchase and use telehealth equipment.

Electronic Health Records (EHR):
The SMHA has implemented all EHR components in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

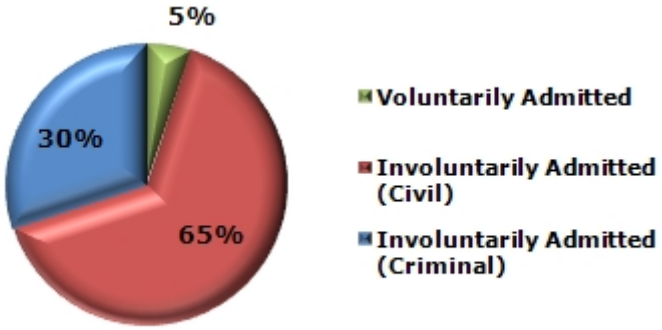
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

SMHA currently uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children		Yes	Yes
Adolescents		Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic		Yes	Yes

The average daily census in FY 2006 for youth was 64 and for adults was 253 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds in the last year.

Services for Armed Forces veterans and National Guard members:

The SMHA is working with the State National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members.

VERMONT 2007

Agency of Human Services Department of Mental Health 108 Cherry Street Burlington, VT 05402	*The restored Department of Mental Health (DMH) contracts with community providers of mental health services for adults with severe mental illness and for children and adolescents experiencing a serious emotional disturbance and their families. The public mental health system has 10 Commissioner-designated nonprofit agencies (designated agencies, or DAs) located in all major geographic areas of Vermont. Many of those agencies have more than one office to serve their respective catchment areas. DMH's central office provides leadership and direction for the community-based public mental health system as well as program and service monitoring and assessment to assure adherence to state and Federal regulations and to manage the quality of services and supports delivered by DAs. DMH also operates the Vermont State Hospital (VSH), Vermont's only public psychiatric hospital. Inpatient psychiatric services at VSH are the only services that DMH provides directly. Additionally, DMH contracts with five designated hospitals (DHs) for emergency inpatient psychiatric assessment and treatment of adults in need of acute hospitalization. DHs also provide voluntary inpatient psychiatric services and limited partial hospitalization.*

Statistics:

State Population (2006):	*623,908*
Number of Persons Served (2007):	*20,806*
Utilization Rate for Adults:	*24 per 1,000*
Utilization rate for Children:	*67 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$109 million
Revenue From Medicaid	$85.7 million
Expenditures for Community Mental Health Services (83% of Total Mental Health Agency Revenues)	$90.6 million
Per Capita State Mental Health Expenditures	$175.16

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Elderly Mental Health Services	Shared with another agency
Adult Forensic Mental Health Services	Shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
State Housing Department	Same umbrella department as the SMHA
State Health Department	Same umbrella department as the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	11	0	11
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	4	4

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	1
Supported Employment	Statewide	10
Family Psychoeducation	Parts of the state	2
Integrated MH/Substance Abuse Services	Statewide	10
Self-Management	Parts of the state	1
Supported Housing	Statewide	10
Consumer-Operated Services	Parts of the state	
Therapeutic Foster Care	Statewide	1

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation
Recovery Education	Available statewide
Dialectical Behavioral Therapy	Available in parts of state

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce; agency of Human Services Quality Council; unifying across departments and divisions.

Managed behavioral healthcare:

Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. State's share of the Medicaid match is 39 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA jointly responsible with Medicaid agency
Contracting	SMHA jointly responsible with Medicaid agency
Monitoring	SMHA jointly responsible with Medicaid agency
Evaluating	SMHA jointly responsible with Medicaid agency
SMHA serves as managed care agent	SMHA jointly responsible with Medicaid agency

Mental health parity laws:

There is no mandate, but Vermont did pass the country's first parity law in 1997. The mandate includes parity with physical health service benefits. The SMHA does not mandate mental health insurance benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	
Health	No	Yes
Housing	Yes	
Education		Yes
Juvenile Justice		Yes
Child Welfare	Yes	Yes

Note: Blank space indicates the state did not report data for this category.

Custody relinquishment:
There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals. The SMHA has some EHR components implemented in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 1 and for adults was 50 receiving state psychiatric inpatient care.

Psychiatric inpatient bed shortages:
There have been declines in general hospital specialty unit psychiatric beds in the last year. The state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; information exchange between designated agencies and Veterans Affairs.

