Funding and Characteristics of State Mental Health Agencies, 2009

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Center for Mental Health Services

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Contents

Acknowledgments iii
Executive Summary xi
I. Introduction 1
1.1 Background 1
1.2 Methods 2
1.2.1 SMHA Profiling System 2
1.2.2 SMHA-Controlled Revenue and Expenditure Study 2
1.2.3 The Uniform Reporting System 3
1.2.4 Limitations 3
1.3 Overview of the Rest of the Report 4
II. Organization and Structure of SMHAs 5
2.1 SMHA Location in State Government 5
2.2 Other Responsibilities of SMHAs 7
2.2.1 Substance Abuse 7
2.2.2 Intellectual Disability 7
2.2.3 Medicaid 7
2.2.4 Housing 7
2.2.5 Health 7
2.3 SMHA Mental Health Responsibilities 7
2.3.1 Forensic Mental Health Services 10
2.3.2 Mental Health Services for Children and Adolescents 10
2.3.3 Brain Impaired (Including Traumatic Brain Injury) and Organic Brain Syndrome (Including Alzheimer's Disease) Services 10
2.3.4 Operation of State Psychiatric Hospitals 10
2.3.5 Housing Services 11
2.4 Reorganization of SMHAs 11
2.5 Number of Mental Health Organizations Operated and/or Funded by SMHAs 11
2.6 SMHA Management Information Systems and Research Functions 12
2.6.1 Organization of MIS 12
2.6.2 MIS Staffing and Budgets 13
2.6.3 Types of Mental Health Information Collected by SMHAs 13
2.6.3.1 Client-Level Data 13
2.6.3.2 Claims/Encounter Data 13
2.6.3.3 Medications Information 14
2.6.3.4 Client Outcomes 14
2.7 Electronic Health Records 15
2.7.1 Implementation of EHR Components 15
2.7.2 Sharing EHR Information 16
2.7.3 Electronic Personal Health Records 16
2.7.4 Telemedicine 16
2.8 Linking SMHA Data With Data of Other State Agencies 16

2.9 Characteristics of Mental Health Consumers Served by SMHA Systems (2008) 17
2.9.1 Consumers Served, by Age and Gender 18
2.9.1.1 Children (0 to 12) and Adolescents (13 to 17) 18
2.9.1.2 Young Adults (18 to 20) and Adults (21 to 64) 19
2.9.1.3 Older Adults (65 and Above) 19
2.9.2 Consumers Served, by Race/Ethnicity and Gender 20
2.9.2.1 Children (0 to 12) and Adolescents (13 to 17) 20
2.9.2.2 Young Adults (18 to 20) and Adults (21 to 64) 20
2.9.2.3 Older Adults (65 and Above) 22
2.9.3 Adults With Serious Mental Illnesses and Children With Serious Emotional Disturbances Served 22
2.10 SMHA Financing of Mental Health Services 23
2.10.1 Major Funding Sources, FY 2007 26
2.10.2 Trends in Financing of Mental Health Services Over Time 30
2.10.3 Medicaid 32
2.10.4 SMHA Mental Health Expenditures Over Time 32
2.10.5 Trends in Community Mental Health and State Hospital Expenditures Over Time 35
2.10.6 Shift From State Psychiatric Hospital-Based Services to Community Mental Health Services 36
2.11 Summary 37
III. SMHA Policies 39
3.1 Eligibility for Mental Health Services 39
3.2 Collaboration With Other State Agencies 39
3.3 Consumer- and Family-Driven Care 40
3.4 Elimination of Disparities in Mental Health Services 41
3.4.1 Cultural Competency 41
3.4.2 Dual Diagnosis 41
3.4.3 Rural Mental Health Initiatives 41
3.5 Mental Health Screening, Assessment, and Service Referral 42
3.5.1 Trauma 42
3.5.2 Older Adults 42
3.5.3 Dual Diagnosis 43
3.6 Outpatient Commitment Statutes 43
3.7 Awareness of Mental Health Issues 43
3.8 Suicide Prevention 43
3.9 Services for Armed Forces Veterans and National Guard Members 43
3.10 Use of Medicaid Options To Fund Mental Health Services 44
3.11 Evidence-Based Practices 44
3.11.1 Assertive Community Treatment 44
3.11.2 Supported Employment 45
3.11.3 Medication Algorithms 46
3.11.3.1 Schizophrenia 46
3.11.3.2 Bipolar Disorder 46
3.11.4 Family Psychoeducation 46
3.11.5 Integrated Dual Diagnosis Treatment (Mental Illness and Substance Abuse) 47
3.11.6 Illness Self-Management 47
3.11.7 Supported Housing 47
3.11.8 Consumer-Operated Services 48
3.11.9 Multisystemic Therapy 48
3.11.10 Functional Family Therapy 48
3.11.11 School-Based Interventions 49
3.11.12 Older Adult EBPs 49

3.11.13 Training for EBPs 49
3.11.14 Barriers to Implementing EBPs 49
3.11.15 SMHA Initiatives To Promote the Adoption of EBPs 50
3.11.16 Emerging EBPs 50
3.12 Summary 50
IV. Community Mental Health Services 51
4.1 SMHA Relationships to Community Mental Health Providers 51
4.1.1 Controlling Entry to State Psychiatric Hospitals 51
4.2 Initiatives To Restructure Community-Based Mental Health Service Delivery 52
4.3 Community Mental Health Services Provided 52
4.4 Consumer-Operated Services 52
4.4.1 Types of Consumer-Operated Services Funded by SMHAs 53
4.5 Clinical Practice Guidelines 53
4.6 SMHAs' Relationship to Criminal and Juvenile Justice 53
4.6.1 Provision of Mental Health Services to Persons in Prison or Jails 53
4.7 Characteristics of Persons Served in Community Settings 54
4.7.1 Consumers Served, by Age Groups 54
4.7.2 Utilization Rates of Consumers Served in Community Settings, by Age and Gender 54
4.7.3 Employment Status of Consumers Served 55
4.7.4 Living Situation of Mental Health Consumers Served 56
4.8 Financing of Community Mental Health Services 56
4.8.1 Overall Expenditures for Community Mental Health Services, FY 2007 56
4.8.2 Trends in Community Mental Health Expenditures 59
4.8.3 Overall Revenues of Community Mental Health Services, FY 2007 60
4.8.4 Trends in Financing of Community Mental Health Services 60
4.8.5 Initiatives To Transform Financing of Mental Health Services 63
4.9 Summary 63
V. Psychiatric Hospitalization and Forensic Services 65
5.1 Characteristics of Persons Served in State Hospitals 66
5.2 Role of State Psychiatric Hospitals 66
5.3 The Closing and Reorganization of State Psychiatric Hospitals 69
5.4 Shortages of Inpatient Psychiatric Beds 69
5.5 Forensic Mental Health Services 71
5.5.1 State Psychiatric Hospital Expenditures per Patient Day 74
5.5.2 Organization of State Forensic Mental Health Services 74
5.5.3 Not Guilty by Reason of Insanity and Guilty but Mentally Ill Statutes 75
5.5.4 Sex Offenders 75
5.6 Financing of SMHA Operated and Funded Psychiatric Hospitals 76
5.6.1 Overall Expenditures for State Hospitals, FY 2007 76
5.6.2 Trends in State Psychiatric Hospital Expenditures 79
5.6.3 Overall Revenues of State Psychiatric Hospitals, FY 2007 79
5.6.4 Trends in Financing of State Psychiatric Hospitals 83
5.7 Summary 83
VI. Summary 85
Glossary 87
References 93
Appendix

List of Tables

Table 1: Organization of SMHAs Within State Government 5
Table 2: SMHA Relationship to Other State Agencies 8
Table 3: SMHA Mental Health-Related Responsibilities 9
Table 4: Number of Mental Health Organizations Operated and/or Funded by SMHAs 12
Table 5: Organizational Locations of Information Management Functions 12
Table 6: Number of SMHAs Monitoring Client Outcome Measures 14
Table 7: EHR Functions Implemented in State Psychiatric Hospitals and Community Mental Health Providers 15
Table 8: Number of SMHAs Linking SMHA Data Systems With Other State Agencies 18
Table 9: Utilization Rate of SMHA Mental Health Services, by Age, Gender, and Race/Ethnicity, 2008 19
Table 10: SMHA Mental Health Actual Dollar and per Capita Expenditures for Mental Health Services, FY 2007 24
Table 11: SMHA-Controlled Mental Health Revenues, by Funding Sources and State, FY 2007 (in millions) 28
Table 12: Total SMHA-Controlled Expenditures, in Current and Constant Inflation-Adjusted Dollars, FY 2001 to FY 2007 (in millions) 33
Table 13: SMHA Collaboration With Other Agencies 39
Table 14: Number of SMHAs Implementing or Planning To Implement EBPs 45
Table 15: Types of SMHA-Funded Consumer-Operated Services 53
Table 16: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Age, FY 2007 (in millions) 57
Table 17: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Service Type (in millions) 58
Table 18: SMHA-Controlled Community Mental Health Revenues, by Funding Sources and State, FY 2007 (in millions) 61
Table 19: State Operated and Funded Psychiatric Hospitals 67
Table 20: Number of SMHAs Using State Psychiatric Hospitals, by Age and Service, 2009 (55 SMHAs reporting) 69
Table 21: SMHA-Controlled Mental Health Expenditures for Forensic and Sex Offender Services in State Psychiatric Hospitals, FY 2007 (in millions) 72
Table 22: Responsibilities for Sex Offender Services 75
Table 23: SMHA-Controlled Mental Health Expenditures for State Psychiatric Hospitals, by Age, FY 2007 (in millions) 76
Table 24: SMHA-Controlled State Psychiatric Hospital Expenditures, by Service Type, FY 2007 (in millions) 77
Table 25: SMHA-Controlled State Psychiatric Hospital Revenues, by Funding Sources and State, FY 2007 (in millions) 81

List of Figures

Figure 1: Percent Distribution of Consumers Served, by Age 18
Figure 2: Utilization Rates of Persons Served, by Age and Gender (rate per 1,000) 20
Figure 3: Percentage of Consumers Served, by Race/Ethnicity 21
Figure 4: Utilization Rates of Children and Adolescents, by Race/Ethnicity and Gender (rate per 1,000) 21
Figure 5: Utilization Rates of Young Adults and Adults, by Race Ethnicity and Age (rate per 1,000) 22
Figure 6: Utilization Rates of Older Adults, by Race/Ethnicity and Gender (rate per 1,000) 23
Figure 7: Total SMHA-Controlled per Capita Expenditures for Mental Health, FY 2007 24
Figure 8: SMHA-Controlled per Capita Expenditures for Mental Health, by SMHA Responsibility for Setting Medicaid Rates, FY 2007 25
Figure 9: SMHA-Controlled per Capita Expenditures for Mental Health, by Primary Method Used To Fund Community Services, FY 2007 27
Figure 10: Percentage of SMHA-Controlled Revenues for Mental Health Services, by Funding Sources, FY 2007 27
Figure 11: Percentage of SMHA-Controlled Revenues From Major Funding Sources, FY 1981 to FY 2007 30
Figure 12: SMHA-Controlled Revenues for Mental Health Services, FY 1981 to FY 2007 31
Figure 13: Percentage of New SMHA-Controlled Revenues, by Major Funding Sources, FY 1981 to FY 2007 31
Figure 14: SMHA-Controlled Medicaid Funds as a Percentage of Total State Medicaid Spending, FY 1981 to FY 2007 32
Figure 15: Trends in SMHA-Controlled Mental Health Spending, FY 1981 to FY 2007 33
Figure 16: Average Annual Percent Change in SMHA-Controlled Mental Health Expenditures, by Decade and Type of Program, FY 1981 to FY 2007 35
Figure 17: SMHA Expenditures for State Psychiatric Hospital Inpatient and Community-Based Mental Health Services, FY 1981 to FY 2007 36
Figure 18: Extent to Which City/County Authorities Administer Community Mental Health Services 51
Figure 19: Percent Distribution of Consumers Served in Community Settings, by Age Groups 54
Figure 20: Utilization Rates (per 1,000 Population) of Persons Served in Community Settings, by Age and Gender 55
Figure 21: Employment Status of Adult Consumers, by Diagnosis 55
Figure 22: Living Situation of Consumers Served 56
Figure 23: Trends in SMHA-Controlled Spending for Community Mental Health Services, FY 1981 to FY 2007 59
Figure 24: Average Annual Change in SMHA-Controlled Community Mental Health Expenditures, by Decade, FY 1981 to FY 2007 60
Figure 25: Percentage of SMHA-Controlled Revenues for Community Mental Health Services, by Funding Sources, FY 2007 61
Figure 26: Percentage of SMHA-Controlled Revenues for Community Mental Health Services From Major Funding Sources, FY 1981 to FY 2007 62
Figure 27: State Psychiatric Hospital Residents per 100,000 Population 65
Figure 28: Breakdown of Consumers Served in All State Psychiatric Hospitals, by Age and Gender 66
Figure 29: Number of States Experiencing Shortages of Psychiatric Beds Over the Last 1 and 5 Years 70
Figure 30: Average and Median State Psychiatric Hospital Expenditures per Patient Day, by Type of Patient, FY 2007 74
Figure 31: Trends in SMHA-Controlled Spending for State Psychiatric Hospitals, FY 1981 to FY 2007 79
Figure 32: Average Annual Change in SMHA-Controlled State Psychiatric Hospital Expenditures, by Decade, FY 1981 to FY 2007 80
Figure 33: SMHA-Controlled Revenues for State Psychiatric Hospitals, by Funding Sources, FY 2007 80
Figure 34: Percentage of SMHA-Controlled State Psychiatric Hospital Mental Health Revenues, by Major Sources, FY 1981 to FY 2007 83

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 over $30 billion to provide mental health services to more than 6 million consumers. SMHAs vary widely in how they are organized within their state government, the specific disability services they are responsible for, methods used to organize and deliver services, and their eligibility and funding requirements. This report provides a review of the various ways SMHAs are organized and structured, their major policy initiatives, the mental health services they provide and/or fund, and how they finance these services.

Organization and Structure of SMHAs

SMHAs, regardless of their organizational location within state government, administer the federal Mental Health Block Grant (MHBG), prepare and implement the state's mental health plan, and fund or directly operate community mental health services. The majority of SMHAs operate as a division under an umbrella agency, often within a Department of Human Services. Fewer SMHAs are cabinet-level departments in which the SMHA commissioner reports directly to the Governor's office or to a mental health oversight board.

In addition to the provision of traditional mental health services, over half of the SMHAs are also responsible for the provision of other disability services. These include substance abuse services, intellectual disability services, and brain impaired and organic brain syndrome services. Most SMHAs are further responsible for the operation of state psychiatric inpatient beds.

All SMHAs serve adults with mental illnesses; however, 12 SMHAs share the responsibility for children's mental health services with a separate state agency. In four states, the SMHA has no responsibility for the provision of children's mental health services. In these states, a separate children's department is responsible for the provision of children's services including child welfare, juvenile justice, and other social services for children and adolescents.

SMHA Policies

Each state determines the eligibility criteria a person must meet to receive services funded and/or operated by a SMHA. In most states, the SMHA provides services to all children and adults with no eligibility requirements, whereas some SMHAs have strict eligibility requirements in which only adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED) are served.

Most SMHAs have several initiatives underway to better meet the needs of the mental health consumers they serve. These include collaborating with other state agencies to reduce fragmentation of services; working on the identification and elimination of disparities in mental health services; cross-training staff for co-occurring mental health and substance abuse services; increasing access to mental health services in rural and geographically remote areas within the state; and addressing the mental health needs of Armed Forces, veterans, and National Guard members.

Community Mental Health Services

As part of the federal Community Mental Health Block Grant requirements, every SMHA develops and implements a plan for a comprehensive mental health service system. SMHAs vary in how they organize and finance the delivery of community-based mental

health services. Although most SMHAs fund private not-for-profit community providers, some fund city or county governments for the provision of these services. Other SMHAs directly provide services using state employees working in mental health centers operated by the SMHA.

In 2008, 94 percent (5.6 million) of SMHAs' consumers received community mental health services. Consumers from the ages of 21 to 64 made up the majority (64 percent) of consumers served; however, consumers aged 18 to 20 had the highest average utilization rate. Persons served by the SMHAs tended to be unemployed, and the majority of adults lived in private residences.

SMHAs devote a significant portion of their SMHA-controlled revenues to community mental health services. In fiscal year (FY) 2007, SMHAs expended 70 percent of their funds on community-based services.

Psychiatric Hospitalization and Forensic Services

Every state government operates psychiatric inpatient beds that provide services to consumers with high levels of need, including those who are a threat to themselves and/or others. State psychiatric hospitals provide acute care services, long-term treatment, and often forensic services to mental health consumers.

Forensic services provide evaluation and treatment to persons who have a mental illness and come into contact with the criminal justice system. In most states, the SMHA is responsible for the provision of forensic mental health services to persons sent to state psychiatric hospitals by the courts because of their involvement in the criminal justice system.