VIRGINIA 2007

Department of Mental Health, Mental Retardation and Substance Abuse Services 1220 Bank Street Richmond, VA 23218 http://www.dmhmrsas.virginia.gov	*Virginia's public mental health, mental retardation and substance abuse services system is comprised of forty community services boards (CSBs) and sixteen state facilitates. The CSBs and state facilities serve children and adults who have or who are at risk of mental illness, serious emotional disturbance, mental retardation, or substance use disorders.*

Statistics:

State Population (2006):	*7,642,884*
Number of Persons Served (SFY2006):	*121,696*
Utilization Rate for Adults:	*16 per 1,000*
Utilization Rate for Children:	*15 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$531.5 million
Revenue From Medicaid	$155.6 million
Expenditures for Community Mental Health Services (42% of Total Mental Health Agency Revenues)	$223.9 million
Per Capita State Mental Health Expenditures	$72.62

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Shared with another agency

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Different state department
Substance Abuse Agency	Part of SMHA
State Housing Department	Different state department
State Health Department	Different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	11	0	11
Community Mental Health Providers	0	40	40
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities *statewide.*

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	18
Supported Employment	Parts of the state	1
Integrated Mh/Substance Abuse Services	Parts of the state	548
Supported Housing	Parts of the state	1
Consumer-Operated Services	Parts of the state	
Multisystemic Therapy (Conduct Disorder)	Parts of the state	4
Therapeutic Foster Care	Parts of the state	1
Functional Family Therapy	Parts of the state	1

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation
Peer-Provided and Consumer-Run Services	Available in parts of state

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce. Currently, direct support staff and others are being provided the College of Direct Support Curriculum, which is a web-based training program targeted at best practices in the field of disabilities. Competency checkoffs are required to ensure learners are competent in skills, thus enhancing services to customers and the competences of the workforce. A direct support career pathway has been developed in partnership with the College of Direct Support, John Tyler Community College, and the Virginia Community College System providing for continuing education and career studies certificates in mental health, developmental disabilities and human services. Workforce and Cultural Competency Conference held October 2007.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.

State's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has no responsibility
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA has no responsibility
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included. There has been no change from previous reportregarding diagnoses included. The mandate includes parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	No
Corrections	No	Yes
Education	Yes	No
Juvenile Justice	No	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: Virginia law does not require parent to relinquish custody in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine; installation of video teleconferencing at all state-run and local community providers.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs. The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:

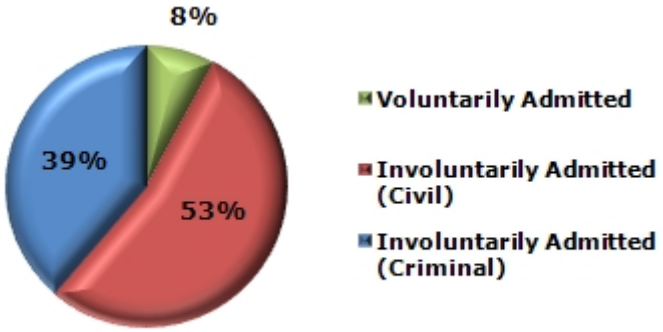
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospital.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 63 and for adults was 1,464 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric, state psychiatric hospital, and private psychiatric hospital beds in the last 5 years.

Services for Armed Forces veterans and National Guard members:

The SMHA is working with the State National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; collaboration and planning underway.

WASHINGTON 2007

P.O. Box 45320 Olympia, WA 98501 http://www1.dshs.wa.gov/Mentalhealth	*Adults: The Mental Health Division (MHD) is a division within the Health and Recovery Services Administration (HRSA) within the Department of Social and Health Services (DSHS). MHD operates an integrated system of care for people with mental illness who are enrolled in Medicaid as well as for those individuals who qualify as "low income"who also meet the statutory need requirements.*

Statistics:

State Population (2006):	*6,395,798*
Number of Persons Served (2007):	*123,614*
Utilization Rate for Adults:	*19 per 1,000*
Utilization Rate for Children:	*22 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$585.5 million
Revenue From Medicaid	$505.1 million
Expenditures for Community Mental Health Services (67% of Total Mental Health Agency Revenues)	$395.4 million
Per Capita State Mental Health Expenditures	$93.96

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Responsibility for services shared with another agency
Elderly Mental Health Services	Responsibility for services shared with another agency
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	Responsibility for services shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	Responsibility for services shared with another agency
Sex Offender Services	No responsibility
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in the same umbrella department as the SMHA
Substance Abuse Agency	Located in the same umbrella department as the SMHA
State Housing Department	Located in a different state department
State Health Department	Located in a different state department

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State psychiatric hospitals	3	0	3
Community Mental Health Providers	0	126	126
Private Psychiatric Hospitals	NA	3	3
General Hospitals With Separate Psychiatric Units	0	22	22

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of programs
Assertive Community Treatment (ACT)	Parts of the state	9
Supported Employment	Parts of the state	7
Medication Algorithms (Schizophrenia)	Parts of the state	1
Medication Algorithms (Bipolar Disorders)	Parts of the state	1
Family Psychoeducation	Parts of the state	3
Integrated MH/Substance Abuse Services	Parts of the state	2
Supported Housing		10
Consumer-Operated Services	Parts of the state	10
Multisystemic Therapy (Conduct Disorder)	Pilot program	3
Therapeutic Foster Care	Parts of the state	4
Functional Family Therapy	Parts of the state	10

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce; training through Washington Institute for Mental Illness Research and Training.

Managed behavioral healthcare:

Mental health services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. State's share of the Medicaid match is 50 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA has lead responsibility
Writing waiver	SMHA has lead responsibility
Contracting	SMHA has lead responsibility
Monitoring	SMHA has lead responsibility
SMHA serves as managed care agent	SMHA has lead responsibility

Mental health parity laws:

The State mandates mental health insurance benefits. The mandate does not include parity with physical health service benefits. State expanded mental health parity laws in 2007 requiring insurance policies issued for all individuals, groups, and the Washington State Health Insurance Pool to include coverage for mental health services equal to coverage for medical and surgical services.

Interagency collaboration:

The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	No	Yes
Child Welfare	No	Yes

Custody relinquishment:

DSHS coordinates among all involved state agencies, including the Children's Administration, state Medicaid program, and HRSA/MHD/SMHA to assure custodial relinquishment is avoided to the maximum extent possible. For example, Washington State has assured through statute that youth 13 and above who desire mental health services may obtain such services, whether outpatient or inpatient, on their own authority.

Telemedicine:

The SMHA promotes the use of telemedicine. Telemedicine is supported through the payment of Medicaid rates for identified services available through the state Medicaid plan.

State psychiatric hospitals:

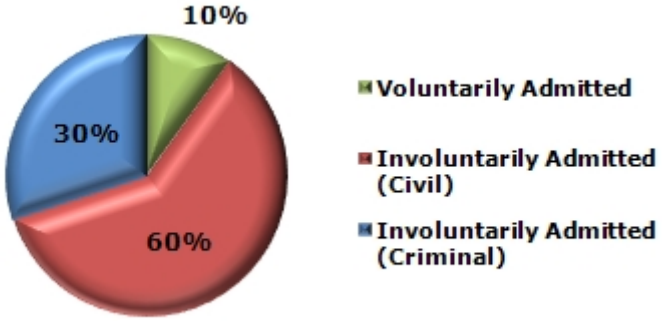
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are three SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 83 and for adults was 1,284 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:

The state is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds in the last year.

Services for Armed Forces veterans and National Guard members:

The SMHA, WADVA, DASA, Governor's Policy Office, National Guard, Employment Security, and Mothers of Military Support jointly applied for and were selected to participate in the 2008 Returning Veterans and Their Families Strategic Planning Conference and Policy Academy. Objectives of the Federal grant program include assisting states to develop interventions addressing mental health, substance abuse, and co-occurring issues specific to returning veterans and their families; strengthening behavioral health systems through collaboration; fostering veteran-to-veteran peer support networks; and suicide prevention.
The SMHA is collaborating with WADVA combat PTSD experts to identify and implement strategies to enhance mental health practitioner war trauma treatment competencies to assure that provision of services meets the mental health needs of veterans and National Guard members.