In 2008, 3 percent of SMHA consumers were served in state psychiatric hospitals. Most consumers served in these hospitals (77 percent) were from the ages of 21 to 64. State psychiatric hospital patients have an average length of stay of 125 days.

Caution

From 2005 to 2007, the majority of SMHAs experienced budgetary expansion and an increase in the number of persons served. However, during 2008, the U.S. economy began a drastic slowdown resulting in the deterioration of state government finances. As a result, almost all state governments are experiencing major declines in state revenue, forcing 48 states to reduce expenditures for FY 2009 and FY 2010. Readers are cautioned that growth in state mental health services may not continue beyond the period covered in this report. During the summer of 2009, the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. (NRI), surveyed SMHAs about the impact of the recession on mental health services. Of the 45 SMHAs responding, 89 percent have experienced a reduction to their fiscal 2010 budgets. While the budget reductions in some SMHAs are relatively small, nine face budget cuts greater than 10 percent to their mental health programs in 2010. Five SMHAs expect budget reductions of 5 to 10 percent, and an additional 13 SMHAs anticipate budget cuts, but whose budgets had not been finalized to the point they could report specific budget reductions.

Funds from the American Recovery and Reinvestment Act (ARRA) of 2009 were distributed to states to increase Medicaid and other state funds. SMHAs report that these funds have helped limit the level of reductions in Medicaid-funded mental health services, but are not sufficient to prevent SMHAs from reducing services. Of those SMHAs reducing services, 53 percent are limiting services to indigent consumers and those not on Medicaid. The demand for public mental health services is increasing because of the recession; as unemployment rises, the number of persons with private insurance decreases, ultimately increasing the number of persons eligible for public mental health services. SMHAs provide services to

individuals who do not have health insurance and to those whose health insurance does not cover mental health services. During the summer of 2009, 44 percent of the SMHAs reported an increased demand for community mental health services, and 20 percent of SMHAs reported an increased demand for acute psychiatric inpatient care at state psychiatric hospitals.

I. Introduction

1.1 Background

State Mental Health Agencies (SMHAs) have evolved greatly over the last century. Their evolution began with government entities that devoted nearly all of their human and fiscal resources to the provision of inpatient care in large state psychiatric hospitals. Now, SMHAs support community-based mental health provider agencies that receive SMHA funds, and the SMHA organizes systems and monitors the quality of care. As persons with mental illnesses 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 illnesses live in the community. SMHAs today provide housing and housing support, employment and education support, and other supports beyond the traditional mental health treatments that were the focus in the past.

While SMHAs vary widely in where they are organizationally located in state government, and in the service and disability responsibilities they are assigned, they share 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, the SMHA directly delivers community mental health services with state employees delivering these services. The most common method of 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;
- Plan the development of an array of comprehensive mental health services and submit an annual community block grant plan to the federal government;
- Work with other state and federal government agencies to ensure the provision of essential mental health, health, and support services to persons with mental illnesses;
- Collect data on public mental health services, measure outcomes and system performance, and improve the quality of public mental health services;
- Play a key public health role in informing the residents of their states about the risks of mental illness, reducing stigma, preventing suicide, and encouraging needed treatments; and
- 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 sex offenders or violent sexual predators).

1.2 Methods

This report utilizes the 2009 cycle of the SMHA Profiling System (SPS) (NRI, 2009a) and the FY 2007 State Mental Health Revenue and Expenditure Study Results (NRI, 2009b) (hereafter called the Revenue and Expenditure Study) as the primary sources of data. These sources are supplemented with data from the 2008 Uniform Reporting System (URS) (CMHS, 2009) to describe the consumers served by the SMHAs.

1.2.1 SMHA Profiling System

The SPS is a database of information that describes the organization, funding, operation, services, policies, statutes, and clients of SMHAs. The information describes each SMHA's organization and structure, service systems, eligible populations, emerging policy issues, fiscal resources, client issues, information management, and research and evaluation structures. Questions are grouped into 10 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 decisionmaking, policy analysis, and research and evaluation.

With the guidance of an advisory group comprising SMHA commissioners, planners, program staff, and researchers, NRI updated the contents of the SPS, to meet the needs of the SMHAs. The revised components (New Freedom Commission; Organization and Structure; Policy; Forensic; Services; Information Management; Workforce; Finance; Managed Behavioral Healthcare; and Research and Evaluation) for the 2009 information update cycle were sent to all SMHA commissioners/directors and their agencies' designated SPS contact persons for completion during 2009. 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 to complete the questions on the forms and fax, mail, or email the completed forms to NRI. Individual state responses to the profiles are available on NRI's Web site at www.nri-inc.org, where users can access state responses by keywords, state, and special topical reports.

The States of Connecticut, Hawaii, and New Jersey submitted two components for some of the Profiles component—one for the adult division and the second for the children's division—because the responsibility for providing mental health services to children/adolescents is split out into a separate state agency.

The Organization and Structure component was completed by 53 SMHAs; Policy by 53 SMHAs; Services by 52 SMHAs; Workforce by 50 SMHAs; Finance by 51 SMHAs; Information Management by 52 SMHAs; New Freedom Commission by 52 SMHAs; Research and Evaluation by 49 SMHAs; Forensic by 47 SMHAs; and Managed Behavioral Healthcare by 52 SMHAs.

1.2.2 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, which are developed only after the state's fiscal year is completed and billing issues are fully reconciled, 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 is used 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 MHBG, 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 this report, the fiscal year (FY) 2007 cycle of the Revenue and Expenditure Study data received from 47 states and the District of Columbia is used to discuss the expenditures and funding sources of SMHAs.

1.2.3 The Uniform Reporting System

The Uniform Reporting System (URS) (CMHS, 2009) is a system used by SMHAs to compile and report annual data 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, comprising 21 tables developed by the federal government in consultation with SMHAs, compiles state-by-state and national aggregate information. Such information includes numbers and sociodemographic characteristics of persons served by the states, outcomes of care, use of selected evidence-based practices (EBPs), client assessment of care, and insurance status. SAMHSA uses the tables to calculate the 10 mental health National Outcome Measures (NOMs) for state and national reporting. For this report, 2008 data submitted by the 50 states, the District of Columbia, and 7 U.S. territories are used to describe clients served by the SMHAs.

1.2.4 Limitations

Although there was a high response rate for each of the SPS components, the level of completion within each component varied. Some SMHAs did not complete every component and some did not provide answers to all questions; therefore, some information presented in this report is based on responses from less than the total number of reporting SMHAs. Also, three SMHAs did not report the FY 2007 data on revenues and expenditures.

While this report includes 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 for 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. Some SMHAs and state Medicaid agencies have conducted thorough analyses of Medicaid-paid claims files to determine total Medicaid expenditures for mental health, but 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 expenditures data is the reporting period. Data for revenues and expenditures are based on actual expenditures data from state FY 2007, lagging behind the SPS and URS data used in this report.

1.3 Overview of the Rest of the Report

Section II discusses the organization and structure of SMHAs, including their location within state government, disability service responsibilities, organization, number of mental health organizations funded and/or operated, and use of information technology to link SMHA data with data of other state agencies.

Section III describes the policies that determine the operation of SMHAs and their relationships with other state agencies. This section discusses major policy initiatives of SMHAs, including the transformation of the SMHAs and the elimination of service disparities.

Section IV presents SMHAs' responsibilities for community mental health services and the characteristics of persons served in community settings. This section also briefly discusses the FY 2007 financing of community mental health services.

Section V discusses state psychiatric hospitals and forensic services, including characteristics of persons served as well as the FY 2007 financing of state psychiatric hospitals.

The Appendix of this report (on CD and SAMHSA's Web site at www.samhsa.gov) provides individual SMHA profiles describing how each SMHA is organized within the state government, the SMHA responsibilities and roles, the number of persons served, and the financing of services.

II. Organization and Structure of SMHAs

The SMHA is the division of state government responsible for the organization and delivery of public mental health services. Every state has a SMHA that is designated to administer the federal Mental Health Block Grant (MHBG); prepare, oversee, and implement the state's mental health plan (as required by the MHBG and often by state statute); and to fund or directly provide community mental health services. Each state operates psychiatric inpatient beds that provide critical services to persons whose mental illness is so severe that they require inpatient services within a controlled specialty environment.

States vary considerably regarding how the SMHA is organized within state government. The SMHA's specific responsibilities are related to disability and mental health services, major policy initiatives, priority populations served by the SMHA, and how services are financed. This section provides an overview of the organization and responsibilities of SMHAs.

2.1 SMHA Location in State Government

The majority of SMHAs operate as divisions under a larger umbrella agency. In 31 states, the SMHA is organized as a division within the Department of Human Services. In eight states, the SMHA is organized as a division within a Department of Health, and in three other states, the SMHA falls under the responsibility of the Health and Human Services Department. The SMHA is an independent department in 12 states. During the last 2 years, Vermont and Georgia's SMHAs transitioned from being a division within an umbrella agency into a separate Department of Mental Health. Vermont created the Department of Mental Health in 2008, and Georgia's Department of Mental Health was established on July 1, 2009.

Most SMHA commissioners report to a cabinet secretary; however, in 17 states, the SMHA commissioner reports to mental health councils or boards that are independent organizations overseeing the operations of the SMHA. In 12 of these states, the Governor appoints the board members, and in 6 states, the legislature approves appointments to the board. The Governor and state legislature jointly approve members in only one state. Table 1 shows the organizational structure of each SMHA and the number of layers that exist between the SMHA commissioner and the Governor.

Table 1: Organization of SMHAs Within State Government

State	Organization and Structure		
	SMHA Located in State Department	Levels Between Commissioner & Governor	SMHA Commissioner Reports to Mental Health Board/Council
Alabama	Independent	0	Yes
Alaska	Human Services	2	No
Arizona	Health Department	1	No
Arkansas	Human Services	2	No
California	Human Services	1	No
Colorado	Human Services	2	No
Connecticut	Independent	0	Yes
Delaware	Human Services	1	No
District of Columbia	Independent	1	No

Table 1: Organization of SMHAs Within State Government (Continued)

State	Organization and Structure		
	SMHA Located in State Department	Levels Between Commissioner & Governor	SMHA Commissioner Reports to Mental Health Board/Council
Florida	Human Services	2	No
Georgia	Human Services	1	Yes
Hawaii	Health Department	2	No
Idaho	Human Services	2	No
Illinois	Human Services	3	No
Indiana	Human Services	1	No
Iowa	Human Services	1	Yes
Kansas	Human Services	2	No
Kentucky	Human Services	3	No
Louisiana	Health Department	1	No
Maine	Human Services	1	No
Maryland	Health Department	1	Yes
Massachusetts	Human Services	1	Yes
Michigan	Health Department	1	No
Minnesota	Human Services	2	No
Mississippi	Independent	1	Yes
Missouri	Independent	0	Yes
Montana	Human Services	1	Yes
Nebraska	Human Services	1	No
Nevada	Human Services	0	Yes
New Hampshire	Human Services	2	No
New Jersey	Human Services	3	No
New Mexico	Human Services	1	Yes
New York	Independent	1	No
North Carolina	Human Services	1	No
North Dakota	Human Services	1	No
Ohio	Independent	0	Yes
Oklahoma	Independent	1	Yes
Oregon	Human Services	1	No
Pennsylvania	Human Services	1	No
Rhode Island	Independent	1	No
South Carolina	Independent	1	Yes
South Dakota	Human Services	1	No
Tennessee	Independent	0	No
Texas	Health Department	2	No
Utah	Human Services	1	No
Vermont	Human Services	1	Yes
Virginia	Independent	1	Yes
Washington	Human Services	2	No
West Virginia	Human Services	1	No
Wisconsin	Health Department	1	Yes
Wyoming	Health Department	1	No
	Independent = 12 Human Services = 31 Health Department = 8	0 (Direct Gov) = 6 1 (One Level) = 31 2 (Two Levels) = 11 3 (Three+ Levels) = 3	Yes = 17 No = 34

2.2 Other Responsibilities of SMHAs

In addition to overseeing the delivery of mental health services, in many states, the SMHA is responsible for administering other disability services, including substance abuse, intellectual disability, Medicaid, housing, and public health (see table 2).

2.2.1 Substance Abuse

Substance abuse services are the responsibility of the SMHA in 27 states, and within the same umbrella agency in 15 additional states. Substance abuse services are located within a different department outside of the SMHA in nine states; however, six of these states have an interagency agreement with the other department to provide these services.

2.2.2 Intellectual Disability

Services for persons with intellectual disabilities (formerly referred to as "developmental disabilities" (DD) or "mental retardation" (MR)) are the responsibility of the SMHA in 12 states. In 29 states, these services are located within the same umbrella agency, but not within the SMHA. Intellectual disability services are located within a different department outside of the SMHA in 10 states.

2.2.3 Medicaid

In Pennsylvania, the state Medicaid agency is part of the SMHA and is located within the same umbrella agency in 28 additional states. The state Medicaid agency is located within a different department outside the SMHA in 21 states; however, in all 21 of these states, the SMHA has an interagency agreement with the Medicaid agency for the planning and delivery of mental health services.

2.2.4 Housing

In six states, the SMHA and the state housing agency are located within the same umbrella agency. The state housing agency is located within a different department outside the SMHA in 42 states. In 11 of these states, the SMHA has an interagency agreement with the state housing agency for the planning and delivery of mental health services.

2.2.5 Health

In Hawaii, Montana, and Texas, the state health department is part of the SMHA; in 22 additional states, the health department is located within the same umbrella agency. The state health department is located within a different department outside the SMHA in 25 states; however, in 14 of these states, the SMHA has an interagency agreement with the state health department for the planning and delivery of mental health services.

2.3 SMHA Mental Health Responsibilities

SMHAs vary widely regarding the specific types of mental health services and populations they serve. In most states, the SMHA is responsible for both state psychiatric hospital services and community services for both children and adults; however, for some states, responsibilities for delivering some of these mental health services are vested outside of the SMHA. Table 3 lists the SMHA responsibilities for specific mental health services.

Table 2: SMHA Relationship to Other State Agencies

State	Relationship to Other State Agencies				
	Alcohol & Drug Abuse	Intellectual Disabilities (MR/DD)	Medicaid	Housing	Health
Alabama	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
Alaska	Part of SMHA	Same Umbrella	Same Umbrella	Same Umbrella	Same Umbrella
Arizona	Part of SMHA	Other Agency	Other Agency	Other Agency	Same Umbrella
Arkansas	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Other Agency
California	Other Agency	Other Agency	Other Agency	Other Agency	Other Agency
Colorado	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella	Other Agency
Connecticut	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Delaware	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
District of Columbia	Other Agency	Other Agency	Other Agency	Other Agency	Other Agency
Florida	Same Umbrella	Other Agency	Other Agency	Other Agency	Other Agency
Georgia	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Same Umbrella
Hawaii	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Part of SMHA
Idaho	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Illinois	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Same Umbrella
Indiana	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Other Agency
Iowa	Other Agency	Part of SMHA	Same Umbrella	Other Agency	Other Agency
Kansas	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Other Agency
Kentucky	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
Louisiana	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Maine	Other Agency	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
Maryland	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Massachusetts	Same Umbrella	Same Umbrella	Same Umbrella	No Response	Same Umbrella
Michigan	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
Minnesota	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Other Agency
Mississippi	Part of SMHA	Part of SMHA	No Response	No Response	No Response
Missouri	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Other Agency
Montana	Other Agency	Same Umbrella	Same Umbrella	Same Umbrella	Part of SMHA
Nebraska	Part of SMHA	Same Umbrella	Same Umbrella	Same Umbrella	Same Umbrella
Nevada	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
New Hampshire	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
New Jersey	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Other Agency
New Mexico	Same Umbrella	Same Umbrella	Same Umbrella	Same Umbrella	Same Umbrella
New York	Other Agency	Other Agency	Other Agency	Other Agency	Other Agency
North Carolina	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
North Dakota	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Other Agency
Ohio	Other Agency	Other Agency	Other Agency	Other Agency	Other Agency
Oklahoma	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Oregon	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Pennsylvania	Other Agency	Same Umbrella	Part of SMHA	Other Agency	Other Agency
Rhode Island	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
South Carolina	Other Agency	Other Agency	Other Agency	Other Agency	Other Agency
South Dakota	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Other Agency
Tennessee	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Texas	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Part of SMHA
Utah	Part of SMHA	Same Umbrella	Other Agency	Other Agency	Other Agency
Vermont	Same Umbrella	Same Umbrella	Same Umbrella	Same Umbrella	Same Umbrella
Virginia	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
Washington	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Other Agency
West Virginia	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
Wisconsin	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Wyoming	Part of SMHA	Same Umbrella	Same Umbrella	No Response	Same Umbrella
	Part of SMHA = 27	Part of SMHA = 12	Part of SMHA = 1	Part of SMHA = 0	Part of SMHA = 3
	Same Umbrella = 15	Same Umbrella = 29	Same Umbrella = 28	Same Umbrella = 6	Same Umbrella = 22
	Other Agency = 9	Other Agency = 10	Other Agency = 21	Other Agency = 42	Other Agency = 25
	No Response = 0	No Response = 0	No Response = 1	No Response = 3	No Response = 1