WEST VIRGINIA 2007

Bureau for Behavioral Health and Health Facilities Department of Health and Human Resources 350 Capitol Street Room 350 Charleston, WV 25301	*The West Virginia Bureau for Behavioral Health and Health Facilities (BHHF) serves as the state authority for the behavioral health system and provides funding for community-based behavioral health services for persons with behavioral health needs, including those who do not have the benefit or the means to purchase services. Within BHHF are two separate, but interrelated offices the Office of Behavioral Health Services (OBHS) and the Office of Health Facilities (OHF). The OHF provides oversight and coordination of planning, development, funding, and monitoring of state psychiatric and long-term care facilities.*

Statistics:

State Population (2006):	*1,818,470*
Number of Persons Served (2007):	*58,918*
Utilization Rate for Adults:	*29 per 1,000*
Utilization Rate for Children:	*45 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY 2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$119.4 million
Revenue From Medicaid	$44.1 million
Expenditures for Community Mental Health Services (59% of Total Mental Health Agency Revenues)	$70.7 million
Per Capita State Mental Health Expenditures	$65.84

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	Responsibility for services is shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Responsibility for services is shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Responsibility for services is shared with another agency
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in the same umbrella department as the SMHA
Substance Abuse Agency	Part of SMHA
State Housing Department	Located in a different state department
State Health Department	Located in the same umbrella department as the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	13	13
Nursing Homes and Other ICF-MI and SNF Providers	4	0	4

Primary mechanism in delivering mental health services:

SMHA directly funds but does not operate local community-based agencies.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	3
Supported Employment	Parts of the state	7
Family Psychoeducation		1
Integrated MH/Substance Abuse Services	Parts of the state	4
Self-Management	Parts of the state	2
Supported Housing	Parts of the state	2
Consumer-Operated Services	Parts of the state	10
Therapeutic Foster Care	Parts of the state	

Note: Blank space indicates the state did not report data for this category.

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Suicide Prevention	Available in parts of state	2
Leadership Academy	Available in parts of state	1
Recovery Education	Available in parts of state	1
Suicide Prevention	Available in parts of state	1

Workforce development initiatives:
The SMHA has initiatives to improve the quality of the the mental health workforce; uses block grant funds to support consumer networks to train peer support specialists to achieve certification while earning college credits. The outcome will allow access to jobs with mental health agencies.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 27 percent.

Mental health parity laws:
The state mandates mental health insurance benefits. Only benefits for specific mental health diagnoses are included. The following diagnoses are included: Adults—schizophrenia, bipolar, depression, anxiety, anorexia and bulimia and addiction. Children—ADHD, separation anxiety, and conduct disorders. The mandate includes parity with physical health service benefits.

Custody relinquishment:
The state does not have laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. The state did not indicate how many children had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine. SMHA is working with Medicaid to expand access to telemedicine via expanded reimbursement for services in rural areas of West Virginia.

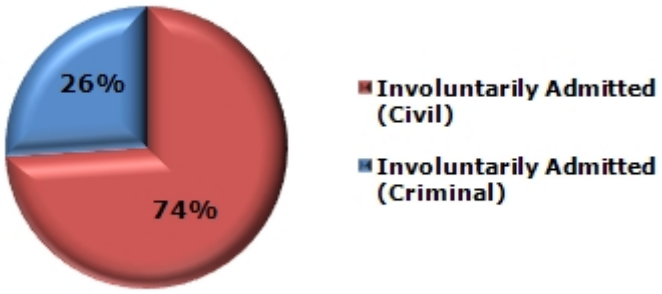
Electronic Health Records (EHR):
The SMHA is in the process of installing an EHR in state hospitals. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are two SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds in the last 5 years.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members. The SMHA is working with the Council of Churches in an ongoing manner, which will include a summit to be held for returning veterans and their families.

WISCONSIN 2007

Division of Mental Health and Substance Abuse Services Department of Health Services 1 West Wilson Street, Room 455 Madison, WI 53707	*Wisconsin employs a strong county-based human service system. The public mental health system is administered through 72 county program boards. Direct services are primarily provided by the county or local private providers contracted by the county. The Division of Mental Health and Substance Abuse Services (DMHSAS) is the state mental health agency that works directly with county mental health agencies.*

Statistics:

State Population (2006):	*5,556,506*
Number of Persons Served (2007):	*84,890*
Utilization Rate for Adults:	*17 per 1,000*
Utilization Rate for Children:	*9 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$579.7 million
Revenue From Medicaid	$135.5 million
Expenditures for Community Mental Health Services (72% of Total Mental Health Agency Revenues)	$417.6 million
Per Capita State Mental Health Expenditures	$104.9

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Part of the SMHA
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Part of the SMHA
State Mental Hospitals	Part of the SMHA
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in the same umbrella department as the SMHA
Substance Abuse Agency	Part of SMHA
State Housing Department	Located in a different state department
State Health Department	Located in the same umbrella department as the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	1	3
Community Mental Health Providers	0	67	67
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable

Primary mechanism in delivering mental health services:

SMHA funds county or city mental health authorities statewide.

Evidence-based services:

Evidence-Based Practice	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	79
Supported Employment	Parts of the state	47
Family Psychoeducation	Parts of the state	31
Integrated MH/Substance Abuse Services	Parts of the state	56
Self-Management	Parts of the state	43
Supported Housing	Statewide	48
Consumer-Operated Services	Statewide	10

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Wraparound Systems of Care	Available in parts of state	36
Psychosocial Rehab Services (Child/Adolescent)	Available in parts of state	9
Psychosocial Rehab Services (Adults)	Available in parts of state	20
Consumer-Run Services	Available in parts of state	12

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce. Annual statewide training conference, monthly training teleconferences with experts; establishment of a Center for Best Practices Development with the University of Wisconsin and The Wisconsin Medical College.

Managed behavioral healthcare:
Mental health and substance abuse services are being delivered via managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.

State's share of the Medicaid match is 41 percent.

The SMHA's role in monitoring and managing the mental health/behavioral health benefits:

Task	Responsibility
Designing the mental health benefit system	SMHA jointly responsible with Medicaid agency
Writing waiver	SMHA has no responsibility
Contracting	SMHA has no responsibility
Monitoring	SMHA has no responsibility
Evaluating	SMHA has no responsibility
SMHA serves as managed care agent	SMHA has no responsibility

Mental health parity laws:
The state mandates minimum mental health insurance benefits. These benefits include a range of mental health and substance abuse service. The mandate does not include parity with physical health service benefits.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes
Corrections	Yes	Yes
Health	Yes	Yes
Housing	Yes	Yes
Education	No	Yes
Juvenile Justice	No	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state does not have specific laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine. Telehealth is a Medicaid benefit that the SMHA promotes to local providers.

Electronic Health Records (EHR):
The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs.

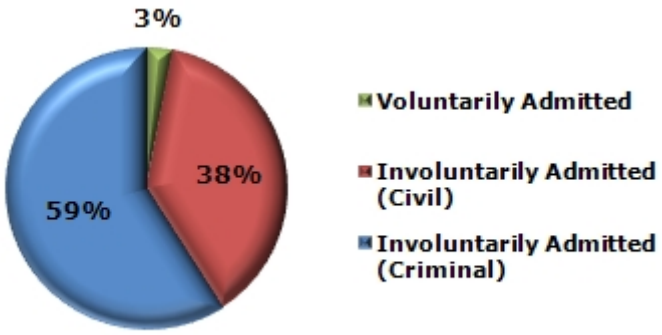
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and/or delivery of community-based mental health services. There are two SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for youth was 82 and for adults was 411 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric, state psychiatric hospital and private psychiatric hospital beds in the last year.

Services for Armed Forces veterans and National Guard members:
The SMHA works with the Federal Department of Veterans Affairs on training counties and providers to assure the provision of services to meet the mental health needs of veterans and National Guard members.

WYOMING 2007

Mental Health and Substance Abuse Services Division Wyoming Department of Health 6101 N. Yellowstone Road Suite 220 Cheyenne, WY 82002	*The Wyoming public mental health system is of the Mental Health Division (MHD), 15 community mental health centers (CMHCs), and the Wyoming State Hospital (WSH). The Mental Health Division, as the state mental health authority, oversees the operations of community mental health centers and acts as the conduit for state and Federal funding for community mental health services.*

Statistics:

State Population (2006):	*515,004*
Number of Persons Served (2007):	*18,081*
Utilization Rate of Adults:	*32 per 1,000*
Utilization Rate for Children:	*45 per 1,000*

Revenues and expenditures:

Revenues and Expenditures (FY2005)	Dollars
Total Mental Health Agency-Controlled Revenue	$49.9 million
Revenue From Medicaid	$7.7 million
Expenditures for Community Mental Health Services (68% of Total Mental Health Agency Revenues)	$34.2 million
Per Capita State Mental Health Expenditures	$98.79