Table 3: SMHA Mental Health-Related Responsibilities

State	Children's Mental Health Services	Alzheimer s Disease/ Organic Brain Syndrome	Brain Impaired Services (including traumatic brain injury)	State Psychiatric Hospitals	Forensic Mental Health Services
AK	Part of SMHA	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA
AL	Part of SMHA	Part of SMHA	No Responsibility	Part of SMHA	Part of SMHA
AR	Part of SMHA	Part of SMHA	No Responsibility	Part of SMHA	Part of SMHA
AZ	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
CA	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
CO	Responsibility Shared	No Responsibility	Responsibility Shared	Outside the SMHA	Responsibility Shared
CT (Adults)	No Responsibility	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA
CT (Children)	Part of DCF*	No Responsibility	No Responsibility	No Response	No Responsibility
DC	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
DE	No Responsibility	Responsibility Shared	Responsibility Shared	Part of SMHA	Responsibility Shared
FL	Part of SMHA	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA
GA	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
HI (Adults)	Part of SMHA	No Responsibility	Part of SMHA	Part of SMHA	Part of SMHA
HI (Children)	Responsibility Shared	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
IA	Responsibility Shared	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	No Responsibility	Responsibility Shared	Part of SMHA	Responsibility Shared
KY	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Responsibility Shared
LA	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
MA	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
MD	Part of SMHA	No Responsibility	Part of SMHA	Part of SMHA	Part of SMHA
ME	Part of SMHA	No Responsibility	Part of SMHA	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	Part of SMHA	Responsibility Shared	No Responsibility	Part of SMHA	Part of SMHA
MT	No Responsibility	Responsibility Shared	Responsibility Shared	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	Part of SMHA	Responsibility Shared
NE	Responsibility Shared	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
NH	Responsibility Shared	No Responsibility	No Responsibility	Outside the SMHA	Responsibility Shared
NJ	Responsibility Shared	Responsibility Shared	Responsibility Shared	Part of SMHA	Responsibility Shared
NM	Part of SMHA	Part of SMHA	Part of SMHA	Outside the SMHA	Part of SMHA
NV	Responsibility Shared	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
NY	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Responsibility Shared
OH	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Responsibility Shared
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	Responsibility Shared	Responsibility Shared	Part of SMHA	Responsibility Shared
RI	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA	Part of SMHA
SC	Responsibility Shared	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
SD	Part of SMHA	Responsibility Shared	No Responsibility	Outside the SMHA	Responsibility Shared
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	Responsibility Shared	Part of SMHA	Part of SMHA
VT	Responsibility Shared	Responsibility Shared	Responsibility Shared	Part of SMHA	Responsibility Shared
WA	Part of SMHA	Responsibility Shared	No Responsibility	Part of SMHA	Part of SMHA
WI	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA

Table 3: SMHA Mental Health-Related Responsibilities (Continued)

State	Children's Mental Health Services	Alzheimer s Disease/ Organic Brain Syndrome	Brain Impaired Services (including traumatic brain injury)	State Psychiatric Hospitals	Forensic Mental Health Services
WV	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
WY	Part of SMHA	No Responsibility	No Responsibility	Outside the SMHA	No Responsibility
	Part of the SMHA = 36	Part of the SMHA = 3	Part of the SMHA = 6	Part of the SMHA = 47	Part of the SMHA = 34
	Shared = 12	Shared = 19	Shared = 23	Outside the SMHA = 5	Shared = 16
	No responsibility = 4	No responsibility = 31	No responsibility = 24	No response = 1	No responsibility = 3
	Part of DCF = 1				
***Department of Children and Families**					

2.3.1 Forensic Mental Health Services

Forensic mental health services are provided to persons sent to the mental health system by a criminal court for evaluation or treatment. Examples of forensic services provided by SMHAs include the determination of competency to stand trial and the provision of mental health services to persons found incompetent to stand trial or those deemed not guilty but mentally ill. Forensic services are a rapidly expanding portion of many states' psychiatric hospital populations.

Thirty-four SMHAs are responsible for adult forensic mental health services. An additional 16 SMHAs share this responsibility with the departments of correction. Of the reporting SMHAs, only Iowa and Wyoming have no responsibility for providing forensic mental health services.

The SMHA is responsible for providing court evaluations of mental health status in 30 states; 19 SMHAs share this responsibility with another agency. Six SMHAs have no responsibility to provide these evaluations. Twenty-nine SMHAs share responsibility with the departments of correction to provide services to persons with mental illness in prisons and jails; only three SMHAs are solely responsible for providing such services. Twenty-one SMHAs are not responsible for administering these services.

2.3.2 Mental Health Services for Children and Adolescents

Thirty-six SMHAs are responsible for providing mental health services to both children and adults; however, in 12 states, the responsibility for children's services is shared between the SMHA and a separate state agency. Four states have a separate children's department that is responsible for services including child welfare, juvenile justice, mental health, substance abuse, and other social services for children and adolescents.

2.3.3 Brain Impaired (Including Traumatic Brain Injury) and Organic Brain Syndrome (Including Alzheimer's Disease) Services

Twenty-three SMHAs share the responsibility of providing services for people with brain impairment with another agency, whereas the SMHAs in Hawaii, Maine, Maryland, New Mexico, North Carolina, and Rhode Island have the sole responsibility for providing these services. Twenty-four additional SMHAs have no responsibility for these services.

In 31 states, the SMHA has no responsibility for the provision of services for people with organic brain syndromes or Alzheimer's disease. Nineteen SMHAs share this responsibility with another state agency. The SMHAs in Alabama, Arkansas, and New Mexico have the sole responsibility for the provision of these services.

2.3.4 Operation of State Psychiatric Hospitals

All state governments operate psychiatric inpatient beds, but not all states assign this responsibility to the SMHA. In 47 states, the SMHA operates state psychiatric inpatient beds; however, separate agencies in Colorado, New Hampshire, New Mexico, South Dakota, and Wyoming are responsible for

the provision of psychiatric inpatient beds. In these states, the SMHA works with the state hospitals to coordinate care between the hospitals and community systems. For example, in South Dakota, the SMHA reported that social workers employed by the Human Services Center work with community mental health center staff, Division of Mental Health staff, and other community agencies to coordinate services for consumers being discharged back into the community.

2.3.5 Housing Services

Helping mental health consumers live outside of institutions in their desired living situations is a critical support service provided by SMHAs. In 37 states, there is a housing coordinator or specialist within the SMHA who is responsible for increasing affordable housing opportunities for persons with serious mental illnesses. In 17 states, there is also a housing coordinator within the state housing agency who works to increase affordable housing opportunities for persons with serious mental illnesses. (In 15 states, there are housing coordinators in both the SMHA and the state housing agency working on affordable housing for persons with mental illnesses.)

SMHAs in 34 states have developed a housing plan—a delineated set of strategies to address the housing needs of persons with serious mental illnesses. The SMHA collaborates with community development corporations or housing authorities in 40 states. SMHAs have working interagency relationships on housing issues with the State Coalition for Homeless Persons (43); State Department of Housing/Community Development (37); State Housing Authority (36); State Housing Finance Agency (35); and State Affordable Housing Coalition (28).

Most SMHAs (35) fund housing support services, and some (16) use Medicaid funds to do so. Colorado's SMHA does not provide housing support services but does provide some funding for a small number of group homes and psychiatric hospitals. The housing support services provided by SMHAs include transitional and permanent housing, as well as a variety of housing supports, including rental assistance, home-based rehabilitative services, Shelter Plus Care, case management, supported employment, Assertive Community Treatment (ACT), and the Project for Assistance in Transition from Homelessness (PATH).

2.4 Reorganization of SMHAs

From 2007 to 2009, eight states reorganized their SMHAs. New Mexico, Vermont, and Wyoming relocated their SMHAs into another department. On July 1, 2009, Georgia reorganized its SMHA into the Department of Mental Health. Nevada, Tennessee, and Wyoming folded substance abuse services into the SMHA. In addition, Colorado merged the substance abuse and mental health agencies, effective August 2008, as did Louisiana, effective July 1, 2009. Kentucky's SMHA no longer has responsibility over intellectual disability services, because these have been moved to a separate state agency.

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

In 2009, SMHAs funded and/or operated 19,628 organizations to provide mental health services (see table 4). SMHAs directly operated (SMHA employees are used to provide services at facilities owned by the SMHA) 553 mental health organizations; of these, 198 were state psychiatric hospitals (47 SMHAs), and 336 were community mental health organizations (15 SMHAs). In addition, several states have privatized the operation of their state psychiatric hospitals and thus report these hospitals as state funded instead of as state operated.

A total of 18,511 community mental health providers are the core of the SMHA mental health system. The vast majority (18,847) of the community mental health providers are funded, but not operated, by the SMHA. Besides community mental health

Table 4: Number of Mental Health Organizations Operated and/or Funded by SMHAs

	State Psychiatric Hospitals	Community Mental Health Providers	Private Psychiatric Hospitals	General Hospitals With Separate Psych Units	Nursing Homes & Other ICF MI & SNF Providers	Total Mental Health Providers
State Operated	198	336	NA	5	14	553
State Funded	14	18,511	70	435	45	19,075
Total	212	18,847	70	440	59	19,628

SNF = Skilled nursing facility.
NA = not applicable.

providers and state psychiatric hospitals, SMHAs also operate and fund an array of additional mental health providers. Twenty-one SMHAs funded or operated 440 general hospital psychiatric units to provide inpatient psychiatric treatment. Thirteen SMHAs funded 70 private psychiatric hospitals to provide inpatient and other mental health services.

Sixteen SMHAs funded or operated 59 nursing homes and intermediate care facilities for persons with mental illness (ICF-MI). ICF-MI facilities are mental health facilities that provide 24-hour residential treatment to persons with mental illnesses in a less intensive environment than that of hospitals.

2.6 SMHA Management Information Systems and Research Functions

All SMHAs measure the quality, outcomes, and effectiveness of their services. This process is done through the collection and reporting of information about the mental health services they fund and operate. The location of Management Information Systems (MIS) and how these systems are organized vary widely among states. In most states, MIS functions are located within the SMHA, but some of these functions are consolidated into an office in the umbrella agency outside of the SMHA.

2.6.1 Organization of MIS

The SMHA MIS responsibilities fall to a variety of agencies. It is the responsibility of 31 SMHAs to generate and analyze data and performance reports. Fourteen SMHAs share the responsibility for these functions with another state agency. In three states, these responsibilities fall outside of the SMHA. As table 5 shows, many information functions are either located outside of the SMHA or shared with another agency (usually located in the SMHA's umbrella organization). These other agencies may have requirements that limit the flexibility and autonomy of the SMHA in changing their information system requirements and outcome reports.

Table 5: Organizational Locations of Information Management Functions

Functions	Within the SMHA	Shared Between the SMHA and Another Agency	Outside the SMHA (in a separate agency)
Generating data and performance reports	31	14	3
Data management, such as updating and quality control	24	15	9
Data warehouses that link SMHA data with other state agency data	11	16	13
Management and operation of computers	10	21	17

In 26 states, the SMHA is part of an umbrella agency that runs computer hardware for the SMHA, and in eight states, the SMHA is part of an umbrella agency that controls hardware acquisition decisions regarding SMHA information management functions.

As states increasingly collocate the responsibility for managing substance abuse and mental health services, they also combine their information management functions. In 2009, 33 states combined the mental health and substance abuse services information management functions. In 12 of these states, the information management functions for 3 major disabilities (mental health, substance abuse, and intellectual disabilities) are combined.

2.6.2 MIS Staffing and Budgets

In 2009, 42 SMHAs had a total of 702 full-time equivalent (FTE) staff working on information management functions for mental health. This total includes 564 FTEs who work within the SMHA and an additional 138 FTEs working in another agency on mental health information technology. States averaged 17 FTEs for mental health information functions, with a minimum of 1 FTE and a maximum of 85 FTEs.

SMHAs in 32 states expended over $92 million to support the information management functions related to mental health. States averaged expenditures of $2.87 million, ranging from a low of $131,639 in New Hampshire to a high of $12.5 million in Pennsylvania. The SMHA budget represented 75 percent of the total expenditures ($68,608,475) for information management functions, whereas other state agencies expenditures for mental health information represented the remaining 25 percent. The major funding sources of these functions included state government (59 percent), federal government (10 percent), and other sources (31 percent).

2.6.3 Types of Mental Health Information Collected by SMHAs

SMHAs collect a variety of information on the consumers served through the public mental health system, including client-level data, claims/encounter data, medications information, and client outcomes.

2.6.3.1 Client-Level Data

Client-level data are information maintained by SMHAs about each individual served by the state's mental health system. Client-level data include both sociodemographic information (such as age, gender, race/ethnicity, marital status, and employment status) and service utilization data (such as diagnoses, clinicians providing services, and services received). Client-level data maintained by SMHAs usually include a unique client identifier that can be used to unduplicate client records between providers and to link with other data systems (such as Medicaid).

Forty-nine SMHAs maintain client-level data for consumers served in some community mental health settings. However, nine SMHAs do not receive unique client information for all community mental health clients. For example, in South Carolina, the SMHA receives client-level data only for consumers served by the Department of Mental Health's network of community mental health centers (no private community programs), and in New Jersey, the SMHA does not receive unique client information from self-help centers or pilot programs.

2.6.3.2 Claims/Encounter Data

Almost all SMHAs (47) receive client-level claims/encounter data for some clients; however, nine SMHAs receive aggregate provider data for some clients rather than claims data. Claims records contain details on specific clinical/client treatment

interactions (such as procedure codes, provider identifications, and billing amounts) generated and submitted for payments. Encounter data are similar to claims records, except they may not include the actual billing amount. Encounter data are often reported instead of claims data when managed care, capitated, or other financing strategies are used that do not require a claim to be filed as a bill for each service event. The states that do not receive claims data for all clients estimate that they receive claims data for 60 to 85 percent of their consumers.

2.6.3.3 Medications Information

Most SMHAs help provide medications to persons with mental illnesses, paid for by SMHA funds or Medicaid. In 35 states, the SMHAs maintain information about the use of psychiatric medications. Twenty SMHAs maintain information on Medicaid-paid prescriptions, whereas 17 maintain this information for SMHA-funded prescriptions. Types of information maintained include the types of medication, quantity of drugs prescribed, date of prescription (28 SMHAs), the number of prescriptions written by prescribing clinicians (24 SMHAs), medications delivered or purchased (19 SMHAs), and information on payments for medications (18 SMHAs). This medications information is received by 34 SMHAs at the client level and can be linked with other client service-use data. Medication data are available at a detailed (per prescription) level in 23 SMHAs, whereas summary medication data (with no prescription details) are available in 9 SMHAs.

2.6.3.4 Client Outcomes

Information management functions within SMHAs are responsible for preparing information for their leadership, MHBG plans, and others on the effectiveness and appropriateness of mental health services offered in their states. Most SMHAs monitor a variety of client outcome measures. The most frequently measured client outcome is consumer perception of care, which is most commonly measured using the Adult Mental Health Statistics Improvement Program (MHSIP) consumer survey. Assessments of client functioning, family involvement/satisfaction, and client employment are also frequently measured client outcome measures (see table 6).

Table 6: Number of SMHAs Monitoring Client Outcome Measures

Client Outcome Measures	Community Mental Health	State Hospitals
Perception of Care	44	28
Functioning	41	24
Family Involvement/Satisfaction	37	11
Change in Employment	37	10
Change in Living Situation	36	7
Client Symptoms	27	17
Recovery/Resilience	16	11
Strength-Based Measures	15	8
Other Outcome Measures	11	9

Table 7: EHR Functions Implemented in State Psychiatric Hospitals and Community Mental Health Providers

EHR Components	State Hospitals	Community Providers
	Number of States	Number of States
Pharmacy	30	9
Patient admissions, discharge, and transfers	29	19
Billing as part of EHR system	26	18
Reporting	21	14
Treatment planning	21	17
Progress/case documentation	20	18
Clinical assessments	20	16
Dietary	18	2
Physician order entry	16	8
Scheduling	16	17
Medication algorithms	7	2
External consultations	7	11
Other EHR functions	5	3
Exchanging client information with other providers	2	7

2.7 Electronic Health Records

SMHAs are actively working to implement health information technology and are expending resources on the implementation of electronic health records (EHRs) within mental health facilities. SMHAs are also working on participating in Health Information Exchanges (HIEs) that share EHR information between health providers and physicians, and SMHAs are sharing personal health records (PHRs) that allow consumers to access elements of their medical records and allow the sharing of that information with persons chosen by the consumers.

Thirty-two SMHAs have an EHR already operating or are installing EHR systems in either state psychiatric hospitals or community mental health systems. SMHAs more frequently implement EHRs in a service setting, such as state psychiatric hospitals, over which they have direct control. EHRs are already operating in hospitals in 14 SMHAs, are being installed in 13 additional SMHAs, and are being considered for implementation in 10 SMHAs.

SMHAs have limited control over community-based mental health providers. Although many community providers are funded by SMHAs, they are either private, not-for-profit organizations or operated by local city or county governments. The community mental health providers in 12 SMHAs have operating EHRs, whereas in 9 SMHAs, the community providers are implementing EHRs. In 30 SMHAs, community providers use a variety of EHR software systems, whereas in 5 SMHAs they use a single EHR system.

2.7.1 Implementation of EHR Components

EHRs fulfill a variety of functions. Many state psychiatric hospitals and community mental health service providers are phasing in EHRs. The most frequently implemented functions of EHRs in state psychiatric hospitals are pharmacy; patient admissions, discharge, and transfers; billings; treatment planning; progress/case documentation; and clinical assessments. For community mental health service providers, the most frequently implemented functions are patient admissions, discharge, and transfers; billings; progress/case documentation; scheduling; and clinical assessments (see table 7, above).

SMHAs that implement EHRs report enhanced quality assurance as the main benefit (17 SMHAs), followed by improved data reporting (15 SMHAs),

improved productivity (14 SMHAs), and reducing billing errors (13 SMHAs).

2.7.2 Sharing EHR Information

SMHAs work within their state government to promote the practice of sharing EHR data between mental health providers and other systems. Fourteen SMHAs participate in their state's Health Information Exchange (HIE) or Regional Health Information Organizations (RHIOs) to share electronic health information. In California, Indiana, Missouri, and Vermont, the SMHA's inclusion of mental health in the state's HIE is in the early stages of development or is not yet open to all mental health providers in the state.

Many SMHAs have agreements that allow the sharing of EHR data between providers to improve the coordination of mental health services. In 21 SMHAs, data-sharing agreements allow state psychiatric hospitals within the states to share EHR information. While in eight SMHAs, such agreements allow the sharing of EHR client data between community mental health providers and state psychiatric hospitals (three of these SMHAs—Delaware, Oklahoma, and South Carolina—operate some community mental health providers, thus facilitating the sharing of EHR client data). The SMHAs in six states share EHR data between community mental health providers. Only Washington and Wisconsin permit the sharing of EHR data between state psychiatric hospitals and general hospitals. Arizona has agreements that allow sharing of EHR data between health maintenance organizations, other managed care firms, and the SMHA.

2.7.3 Electronic Personal Health Records

SMHAs are in the very early stages of implementing electronic personal health records (PHRs) that provide mental health consumers electronic access to their medical records. Currently, only Missouri and Ohio are working with other providers to support PHRs. Other SMHAs are very interested in allowing consumers to have PHRs related to mental health services. For example, in Ohio, the SMHA is participating in a statewide initiative to define a statewide EHR/PHR hub and service framework; in Oklahoma, the SMHA is participating in a state agency HIE that plans to include PHRs at a later date; and in Vermont, while there are not yet definitive PHR implementation plans, PHRs are anticipated as one part of the state health information technology (HIT) plan. One of the EHR products under consideration at the state psychiatric hospital does have a patient portal that could enable a PHR.

Forty-four SMHAs use technology to help consumers find information about where and how to access mental health care, whereas 41 SMHAs use technology to help consumers find general information about mental illnesses. Most SMHAs (41) have Web sites that promote education about mental health treatments and 18 states have call centers that provide such information to consumers.

2.7.4 Telemedicine

Telemedicine uses telephone, video conferencing, and/or Internet technologies to allow medical staff to consult with each other and provide service to individuals in remote locations. Most SMHAs (42) promote the use of telemedicine to provide mental health services. Twenty-nine SMHAs reimburse mental health providers for providing telemedicine services, and Medicaid reimburses mental health providers for telemedicine services in 35 states. Six states have changed their licensure or scope of practice to promote and encourage the use of telemedicine in their state.

2.8 Linking SMHA Data With Data of Other State Agencies

SMHAs are working with their state Medicaid agencies and other state government agencies in order to facilitate a more comprehensive understanding of the services that consumers receive. Forty-four SMHAs have access to Medicaid-paid claims files. In 30 states, the SMHA directly

receives and analyzes Medicaid claims files. SMHA client data are linked with Medicaid paid claims files in 32 states. In 12 states, a data warehouse is run by a separate agency that combines SMHA and Medicaid data, whereas in 19 states, another mechanism is used to link Medicaid-paid claims with SMHA client data. SMHA data are linked with Medicaid data on a monthly basis in 12 states, but these data are linked weekly in 3 states, daily in 2 additional states, and at other intervals in the remaining states.

The major reasons cited by SMHAs for linking Medicaid data were analysis of mental health services (36 SMHAs), policy analysis and administrative purposes (35 SMHAs), and identification of fraud and abuse (15 SMHAs).

In 16 states, the SMHA is working with the state's Medicaid agency to combine the 2 data systems. SMHAs in 12 states are working with their Medicaid agency to use the Medicaid Information Technology Architecture (MITA) of the federal Centers for Medicare and Medicaid Services (CMS) to combine their data systems. For example:

- MITA's goal is interoperability for potentially reducing costs, improving outcomes, and reducing errors. Through the data warehouse, the Michigan Department of Community Health (MDCH) enables the sharing of data to improve mission performance. Once data are received, relationships are identified and established to enable the sharing of information so that there is a mutual understanding of what the information represents. Information once held independently can now be linked and shared to allow analysis for use in improving mission performance outcomes.
- Washington is replacing its Medicaid Management Information System (MMIS), and the new system has been developed using the MITA framework. All Medicaid payments will be processed through the new MMIS when it goes live, and ultimately all provider payments will be made through this system for the Department of Social and Health Services (which includes the SMHA).

Twenty-six SMHAs are moving beyond linking SMHA data with Medicaid data to also linking their data with several other state agency (OSA) data systems (see table 8). SMHAs most frequently link their client data system with substance abuse and criminal justice client data systems.

2.9 Characteristics of Mental Health Consumers Served by SMHA Systems (2008)

In 2008, a total of 6,332,983 consumers (just over 2 percent of the U.S. population) were served by the 50 states, the District of Columbia, and seven territories. The number of consumers served by each SMHA ranged from a high of 687,867 in New York, to a low of 9,343 in Delaware. Slightly under half (48 percent) of consumers served were male (with a utilization rate* of 20.2 per 1,000 population), whereas 51 percent were female (with a utilization rate of 20.9 per 1,000 population). Of all SMHAs reporting data, consumers served in Wyoming had the highest utilization rate (3,880.2 per 100,000), whereas consumers in Massachusetts had the lowest utilization rate (428 per 100,000).

*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.

Table 8: Number of SMHAs Linking SMHA Data Systems With Other State Agencies

	Update Frequency		Purpose			Agency Responsible for Linking Data		
	Regularly	Special Projects	Analysis of Mental Health Services	Admin Purposes	Identify Fraud & Abuse	SMHA	Other State Agency*	Other Agency**
Alcohol and Drug Abuse	16	10	17	16	1	20	8	6
Criminal Justice	5	14	10	11	0	15	3	1
Health	6	9	12	7	1	0	2	3
Employment/Vocational Rehabilitation	4	7	8	7	0	10	2	0
Child Welfare	7	8	9	11	0	13	3	1
Juvenile Justice	4	11	9	10	0	13	2	0
Education	1	3	2	4	1	1	2	0

*Agency listed in the row.
**Other agency besides the SMHA or OSA listed in the row.

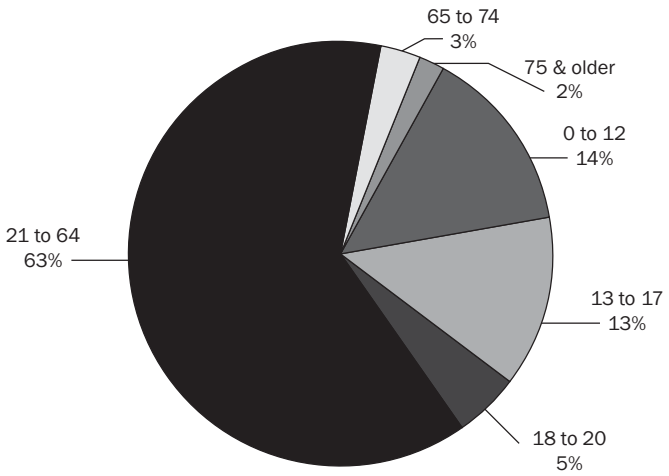
2.9.1 Consumers Served, by Age and Gender

Adults from the ages of 21 to 64 made up the majority (63 percent) of the total number of persons served, whereas young adults (18 to 20) and older adults (65 and older) made up only 5 percent each. See figure 1 for the percent distribution of consumers served, by age group, and table 9 for utilization rates per 1,000 population, by age, by gender, and by racial groups. Not all of the data discussed in the text are reflected in the figures.

2.9.1.1 Children (0 to 12) and Adolescents (13 to 17)

Children and adolescents had an average utilization rate of 27.2 per 1,000 U.S. resident population. Children had an average utilization rate of 16.9, with higher male rates (21.1) than female rates (12.3 per 1,000). Although adolescents accounted for only 13 percent of the total population served, they averaged the highest utilization rate (37.6 per 1,000) of all age groups (see table 9 and figure 2). As in the children rates, male adolescent consumers had higher utilization rates (40.7) than female consumers (34.1).

Figure 1: Percent Distribution of Consumers Served, by Age



2.9.1.2 Young Adults (18 to 20) and Adults (21 to 64)

Young adults and adults had an average utilization rate of 23 per 1,000. Young adults had an average utilization rate of 23.5 per 1,000, with no gender differences. Male adults from the ages of 21 to 64 had lower average utilization rates (19.7) than their female counterparts (24.8).

2.9.1.3 Older Adults (65 and Above)

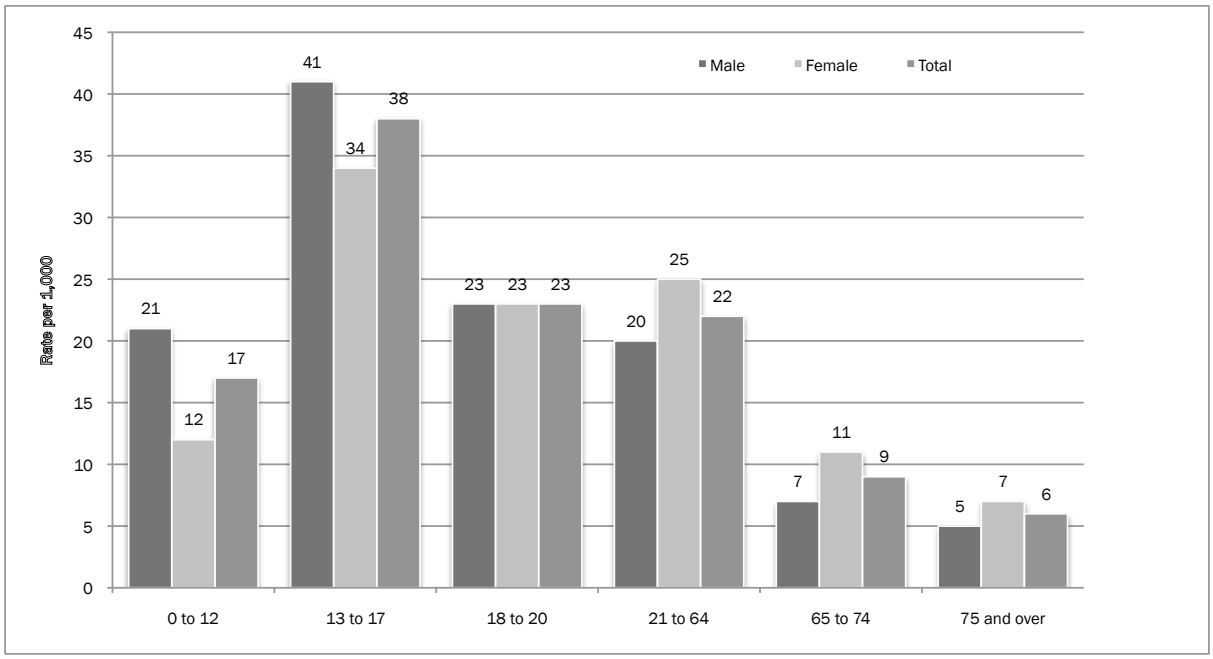
Older adults had an average utilization rate of 7.5 per 1,000. Older adults from 65 to 74 had an average utilization rate of 9 per 1,000, with slightly higher rates for females (10.6) than males (6.9). Consumers who were 75 and older had the lowest average utilization rates (6.1) of all age groups, with lower male rates (4.8) than female rates (6.9).

Figure 2 shows that adolescents were served at the highest rate for both males and females. In the older populations served by the SMHAs, male consumers have lower utilization rates than females, whereas in the younger age groups, male consumers have higher utilization rates.

Table 9: Utilization Rate of SMHA Mental Health Services, by Age, Gender, and Race/Ethnicity, 2008

Age	Gender	Rate per 1,000 Population							
		Total	American Indian/ Alaskan Native	Asian	Black/ African American	Native Hawaiian/ Pacific Islander	White	Hispanic or Latino (reported by "race" or "ethnicity)	Multiracial
0 to 12	Total	16.9	22.8	2.9	24.4	14.0	12.9	8.2	20.1
	Female	12.3	17.9	2.2	16.8	10.0	9.6	9.0	15.2
	Male	21.1	27.5	3.6	31.7	17.7	16.0	16.0	24.5
13 to 17	Total	37.6	50.5	9.4	54.7	32.8	28.3	32.9	48.4
	Female	34.1	48.0	8.3	45.8	28.5	26.4	30.2	47.1
	Male	40.7	52.9	10.3	63.3	36.9	30.0	35.4	49.6
Average for Children		**27.2**	**36.6**	**6.1**	**39.5**	**23.4**	**20.6**	**20.6**	**34.2**
18 to 20	Total	23.5	25.4	7.3	31.8	27.6	19.3	16.2	25.8
	Female	23.3	26.3	7.1	28.7	27.2	19.7	15.9	27.1
	Male	23.4	24.4	7.5	34.8	28.0	18.8	16.5	24.4
21 to 64	Total	22.4	24.6	7.3	34.7	30.6	18.6	16.0	32.7
	Female	24.8	29.0	7.8	34.8	30.7	21.2	19.2	34.3
	Male	19.7	20.2	6.5	34.6	30.3	15.9	13.1	30.8
Average for Adults		**23.0**	**25.0**	**7.3**	**33.3**	**29.1**	**18.9**	**16.1**	**29.2**
65 to 74	Total	9.0	9.3	5.7	14.7	20.1	7.3	13.6	14.1
	Female	10.6	10.4	6.6	16.1	17.4	8.8	16.9	16.8
	Male	6.9	8.1	4.6	12.6	23.2	5.6	9.5	10.8
75 and over	Total	6.1	7.9	4.0	8.9	11.9	5.3	7.6	9.3
	Female	6.9	7.7	4.3	9.7	11.4	6.0	8.6	9.7
	Male	4.8	8.3	3.5	7.5	12.9	4.1	6.0	8.4
Average for Older Adults		**7.5**	**8.6**	**4.9**	**11.8**	**16.0**	**6.3**	**10.6**	**11.7**
TOTAL ALL AGES	Total	20.7	25.5	6.5	32.4	26.2	16.6	16.3	28.0
	Female	20.9	26.9	6.7	29.8	25.0	17.5	17.0	27.1
	Male	20.2	24.0	6.1	35.1	27.2	15.8	15.7	28.8

Figure 2: Utilization Rates of Persons Served, by Age and Gender (rate per 1,000)



Note: Figures are rounded.

2.9.2 Consumers Served, by Race/Ethnicity and Gender

Sixty-three percent of all consumers served by the SMHAs were white, with African Americans representing 20 percent of consumers. Native Hawaiians/Pacific Islanders represented the smallest percentage (0.2) of consumers served (see figure 3 for the race/ethnicity breakdown of all consumers served).

2.9.2.1 Children (0 to 12) and Adolescents (13 to 17)

African American children from the ages of 0 to 17 had the highest average utilization rates (39.5 per 1,000) of all groups, whereas Asian Americans averaged the lowest (6.1) utilization rate. See figure 4 for the average utilization rates of children and adolescents, by race/ethnicity and gender; this figure does not show the following data: For young children (ages 0 to 12), African American males had the highest utilization rate (31.7 per 1,000), whereas Asian American females had the lowest utilization rate (2.2 per 1,000). Similar to the rates for young children, male African American adolescents (ages 13 to 17) had the highest utilization rate (63.3 per 1,000), whereas Asian American females also had the lowest (8.3) utilization rates. Overall among children, boys had higher utilization rates than did girls among all racial groups.

2.9.2.2 Young Adults (18 to 20) and Adults (21 to 64)

Adult utilization rates were similar to children and adolescent rates for most minority groups. Adult African American consumers (from the ages of 18 to 64) had the highest utilization rates (33.2 per 1,000), whereas Asian Americans had the lowest rates (7.3) (see figure 5). African American adults (ages 21 to 64) had the highest utilization rates (34.7), with no significant difference between males (34.6) and females (34.8). Similarly, Native Hawaiians/Pacific Islanders in this age group had high utilization rates (when compared with other groups) averaging 30.6 consumers per 1,000, with no significant difference between males (30.3) and females (30.7). Overall rates for young adults (ages 18 to 21) were similar to adults ages 21 to 64.