Responsibilities of the SMHA in administering specific mental health services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Elderly Mental Health Services	Part of the SMHA
Adult Forensic Mental Health Services	Responsibility of services shared with another agency
Brain Impaired Services (including Traumatic Brain Injuries)	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Responsibility of services shared with another agency
Services to Persons With Mental Illness in Prison/Jail	Responsibility of services shared with another agency
Sex Offender Services	No responsibility
State Mental Hospitals	Responsibility of services shared with another agency
Community Mental Health Program	Part of the SMHA

Location of other state agencies in relation to the SMHA:

Agency	Location
State Medicaid Agency	Located in the same umbrella department as the SMHA
Substance Abuse Agency	Located in the same umbrella department as the SMHA
State Housing Department	Located in a different state department
State Health Department	Located in the same umbrella department as the SMHA

The number of mental health providers the SMHA operates or funds:

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	15	15

Primary mechanism in delivering mental health services:

SMHA directly funds, but does not operate local community-based agencies

Evidence-based services:

Evidence-Based Practice	Implementation
Assertive Community Treatment (ACT)	Parts of the state
Supported Employment	Parts of the state
Medication Algorithms (Schizophrenia)	Parts of the state
Family Psychoeducation	Parts of the state
Integrated Mh/Substance Abuse Services	Statewide
Self-Management	Statewide
Supported Housing	Parts of the state
Consumer-Operated Services	Parts of the state
Multisystemic Therapy (Conduct Disorder)	Pilot program
Therapeutic Foster Care	Parts of the state

Emerging evidence-based and innovative practices:

Evidence-Based Practice	Implementation	Number of Programs
Wraparound Services	Available in parts of state	15
Psychosocial Rehab	Available in parts of state	7
Consumer-Run Services		9
Gatekeeping	Available in parts of state	1

Note: Blank space indicates the state did not report data for this category.

Workforce development initiatives:

The SMHA has initiatives to improve the quality of mental health workforce; periodic training events.

Managed behavioral healthcare:
Neither mental health nor substance abuse services are being delivered via managed care. State's share of the Medicaid match is 49 percent.

Interagency collaboration:
The SMHA has the following initiatives with other state government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams:

Agency	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Education	Yes	Yes
Child Welfare	Yes	Yes

Custody relinquishment:
The state has laws or policies designed to avoid parents having to relinquish custody of children (to the SMHA, Child Welfare, or Juvenile Justice Systems) in order for them to obtain mental health services. Description of the policies/laws: The Medicaid Children's Mental Health Waiver and the SAMHSA Children and Families System of Care are in place. The waiver project predicts that there will be 175 families who will benefit from the waiver over 3 years. There were no children who had their parents' custody relinquished in 2007 in order to receive mental health services.

Telemedicine:
The SMHA promotes the use of telemedicine; funding telemedicine projects.

Electronic Health Records (EHR):
The SMHA has some EHR components implemented in state hospitals and community mental health programs. The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

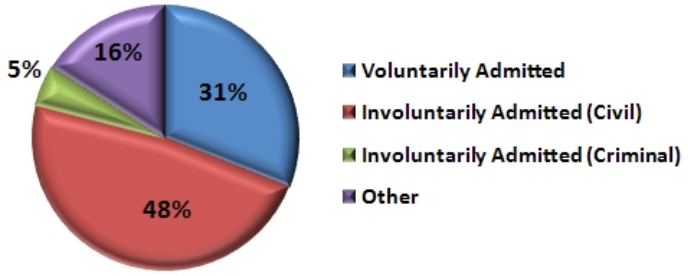
State psychiatric hospitals:
The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding and/or delivery of community-based mental health services. There is one SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (fewer than 30 days)	Intermediate Inpatient (30–90 days)	Long-Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

The average daily census in FY 2006 for adults was 69 receiving state psychiatric inpatient care.

State psychiatric hospital patient legal status:



Psychiatric inpatient bed shortages:
The state is experiencing a shortage of psychiatric beds. There have been declines in state psychiatric hospital beds in the last 5 years due to new physical plant construction projects.

Services for Armed Forces veterans and National Guard members:
The SMHA is working with the state National Guard and the Federal Department of Veterans Affairs to assure the provision of services to meet the mental health needs of veterans and National Guard members; developing screening instruments.

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