Figure 3: Percentage of Consumers Served, by Race/Ethnicity

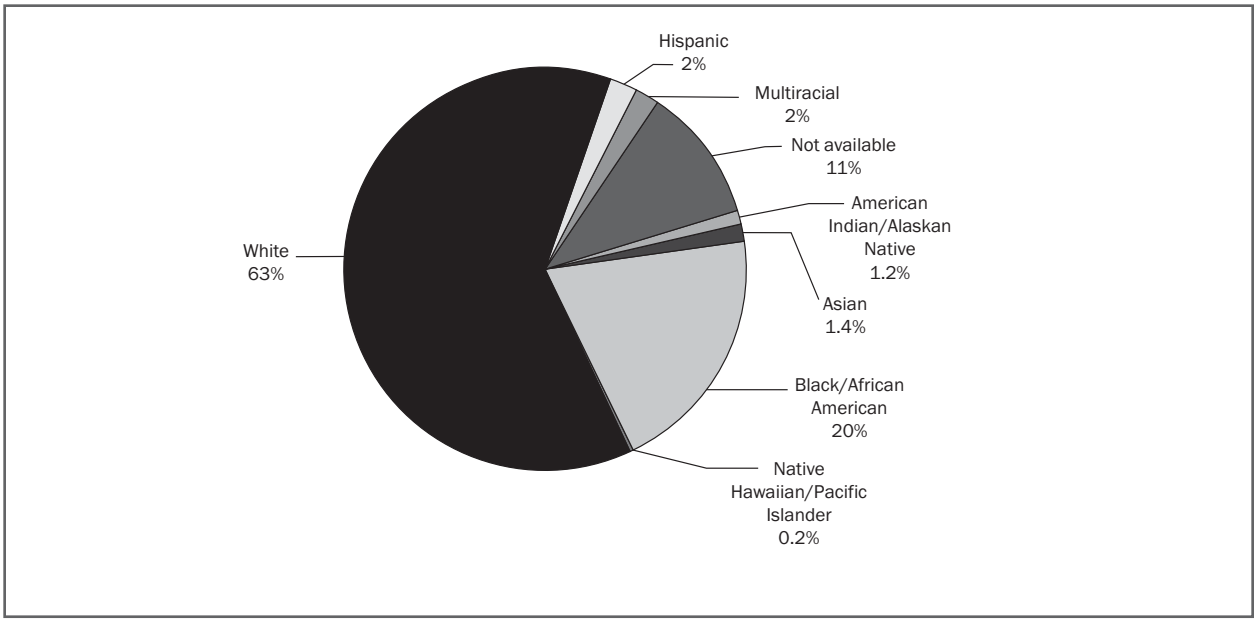


Figure 4: Utilization Rates of Children and Adolescents, by Race/Ethnicity and Gender (rate per 1,000)

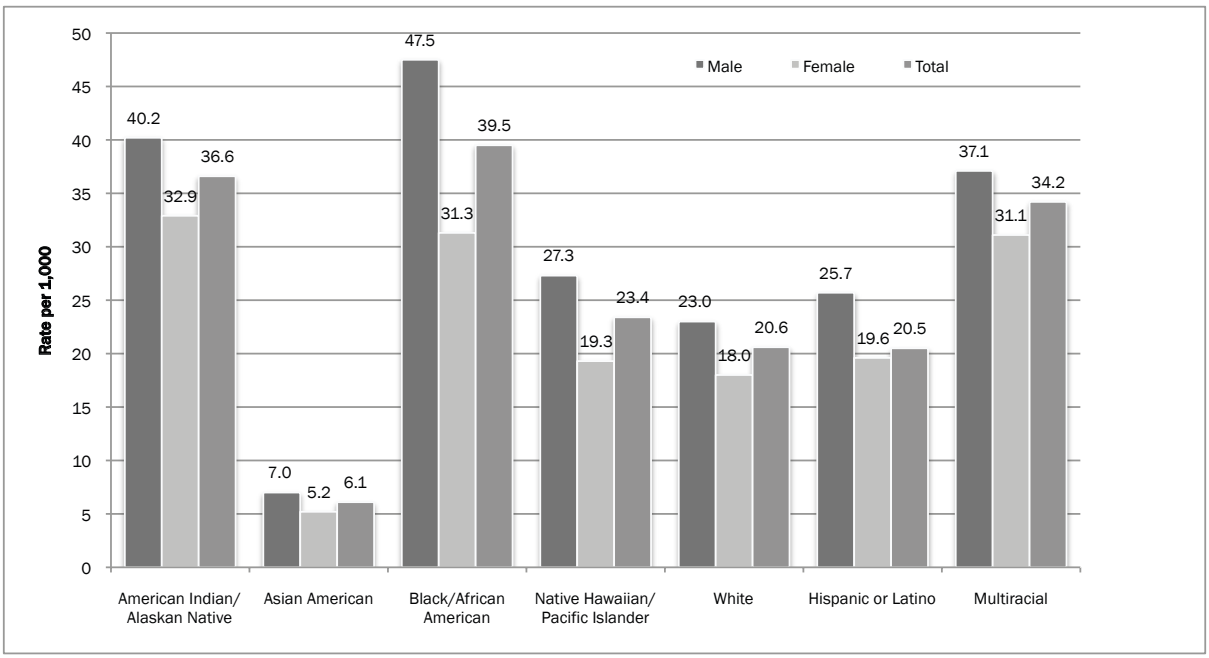
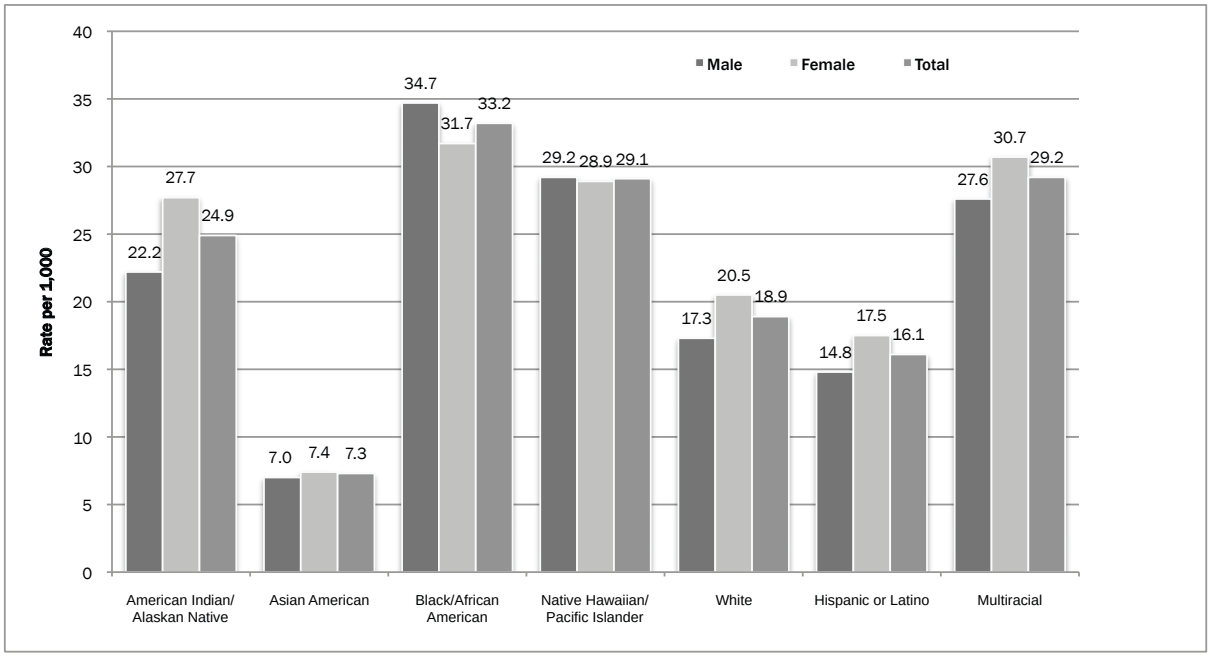


Figure 5: Utilization Rates of Young Adults and Adults, by Race Ethnicity and Age (rate per 1,000)



2.9.2.3 Older Adults (65 and Above)

Unlike all other age groups, Native Hawaiian/Pacific Islanders who were 65 and older had the highest utilization rates (16 per 1,000); however, similar to other age groups, Asian Americans averaged the lowest (4.9) utilization rates. Native Hawaiian consumers from the ages of 65 to 74 averaged the highest utilization rates (20.1); females had lower rates (17.4) than male consumers (23.2). Asian American consumers who were 75 and older had the lowest utilization rate (4.0), with slightly higher rates for females (4.3) than male (3.5) consumers. Much like Asian Americans within this age group, white Americans also had lower utilization rates (6.3 per 1,000), with males averaging much lower rates (4.8) than females (7.4). See figure 6 for the average utilization rates of older adults, by race/ethnicity and gender; some data previously mentioned are not shown in this figure.

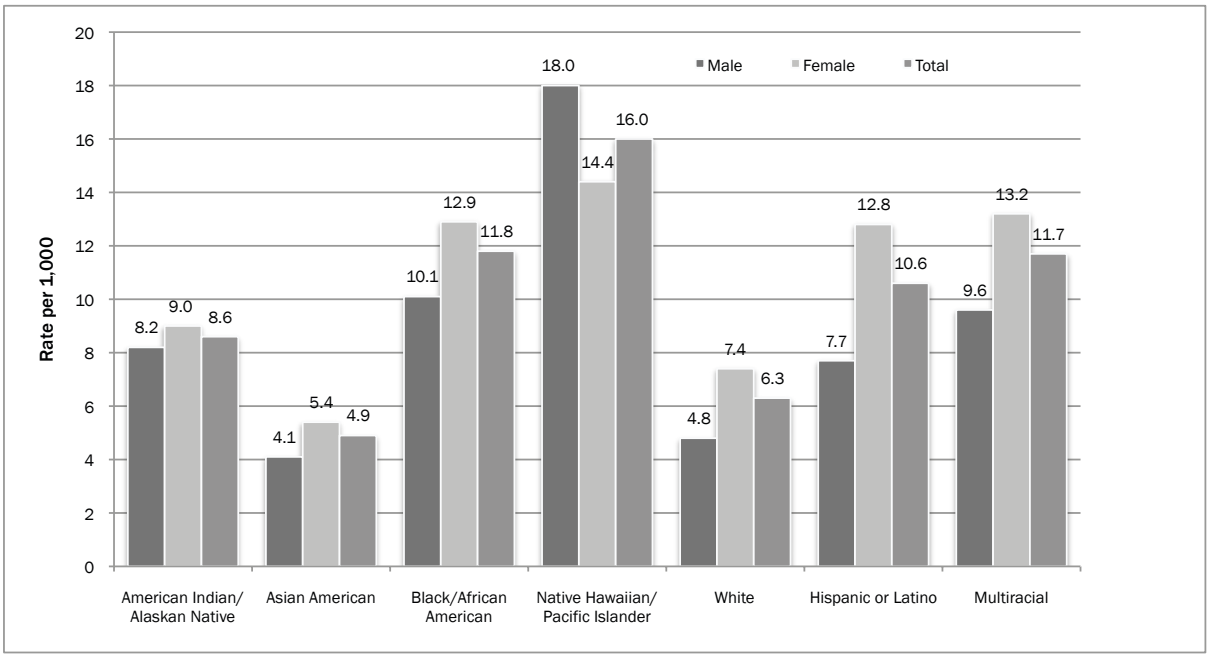
2.9.3 Adults With Serious Mental Illnesses and Children With Serious Emotional Disturbances Served

SAMHSA defines SMI as "persons age 18 and over, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-III-R, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities" (Federal Register, 1993, p. 29425). In 26 SMHAs, the state definition of SMI matches that of the federal government; however, in 22 SMHAs, the state has its own definition of SMI.

SAMHSA defines SED as "persons from birth up to age 18, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-III-R, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities" (Federal Register, 1993, p. 29425). In 27 SMHAs, the state definition of SED matches that of the federal government, whereas in 19 SMHAs, the state has its own definition of SED.

Twenty-six SMHAs have adopted the federal definition of SMI, whereas 27 have adopted the

Figure 6: Utilization Rates of Older Adults, by Race/Ethnicity and Gender (rate per 1,000)



federal definition of SED. The majority of all adult consumers (66 percent) served by the SMHAs had a SMI, whereas 68 percent of all children served had SED. In eight SMHAs, 100 percent of adults and children served were diagnosed with SMI or SED. These SMHAs have strict eligibility requirements for mental health services where only consumers with SMI or SED are served.

2.10 SMHA Financing of Mental Health Services

SMHAs administer and oversee funds from a variety of sources, including federal, state, and local sources, to finance public mental health services. In FY 2007, SMHAs spent an estimated* $33.5 billion (2.3 percent of total state government expenditures) for mental health services in state psychiatric hospitals, community mental health agencies, and the SMHA's research, training, and administration operations.

*California, Hawaii, and Iowa did not submit FY 2007 data on revenues and expenditures. To estimate total expenditures across the Nation, FY 2006 data are used for these three states.

SMHAs averaged estimated per capita expenditures of $111.71 (the median was $95.62). SMHAs vary widely regarding how they are organized, the services they are responsible for providing, the priority populations they serve, and the cost of providing mental health services. As a result, there is considerable variation in the level of expenditures. In FY 2007, SMHA per capita expenditures varied from over $200 in the District of Columbia, Maine, New York, Pennsylvania, and Vermont to less than $50 per capita in Arkansas, Florida, Georgia, Idaho, and Texas (see figure 7 and table 10).

SMHAs that are responsible for administering some of the Medicaid benefits for mental health have much higher expenditures than states where the SMHA is not responsible for setting Medicaid rates for mental health or for managing Medicaid mental health benefits (see figure 8).

Figure 7: Total SMHA-Controlled per Capita Expenditures for Mental Health, FY 2007

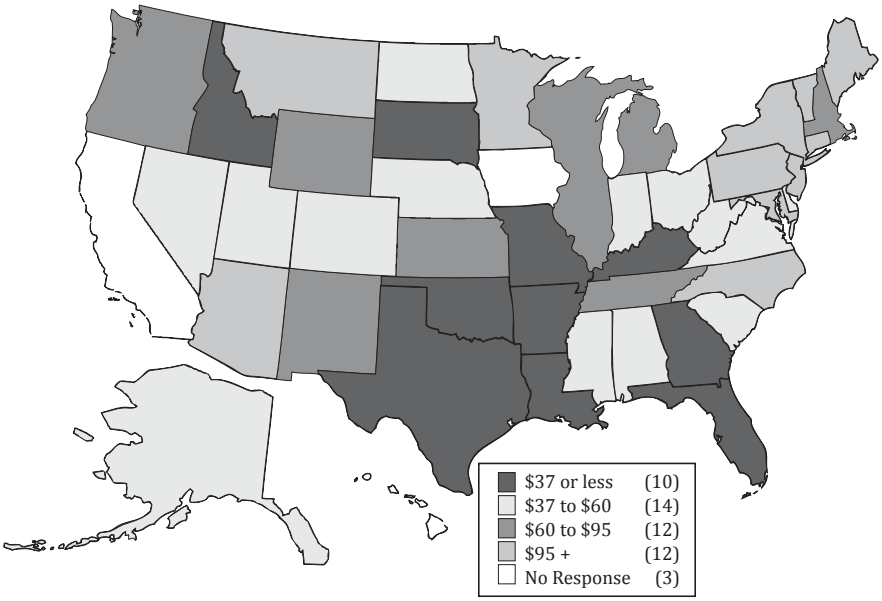


Table 10: SMHA Mental Health Actual Dollar and per Capita Expenditures for Mental Health Services, FY 2007

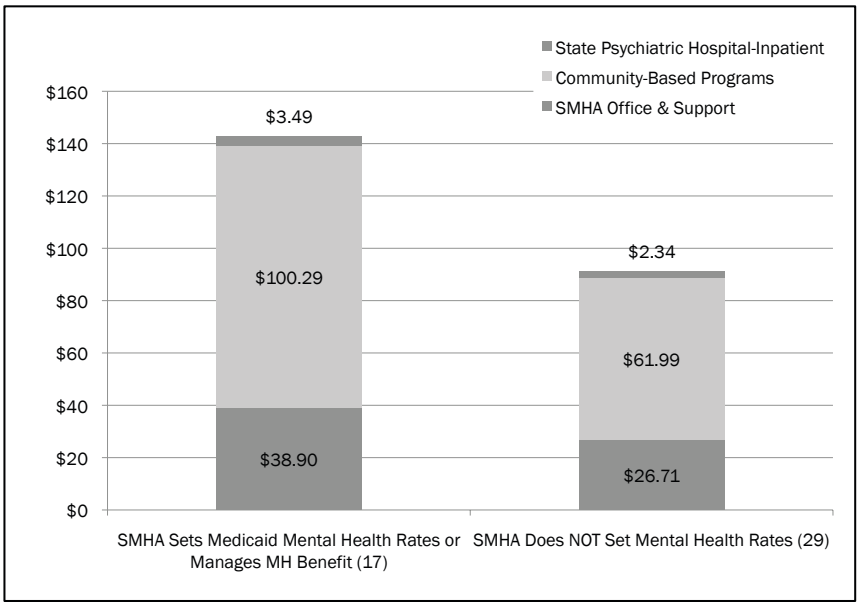
State	Total SMHA Expenditure	Rank	Per Capita	Rank
Alabama	$341,500,000	26	$74.03	35
Alaska (a)	$54,674,100	46	$82.68	29
Arizona	$1,001,000,000	7	$158.07	9
Arkansas (a)	$112,168,901	41	$39.72	47
California	NR	NA	NA	NA
Colorado	$367,725,381	24	$76.33	34
Connecticut (ac)	$609,200,000	16	$174.94	8
Delaware (ac)	$90,734,990	43	$105.75	20
District of Columbia	$229,460,700	31	$392.27	1
Florida	$722,660,669	13	$39.87	46
Georgia	$448,100,581	22	$47.33	45
Hawaii	NR	NA	NA	NA
Idaho	$71,445,200	44	$47.91	44
Illinois	$1,088,000,000	5	$85.06	28
Indiana	$552,795,797	19	$87.30	26
Iowa	NR	NA	NA	NA
Kansas	$258,600,000	29	$93.62	25
Kentucky	$230,375,700	30	$54.69	42
Louisiana	$271,174,502	28	$62.27	41
Maine (b)	$451,276,446	21	$343.99	2
Maryland (b)	$858,300,000	8	$153.55	10
Massachusetts (c)	$753,900,000	12	$116.68	15
Michigan (b)	$1,065,100,000	6	$106.03	19
Minnesota	$773,230,649	11	$149.30	11
Mississippi (b)	$351,900,000	25	$121.12	14
Missouri	$451,811,399	20	$77.13	33
Montana	$138,922,254	37	$145.79	12
Nebraska (b)	$116,195,823	40	$65.93	38
Nevada	$200,827,178	32	$78.92	31
New Hampshire	$170,821,602	36	$130.30	13
New Jersey	$1,632,732,876	4	$188.91	7

Table 10: SMHA Mental Health Actual Dollar and per Capita Expenditures for Mental Health Services, FY 2007 (Continued)

State	Total SMHA Expenditure	Rank	Per Capita	Rank
New Mexico	$190,691,833	33	$97.61	24
New York (b)	$4,319,400,000	1	$222.58	4
North Carolina	$1,724,657,723	3	$192.49	6
North Dakota	$50,233,726	48	$79.66	30
Ohio	$839,001,760	9	$73.16	37
Oklahoma	$190,000,000	34	$53.02	43
Oregon	$430,600,000	23	$115.39	16
Pennsylvania (b)	$3,222,447,834	2	$259.65	3
Rhode Island (c)	$111,718,238	42	$106.47	17
South Carolina	$284,000,000	27	$65.07	39
South Dakota	$61,310,070	45	$77.34	32
Tennessee	$598,200,000	17	$97.62	23
Texas (b)	$817,100,000	10	$34.43	48
Utah (b)	$172,848,897	35	$64.93	40
Vermont	$132,600,000	39	$213.82	5
Virginia (b)	$647,800,000	15	$85.47	27
Washington	$681,400,000	14	$106.29	18
West Virginia (b)	$133,200,000	38	$73.66	36
Wisconsin	$585,806,971	18	$104.69	21
Wyoming (a)	$51,750,807	47	$99.55	22
Total	**$28,659,402,607**		**$110.36**	
Average (Mean)	**$561,949,071**		**$115.05**	
Median	**$341,500,000**		**$95.62**	
Number of States Reporting	**48**		**48**	

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 = not applicable.
NR = not reported.

Figure 8: SMHA-Controlled per Capita Expenditures for Mental Health, by SMHA Responsibility for Setting Medicaid Rates, FY 2007



The 16 SMHAs that are responsible for setting some of the Medicaid rates for mental health services averaged $143.26 in per capita expenditures, whereas the 29 SMHAs that are not responsible for setting Medicaid rates averaged $91.18. The states where the SMHA is involved in setting Medicaid rates for mental health services reported much greater SMHA-controlled revenues from Medicaid (on average, 56 percent of SMHA revenues were from Medicaid) than states that are not involved in setting Medicaid rates (on average, 41 percent of revenues were from Medicaid). Arkansas reported no Medicaid revenues as part of their community mental health system and averaged per capita expenditures of only $43.52, less than half of the U.S. average. In Arkansas, Medicaid revenues go directly to local community mental health providers without any "control" by the SMHA and are not included in the SMHA reports of their expenditures and funding sources.

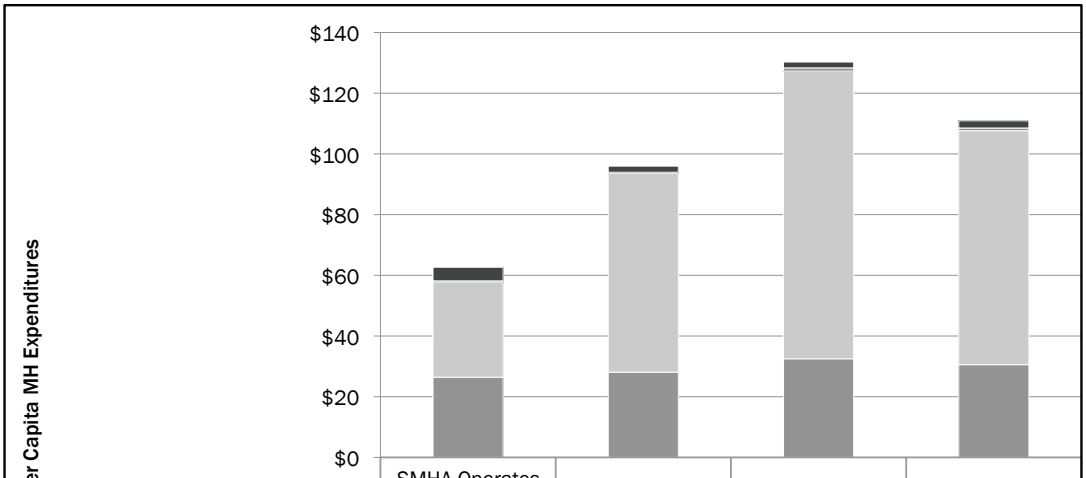
SMHAs organize and fund community mental health services using several methods. The three primary methods used are (1) SMHAs directly operate community mental health services with state employees, (2) SMHAs fund county/city governments or boards to organize and deliver community mental health services, and (3) SMHAs directly contract with community mental health providers, which are typically not-for-profit organizations. SMHAs that directly operate community mental health services reported the lowest level of SMHA expenditures. States that directly operate their community mental health services also tend to rely more heavily on state general fund dollars and less on Medicaid and other reimbursements for services than states where the community mental health providers are private not-for-profits or county based. The SMHAs that operate community services also have the highest reported average administration costs. The SMHAs may have such high administration costs because they have to directly pay for the administration and personnel expenses of state-operated community providers. Such providers are included in the services expenditures in states that do not directly operate community providers. SMHAs that organize their community mental health systems by primarily funding city/county governments to provide services have the highest per capita expenditures for community mental health and for state psychiatric hospitals. The majority of SMHAs directly funded providers and averaged the second highest expenditures for both state hospitals and community mental health programs, but these SMHAs had administrative expenses higher than those of county-based systems (see figure 9).

2.10.1 Major Funding Sources, FY 2007

In FY 2007, 63 percent of SMHA-controlled revenues came from state government sources. The largest share of state funds was the state general revenue funds (40 percent), the state Medicaid match (20 percent), and other special funds such as special funding sources dedicated to mental health, or interdepartmental funds received by the SMHA from other state government agency or entity via fund transfer, contract, or memorandum of agreement (3 percent).

The federal government (33 percent) was the second largest source of funding. The federal share of Medicaid (28 percent) was the largest single federal source, followed by Medicare (2 percent), the Community Mental Health Services Block Grant (1 percent), and other federal funds (2 percent). Local county and city government contributed 2 percent. Cities and counties, in some states, spend their own tax dollars to provide mental health services that are not counted as part of the SMHA-controlled system. SMHAs also received 2 percent of revenues from other sources that include private health insurance reimbursement and consumer copays, as well as donations and all other funding sources. Total Medicaid expenditures, combining the state and federal shares, totaled $13.9 billion and were the largest single funding source (48 percent) for the SMHAs. See figure 10 for a breakdown of total revenues, by funding sources, and table 11.

Figure 9: SMHA-Controlled per Capita Expenditures for Mental Health, by Primary Method Used To Fund Community Services, FY 2007



	SMHA Operates Community Providers (6 states)	SMHA Directly Funds Providers (29 states)	SMHA Funds City/Country (14 states)	All SMHAs
Administration	$4.47	$2.01	$1.93	$2.37
Prevention, Research & Training	$0.45	$0.34	$1.08	$0.89
Community-Based	$31.29	$65.52	$94.77	$77.09
State Psychiatric Hospital-Inpatient	$26.44	$28.10	$32.50	$30.56

Figure 10: Percentage of SMHA-Controlled Revenues for Mental Health Services, by Funding Sources, FY 2007

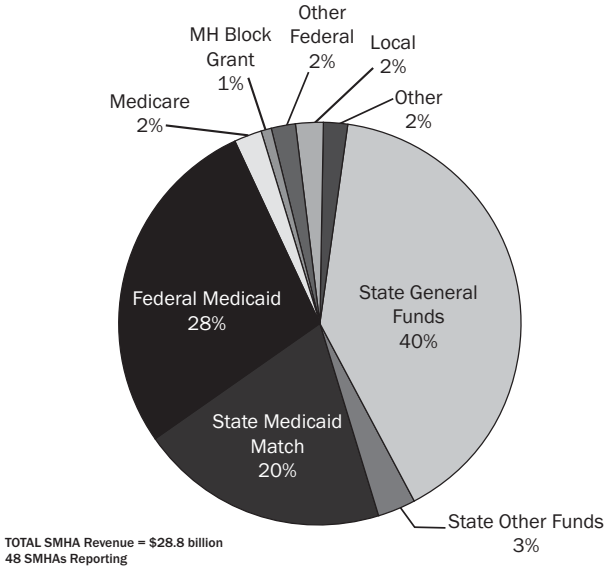


Table 11: SMHA-Controlled Mental Health Revenues, by Funding Sources and State, FY 2007 (in millions)

State	State General Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Alabama	$186.9	54%	$129.9	38%	$12.6	4%	$6.2	2%	$1.9	1%	$0.0	0%	$0.0	0%	$8.2	2%	$345.7
Alaska (a)	$31.8	58%	$18.0	33%	$1.3	2%	$0.5	1%	$1.7	3%	$0.0	0%	$1.3	2%	$0.0	0%	$54.7
Arizona	$160.7	16%	$796.7	79%	$0.4	0%	$8.0	1%	$4.6	0%	$0.0	0%	$42.3	4%	$0.1	0%	$1,012.8
Arkansas (a)	$69.1	62%	$28.9	26%	$2.2	2%	$3.8	3%	$2.9	3%	$0.0	0%	$4.0	4%	$1.3	1%	$112.2
California	NR		NR		NR		NR		NR		NR		NR		NR		NR
Colorado	$116.6	32%	$231.1	63%	$8.7	2%	$5.8	2%	$1.1	0%	$1.0	0%	$3.0	1%	$0.3	0%	$367.7
Connecticut (ac)	$585.9	92%	$17.0	3%	$8.3	1%	$3.9	1%	$13.5	2%	$0.0	0%	$2.3	0%	$5.9	1%	$636.8
Delaware (ac)	$73.0	78%	$14.8	16%	$0.7	1%	$0.7	1%	$2.9	3%	$0.0	0%	$1.0	1%	$0.0	0%	$93.1
District of Columbia	$180.4	78%	$40.5	18%	$1.5	1%	$0.8	0%	$7.0	3%	$0.0	0%	$0.0	0%	$0.0	0%	$230.3
Florida	$535.3	74%	$125.5	17%	$0.0	0%	$25.0	3%	$36.9	5%	$0.0	0%	$0.0	0%	$0.0	0%	$722.7
Georgia	$398.2	89%	NA		$9.1	2%	$19.3	4%	$5.1	1%	$0.0	0%	$0.5	0%	$15.9	4%	$448.1
Hawaii	NR		NR		NR		NR		NR		NR		NR		NR		NR
Idaho	$47.4	66%	$10.6	15%	$2.3	3%	$1.5	2%	$8.6	12%	$0.0	0%	$0.9	1%	$0.2	0%	$71.4
Illinois	$607.7	56%	$444.3	41%	$10.5	1%	$16.2	1%	$7.1	1%	$0.0	0%	$2.2	0%	$0.0	0%	$1,088.0
Indiana	$177.2	32%	$352.5	64%	$6.5	1%	$8.1	1%	$6.9	1%	$0.0	0%	$0.9	0%	$0.7	0%	$552.8
Iowa	NR		NR		NR		NR		NR		NR		NR		NR		NR
Kansas	$119.4	46%	$136.3	53%	$0.0	0%	$2.7	1%	$0.2	0%	$0.0	0%	$0.0	0%	$0.0	0%	$258.6
Kentucky	$139.5	61%	$66.3	29%	$12.0	5%	$5.7	2%	$3.1	1%	$0.0	0%	$3.8	2%	$0.0	0%	$230.4
Louisiana	$106.0	39%	$96.9	36%	$0.2	0%	$4.5	2%	$41.2	15%	$0.0	0%	$0.0	0%	$22.4	8%	$271.2
Maine (b)	$52.7	12%	$394.9	88%	$0.0	0%	$1.7	0%	$2.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$451.3
Maryland (b)	$581.3	68%	$263.9	31%	$0.0	0%	$7.4	1%	$5.7	1%	$0.0	0%	$0.0	0%	$0.0	0%	$858.3
Massachusetts (c)	$740.9	83%	$128.7	14%	$8.0	1%	$8.4	1%	$4.5	1%	$0.0	0%	$1.0	0%	$4.9	1%	$896.4
Michigan (b)	$361.5	34%	$667.8	63%	$1.3	0%	$9.7	1%	$0.9	0%	$21.8	2%	$2.1	0%	$0.0	0%	$1,065.1
Minnesota	$346.9	45%	$339.2	44%	$5.3	1%	$6.4	1%	$19.4	3%	$27.9	4%	$19.1	2%	$9.0	1%	$773.2
Mississippi (b)	$154.7	44%	$169.7	48%	$7.1	2%	$4.1	1%	$3.8	1%	$0.0	0%	$0.7	0%	$11.8	3%	$351.9
Missouri	$313.4	51%	$260.7	43%	$14.3	2%	$7.0	1%	$13.4	2%	$0.0	0%	$2.8	0%	$0.4	0%	$611.9
Montana	$43.0	31%	$92.3	66%	$0.0	0%	$1.2	1%	$2.4	2%	$0.0	0%	$0.0	0%	$0.0	0%	$138.9
Nebraska (b)	$83.1	72%	$16.9	15%	$0.7	NA	$1.9	2%	$3.5	3%	$0.0	0%	$5.7	5%	$4.4	4%	$116.2
Nevada	$146.6	73%	$27.9	14%	$9.0	4%	$1.5	1%	$8.9	4%	$0.0	0%	$1.0	0%	$5.9	3%	$200.8
New Hampshire	$10.7	6%	$137.3	80%	$10.9	6%	$1.5	1%	$4.9	3%	$0.0	0%	$0.0	0%	$5.5	3%	$170.8
New Jersey	$957.2	59%	$454.2	28%	$56.7	3%	$15.5	1%	$6.3	0%	$71.7	4%	$41.5	3%	$29.7	2%	$1,632.7
New Mexico	$68.0	36%	$117.7	62%	$0.3	0%	$2.0	1%	$0.5	0%	$0.0	0%	$0.4	0%	$1.8	1%	$190.7
New York (b)	$1,074.4	26%	$2,454.1	59%	$230.8	6%	$28.3	1%	$77.1	2%	$70.4	2%	$207.0	5%	$0.0	0%	$4,142.1
North Carolina	$334.2	19%	$1,258.5	73%	$29.1	2%	$9.7	1%	$1.9	0%	$70.9	4%	$9.1	1%	$11.3	1%	$1,724.7
North Dakota	$28.1	56%	$9.7	19%	$1.7	3%	$1.2	2%	$4.0	8%	$0.0	0%	$1.5	3%	$4.1	8%	$50.2
Ohio	$482.5	55%	$343.6	39%	$15.1	2%	$15.1	2%	$16.3	2%	$0.0	0%	$1.6	0%	$0.0	0%	$874.2

Table 11: SMHA-Controlled Mental Health Revenues, by Funding Sources and State, FY 2007 (in millions) (Continued)

State	State General Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Oklahoma	$147.2	77%	$24.0	13%	$4.4	2%	$5.4	3%	$4.2	2%	$0.0	0%	$1.4	1%	$3.4	2%	$190.0
Oregon	$140.2	33%	$276.0	64%	$0.0	0%	$4.1	1%	$1.4	0%	$0.0	NA	$0.0	0%	$0.0	0%	$430.6
Pennsylvania (b)	$938.0	29%	$2,000.8	62%	$23.7	1%	$14.6	0%	$213.8	7%	$20.1	1%	$11.4	0%	$0.0	0%	$3,222.4
Rhode Island (c)	$14.1	13%	$95.6	86%	$0.0	0%	$1.1	1%	$0.8	1%	$0.0	0%	$0.0	0%	$0.0	0%	$111.7
South Carolina	$125.1	44%	$126.8	44%	$0.5	0%	$5.6	2%	$9.8	3%	$3.2	1%	$14.6	5%	$1.7	1%	$287.3
South Dakota	$33.6	56%	$21.1	35%	$2.7	4%	$1.0	2%	$1.3	2%	$0.0	0%	$0.0	0%	$0.6	1%	$60.3
Tennessee	$155.3	26%	$414.8	69%	$10.5	2%	$8.0	1%	$3.7	1%	$0.0	0%	$3.0	1%	$2.9	0%	$598.2
Texas (b)	$537.4	66%	$160.8	20%	$22.5	3%	$30.9	4%	$30.4	4%	$21.0	3%	$14.1	2%	$0.0	0%	$817.1
Utah (b)	$38.5	22%	$116.8	68%	$1.2	1%	$2.8	2%	$2.1	1%	$9.8	6%	$0.0	0%	$1.6	1%	$172.8
Vermont	$20.4	15%	$109.2	82%	$0.1	0%	$0.8	1%	$1.9	1%	$0.0	0%	$0.0	0%	$0.2	0%	$132.6
Virginia (b)	$399.8	62%	$207.6	32%	$18.3	3%	$10.0	2%	$0.0	0%	$0.0	0%	$10.0	2%	$3.0	0%	$648.7
Washington	$184.9	27%	$457.3	67%	$14.9	2%	$7.6	1%	$3.1	0%	$0.0	0%	$8.9	1%	$4.9	1%	$681.6
West Virginia (b)	$53.5	42%	$66.5	52%	$3.4	3%	$2.3	2%	$0.6	0%	$0.0	0%	$0.9	1%	$0.0	0%	$127.2
Wisconsin	$269.2	46%	$154.3	26%	$7.2	1%	$7.5	1%	$9.6	2%	$126.6	22%	$11.4	2%	$0.0	0%	$585.8
Wyoming (a)	$55.6	85%	$8.2	12%	$0.0	0%	$0.4	1%	$1.2	2%	$0.0	0%	$0.0	0%	$0.0	0%	$65.4
Total	**$12,427.3**	**43%**	**$13,886.0**	**48%**	**$575.8**	**2.0%**	**$337.7**	**1.2%**	**$604.0**	**2.1%**	**$444.4**	**1.5%**	**$431.2**	**1.5%**	**$162.3**	**0.6%**	**$28,878**
Average (Mean)	**$243.7**		**$277.7**		**$11.3**		**$6.6**		**$11.8**		**$8.7**		**$8.5**		**$3.2**		**$566**
Median	**$146.6**		**$127.8**		**$2.7**		**$4.5**		**$3.7**		**$0.0**		**$1.0**		**$0.2**		**$346**

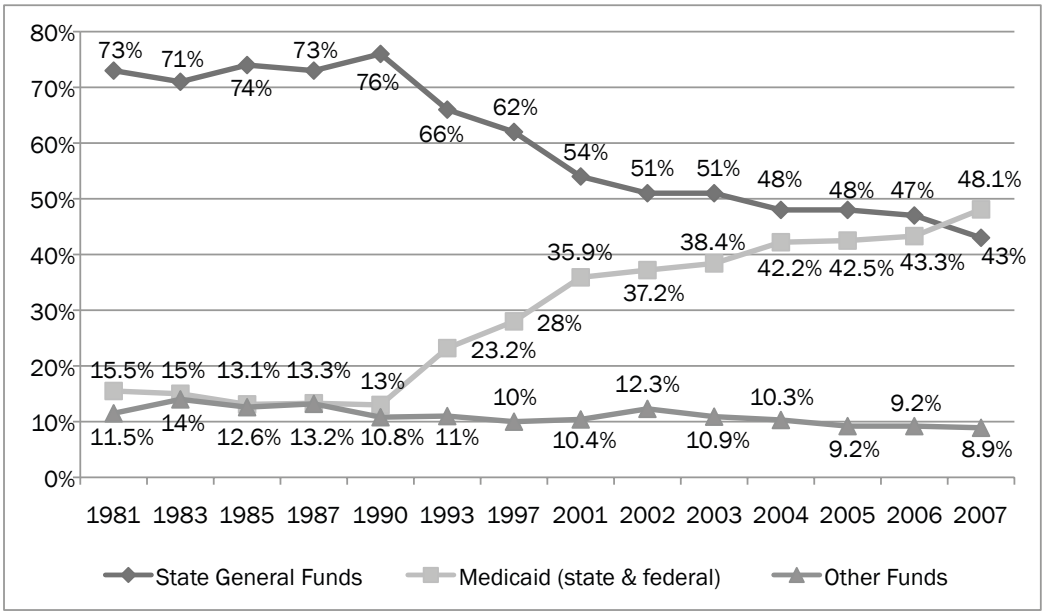
a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.
c = Children's mental health services are not included in SMHA-controlled expenditures.
NA = Services provided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

2.10.2 Trends in Financing of Mental Health Services Over Time

The funding sources that SMHAs rely on to pay for their mental health systems have shifted over time. In FY 2007, for the first time, Medicaid funding became the largest single source of funding, replacing state general revenue funds. Traditionally, state government tax dollars appropriated to the SMHA as general or special funds were the largest funding source. In FY 1981, over 73 percent of funding came from state general funds, and as recently as FY 2003, state general funds represented half (51 percent) of SMHA revenues. Medicaid, on the other hand, has grown from representing only 16 percent of SMHA funding in 1981 to 48 percent in FY 2007 (see figure 11). Most of the increase in Medicaid occurred after 1990, when states began using the rehabilitation services and targeted case management Medicaid options to expand community mental health services.

Although state general funds have dropped as a share of SMHA revenues, the actual amount of state general fund dollars have increased over the last 26 years. As figure 12 shows, state general funds grew from $4 billion in FY 1981 to $12.4 billion in FY 2007, an annual average increase of 4.4 percent per year. Medicaid, however, has increased at a much faster rate, an annual average rate of 11.6 percent, from $0.9 billion in FY 1981 to $13.9 billion in FY 2007.

Figure 11: Percentage of SMHA-Controlled Revenues From Major Funding Sources, FY 1981 to FY 2007



During the 1980s, 79 percent of new funds for SMHAs came from state general funds, whereas Medicaid accounted for only 10 percent of new funds and other federal funds (including the MHBG) accounted for 9 percent. During the 1990s and the first 7 years of the 2000s, most of the funding increases were from Medicaid. During the 1990s, Medicaid was 64 percent of the increased funding, whereas state general funds were 26 percent. From FY 2001 to FY 2007, the trend accelerated with Medicaid accounting for 75 percent of increased funding, whereas state general funds were 20 percent. All other funds provided only about 3 percent of increased funding from FY 1981 to FY 2007 (see figure 13).

Figure 12: SMHA-Controlled Revenues for Mental Health Services, FY 1981 to FY 2007

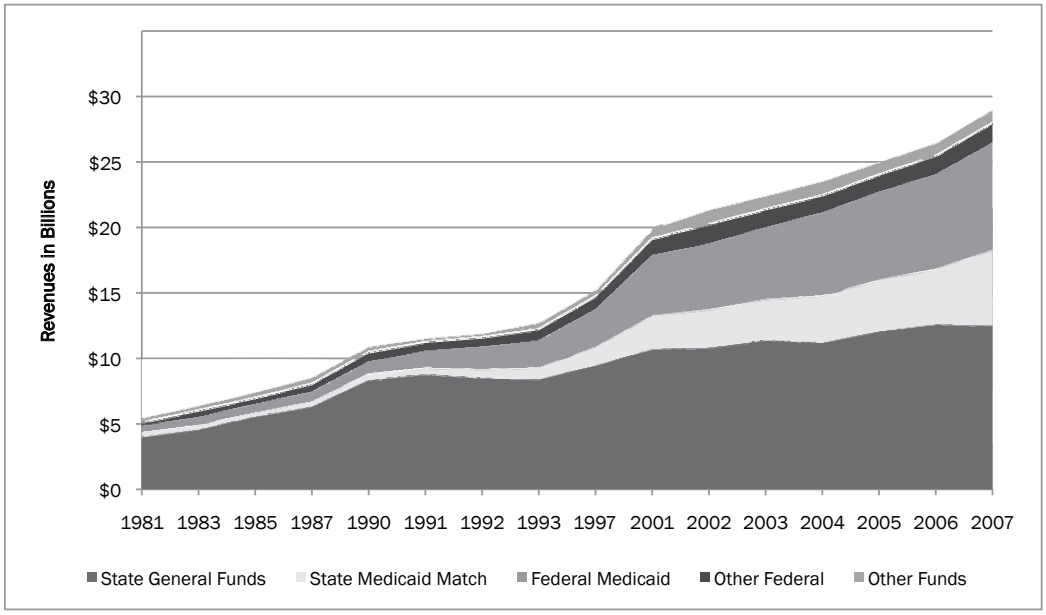
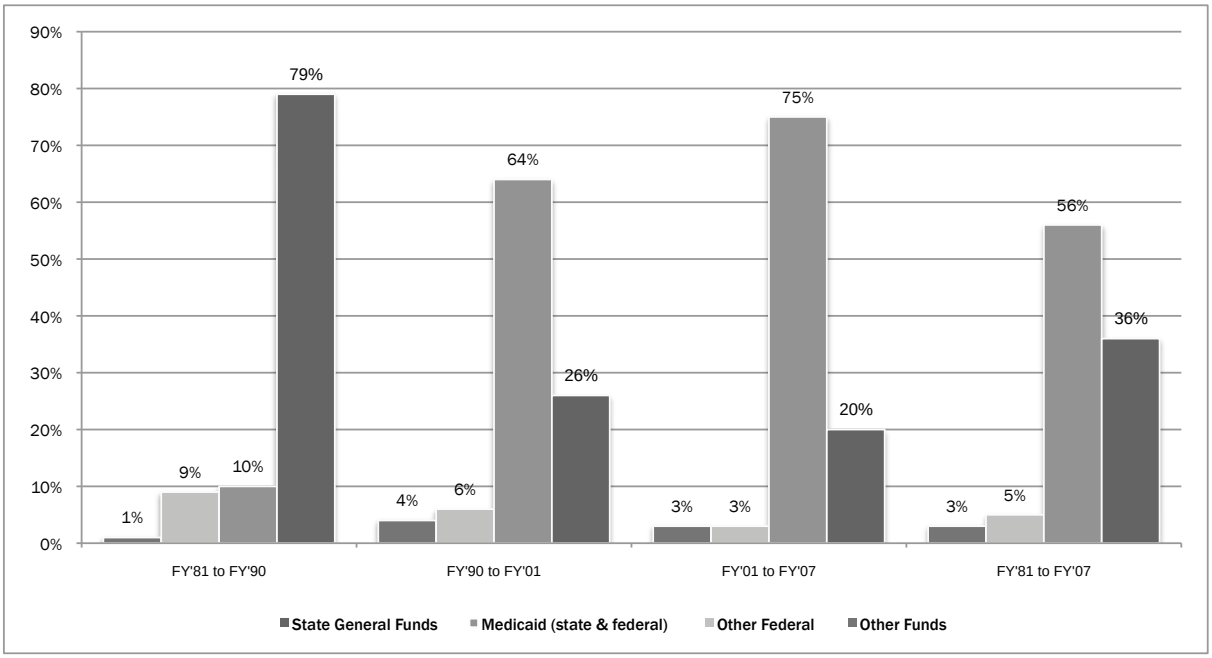


Figure 13: Percentage of New SMHA-Controlled Revenues, by Major Funding Sources, FY 1981 to FY 2007

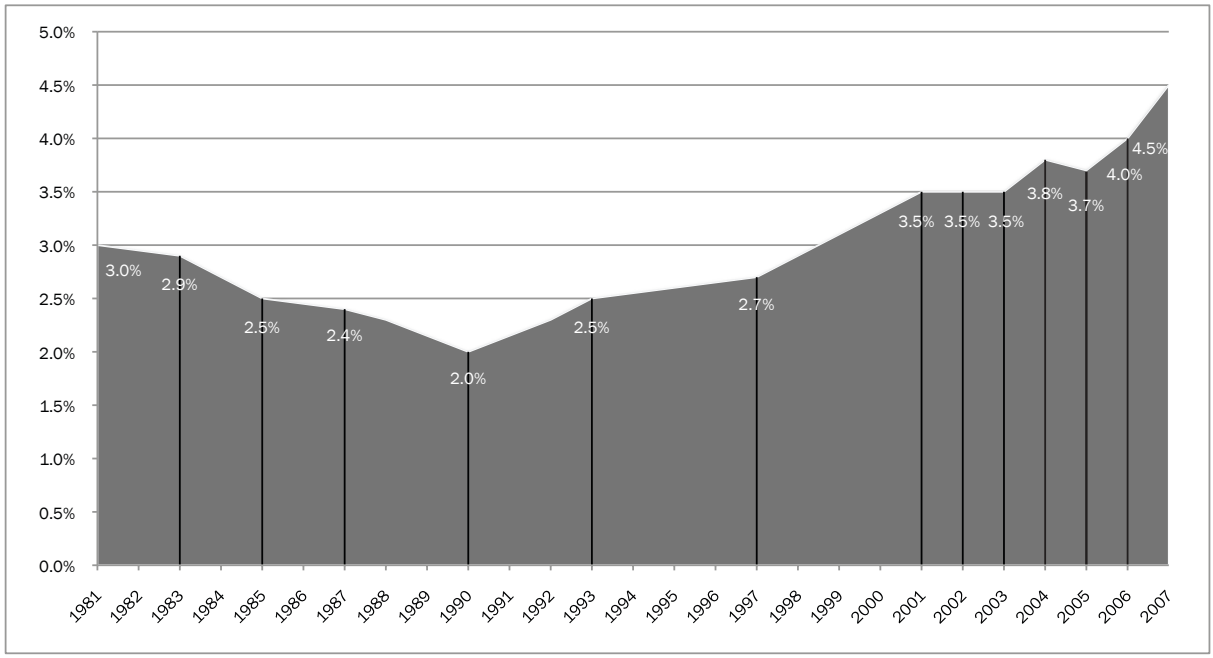


The growth in Medicaid revenues has mostly been due to an increased use of Medicaid to pay for community mental health services. From FY 1981 to FY 2007, Medicaid funding for the community mental health system increased by 24 percent per year. Meanwhile, state general funds for community mental health increased 5.8 percent per year. All other funds for community mental health increased 7 percent per year.

2.10.3 Medicaid

Since 1990, Medicaid revenues devoted to the provision of SMHA services have grown faster than the overall growth rate of Medicaid. State government total Medicaid expenditures have grown at an annual rate of 8.9 percent per year since FY 1981 (National Association of State Budget Officers, 2008). During this same time period, SMHA-controlled Medicaid revenues for mental health services increased at an annual rate of 10.8 percent per year. As a result of the increases in Medicaid funding going into SMHA systems, Medicaid devoted to SMHA services as a share of total Medicaid has grown from 2 percent of all Medicaid spending in FY 1990 to 4.5 percent in FY 2007 (see figure 14).

Figure 14: SMHA-Controlled Medicaid Funds as a Percentage of Total State Medicaid Spending, FY 1981 to FY 2007



2.10.4 SMHA Mental Health Expenditures Over Time

From 2001 to 2007, SMHA expenditures increased at an average annual rate of 6.5 percent, from $23 billion in 2001 to an estimated $33.5 billion in 2007. When the constant inflation-adjusted dollars are looked at (using the Medicaid component of the Consumer Price Index for each fiscal year), SMHA expenditures increased by only 2.1 percent per year (see figure 15). When adjusted for the growth in population and inflation, SMHA-controlled expenditures increased only 1.1 percent per year. Not all SMHAs experienced equal growth in expenditures. From FY 2001 to 2007, 47 SMHAs increased expenditures, whereas 1 state (South Carolina) experienced a decline. When expenditures are adjusted for inflation, 28 SMHAs experienced a growth in expenditures from 2001 and 20 SMHAs experienced a decline in total expenditures (see table 12).

Figure 15: Trends in SMHA-Controlled Mental Health Spending, FY 1981 to FY 2007

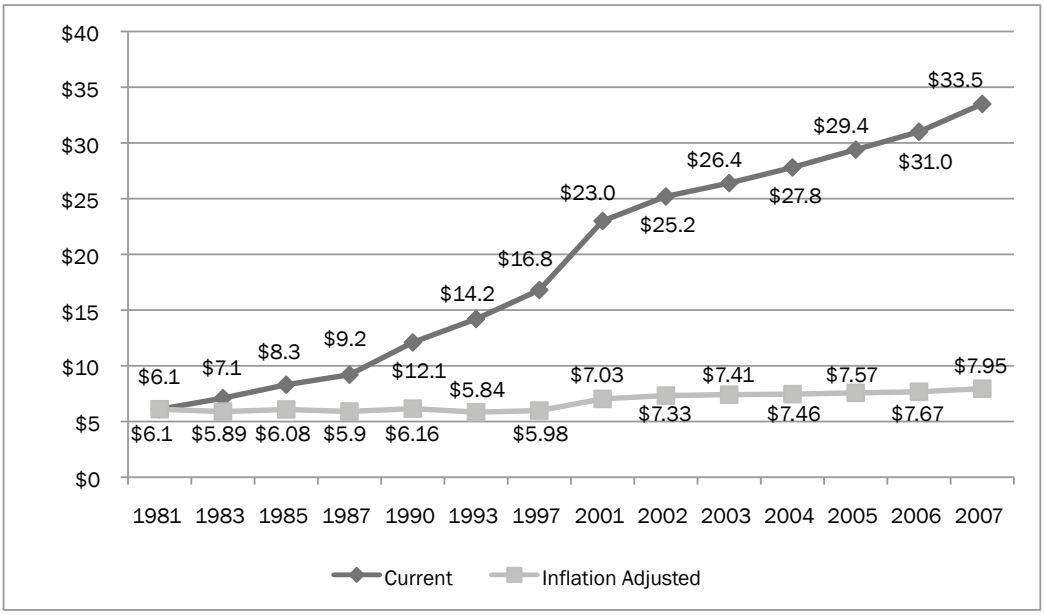


Table 12: Total SMHA-Controlled Expenditures, in Current and Constant Inflation-Adjusted Dollars, FY 2001 to FY 2007 (in millions)

State	Total SMHA Controlled Mental Health Expenditures (in millions)						Average Annual Change			
	Current Expenditures			Constant Inflation Adjusted 2001 Expenditures			Current Dollars		Constant Dollars	
	FY'01	FY'06	FY'07	FY'01	FY'06	FY'07	FY 06 to '07	FY 01 to '07	FY 06 to '07	FY 01 to '07
Alabama	$253.3	$294.9	$341.5	$253.3	$238.8	$264.9	15.8%	5.1%	10.9%	0.8%
Alaska (a)	$51.4	$183.5	$54.7	$51.4	$148.6	$42.4	-70.2%	1.0%	-71.5%	-3.2%
Arizona	$472.3	$963.3	$1,001.0	$472.3	$780.0	$776.5	3.9%	13.3%	-0.5%	8.6%
Arkansas (a)	$75.7	$108.1	$112.2	$75.7	$87.5	$87.0	3.7%	6.8%	-0.6%	2.3%
California	3,147.8	4,439.6	NR	3,147.8	3,594.9	NR				
Colorado	$282.6	$339.9	$367.7	$282.6	$275.3	$285.2	8.2%	4.5%	3.6%	0.2%
Connecticut (ac)	$439.5	$591.6	$609.2	$439.5	$479.0	$472.6	3.0%	5.6%	-1.4%	1.2%
Delaware (ac)	$73.5	$88.0	$90.7	$73.5	$71.3	$70.4	3.1%	3.6%	-1.2%	-0.7%
District of Columbia	$226.6	$229.5	$229.5	$226.6	$185.9	$178.0	0.0%	0.2%	-4.2%	-3.9%
Florida	$578.3	$686.6	$722.7	$578.3	$555.9	$560.6	5.3%	3.8%	0.8%	-0.5%
Georgia	$380.6	$565.0	$448.1	$380.6	$457.5	$347.6	-20.7%	2.8%	-24.0%	-1.5%
Hawaii	213.64	167.9	NR	213.6	136	NR				
Idaho	$60.5	$67.0	$71.4	$60.5	$54.3	$55.4	6.6%	2.8%	2.1%	-1.5%
Illinois	$789.9	$1,052.4	$1,088.0	$789.9	$852.2	$844.0	3.4%	5.5%	-1.0%	1.1%
Indiana	$411.9	$556.0	$552.8	$411.9	$450.2	$428.8	-0.6%	5.0%	-4.8%	0.7%
Iowa	152.37	299.36	NR	152.4	242.4	NR				
Kansas	$161.8	$248.7	$258.6	$161.8	$201.4	$200.6	4.0%	8.1%	-0.4%	3.6%
Kentucky	$196.9	$206.7	$230.4	$196.9	$167.4	$178.7	11.4%	2.6%	6.8%	-1.6%
Louisiana	$200.9	$257.3	$271.2	$200.9	$208.3	$210.3	5.4%	5.1%	1.0%	0.8%
Maine (b)*	$137.5	$463.8	$451.3	$137.5	$375.6	$350.1	-2.7%	21.9%	-6.8%	16.9%
Maryland (b)	$677.8	$810.0	$858.3	$677.8	$655.9	$665.8	6.0%	4.0%	1.5%	-0.3%
Massachusetts (c)	$682.2	$717.2	$753.9	$682.2	$580.7	$584.8	5.1%	1.7%	0.7%	-2.5%
Michigan (b)	$844.4	$1,010.0	$1,065.1	$844.4	$817.8	$826.2	5.5%	3.9%	1.0%	-0.4%
Minnesota	$518.0	$721.0	$773.2	$518.0	$583.9	$599.8	7.2%	6.9%	2.7%	2.5%
Mississippi (b)	$246.8	$317.5	$351.9	$246.8	$257.1	$273.0	10.8%	6.1%	6.2%	1.7%
Missouri	$336.2	$436.5	$451.8	$336.2	$353.4	$350.5	3.5%	5.0%	-0.8%	0.7%

Table 12: Total SMHA-Controlled Expenditures, in Current and Constant Inflation-Adjusted Dollars, FY 2001 to FY 2007 (in millions) (Continued)

State	Total SMHA Controlled Mental Health Expenditures (in millions)						Average Annual Change			
	Current Expenditures			Constant Inflation Adjusted 2001 Expenditures			Current Dollars		Constant Dollars	
	FY'01	FY'06	FY'07	FY'01	FY'06	FY'07	FY 06 to '07	FY 01 to '07	FY 06 to '07	FY 01 to '07
Montana	$111.7	$137.6	$138.9	$111.7	$111.4	$107.8	0.9%	3.7%	-3.3%	-0.6%
Nebraska (b)	$86.6	$108.6	$116.2	$86.6	$88.0	$90.1	7.0%	5.0%	2.5%	0.7%
Nevada	$120.2	$150.9	$200.8	$120.2	$122.2	$155.8	33.0%	8.9%	27.5%	4.4%
New Hampshire	$140.5	$166.0	$170.8	$140.5	$134.5	$132.5	2.9%	3.3%	-1.5%	-1.0%
New Jersey	$763.1	$1,241.6	$1,632.7	$763.1	$1,005.4	$1,266.5	31.5%	13.5%	26.0%	8.8%
New Mexico	$59.0	$49.4	$190.7	$59.0	$40.0	$147.9	286.0%	21.6%	269.8%	16.6%
New York (b)	$3,331.7	$4,107.5	$4,319.4	$3,331.7	$3,326.0	$3,350.5	5.2%	4.4%	0.7%	0.1%
North Carolina	$442.7	$1,105.4	$1,724.7	$442.7	$895.0	$1,337.8	56.0%	25.4%	49.5%	20.2%
North Dakota	$49.9	$45.5	$50.2	$49.9	$36.8	$39.0	10.5%	0.1%	5.8%	-4.0%
Ohio	$692.3	$781.3	$839.0	$692.3	$632.7	$650.8	7.4%	3.3%	2.9%	-1.0%
Oklahoma	$136.1	$174.1	$190.0	$136.1	$141.0	$147.4	9.1%	5.7%	4.5%	1.3%
Oregon	$201.9	$432.3	$430.6	$201.9	$350.0	$334.0	-0.4%	13.5%	-4.6%	8.8%
Pennsylvania (b)	$1,859.8	$2,584.2	$3,222.4	$1,859.8	$2,092.5	$2,499.6	24.7%	9.6%	19.5%	5.1%
Rhode Island (c)	$92.5	$107.6	$111.7	$92.5	$87.1	$86.7	3.8%	3.2%	-0.6%	-1.1%
South Carolina	$299.4	$282.0	$284.0	$299.4	$228.3	$220.3	0.7%	-0.9%	-3.5%	-5.0%
South Dakota	$45.7	$57.8	$61.3	$45.7	$46.8	$47.6	6.0%	5.0%	1.6%	0.7%
Tennessee	$395.2	$533.6	$598.2	$395.2	$432.1	$464.0	12.1%	7.2%	7.4%	2.7%
Texas (b)	$797.0	$805.2	$817.1	$797.0	$652.0	$633.8	1.5%	0.4%	-2.8%	-3.7%
Utah (b)	$159.3	$150.0	$172.8	$159.3	$121.4	$134.1	15.2%	1.4%	10.4%	-2.8%
Vermont	$79.7	$122.5	$132.6	$79.7	$99.2	$102.9	8.2%	8.9%	3.7%	4.4%
Virginia (b)	$466.6	$613.4	$647.8	$466.6	$496.7	$502.5	5.6%	5.6%	1.2%	1.2%
Washington	$525.6	$625.5	$681.4	$525.6	$506.5	$528.6	8.9%	4.4%	4.4%	0.1%
West Virginia (b)	$87.1	$129.2	$133.2	$87.1	$104.6	$103.3	3.1%	7.3%	-1.2%	2.9%
Wisconsin	$405.4	$600.4	$585.8	$405.4	$486.2	$454.4	-2.4%	6.3%	-6.5%	1.9%
Wyoming (a)	$30.1	$45.1	$51.8	$30.1	$36.5	$40.1	14.7%	9.5%	9.8%	4.9%
Total **	**$19,477.6**	**$26,071.6**	**$28,659.4**	**$19,477.6**	**$21,111.1**	**$22,230.8**	**9.9%**	**6.6%**	**5.3%**	**2.2%**
Median	**$250.0**	**$328.7**	**$359.8**	**$250.0**	**$266.2**	**$279.1**	**5.4%**	**5.0%**	**1.0%**	**0.7%**
Average	**$405.8**	**$543.2**	**$597.1**	**$405.8**	**$439.8**	**$463.1**	**11.9%**	**6.3%**	**7.2%**	**1.9%**
States Reporting	**48**	**48**	**48**	**48**	**48**	**48**	**48**	**48**	**48**	**48**
States Increasing							**41**	**47**	**28**	**30**
States Decreasing							**7**	**1**	**20**	**18**

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.
*In FY 2001, Maine was using different methodology to calculate expenditures, which accounts for the large increase from FY 2001 to FY 2006.
**Total percent changes are calculated based only on a comparison between states reporting data for both years.
NR = not reported.

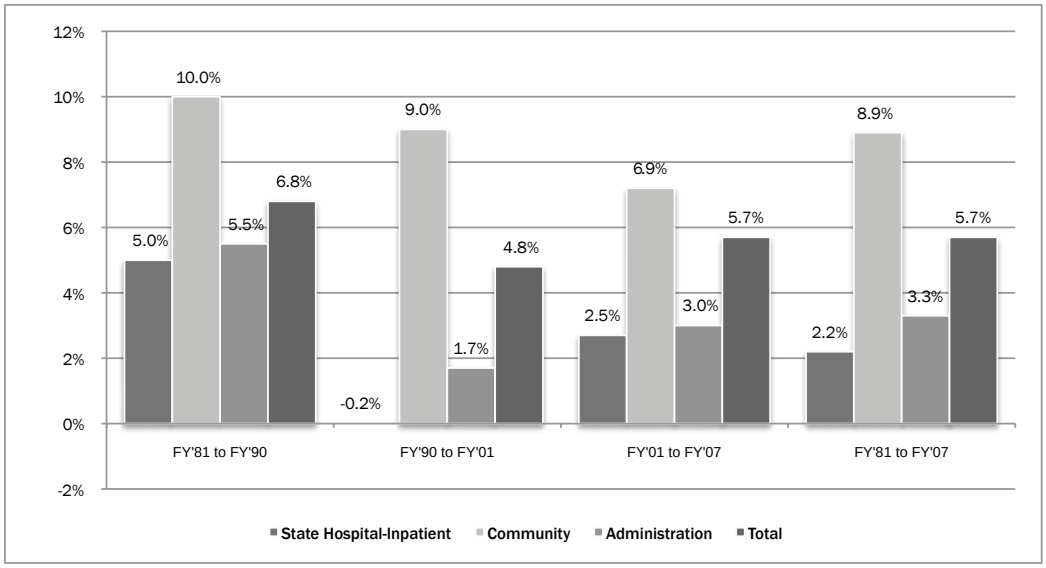
2.10.5 Trends in Community Mental Health and State Hospital Expenditures Over Time

From FY 2001 to 2007, expenditures for community mental health services increased by 6.9 percent per year, whereas state psychiatric hospital-inpatient expenditures increased by 2.5 percent per year (see figure 16). When adjusted for inflation and population growth, community mental health expenditures increased by 2.5 percent per year, whereas state psychiatric hospital-inpatient expenditures declined by 1.8 percent per year.

From FY 2001 to 2007, 45 SMHAs increased their expenditures for community mental health services, whereas 3 decreased their expenditures. Thirty-nine SMHAs increased state psychiatric hospital expenditures, whereas nine expended less in state hospitals in FY 2007 than in FY 2001. Since FY 2001, expenditures for community mental health, adjusted for inflation and population, have increased in 30 states and decreased in 18 states. Inflation- and population-adjusted expenditures for state hospitals show that more states have had a decrease in expenditures (27) than had an increase (21).

Over the 26-year time period from FY 1981 to FY 2007, SMHA-controlled expenditures increased from $6.1 billion to an estimated $33.8 billion, an increase of 449 percent (an average annual increase of 6.8 percent). When total SMHA expenditures were adjusted for medical inflation, expenditures increased by only 30.3 percent (an annualized increase of 1 percent). When adjusted for inflation and population growth, SMHA expenditures show a 1.1 percent decline.

Figure 16: Average Annual Percent Change in SMHA-Controlled Mental Health Expenditures, by Decade and Type of Program, FY 1981 to FY 2007

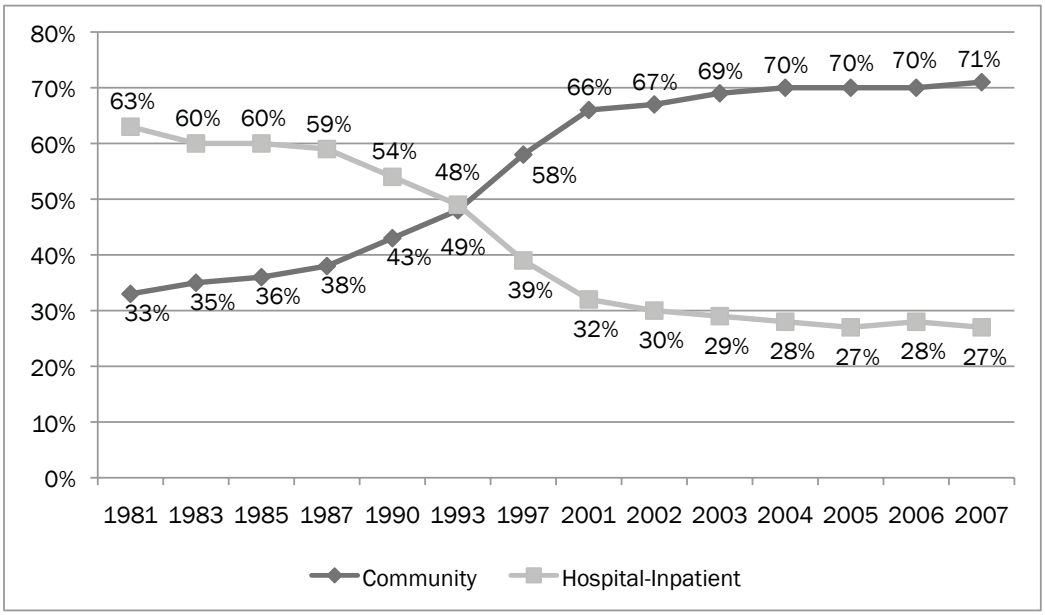


Most of the increase in SMHA expenditures has been devoted to community mental health services, which increased from $2 billion in FY 1981 to $23.9 billion in FY 2007, a tenfold increase (an average annual increase of 10 percent). When community mental health expenditures are adjusted for population growth and inflation, they increased by 114.4 percent (an average increase of 3 percent per year over the last 26 years). State psychiatric hospital expenditures for inpatient services grew at a much slower rate than those for community mental health services, increasing from $3.8 billion in FY 1981 to $8.9 billion in FY 2007, an increase of 134 percent (or an average increase of 3 percent per year). When state psychiatric hospital expenditures are adjusted for population growth and inflation, expenditures decreased by 58.4 percent (an average decrease of 3.3 percent per year).

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

SMHAs have increased their mental health expenditures for community mental health at a much faster rate than state psychiatric hospitals. This trend has resulted in a historic shift in emphasis of where SMHAs devote their resources. In FY 2007, SMHAs expended over 71 percent of their funds on community mental health services, whereas state psychiatric hospital inpatient services represented only 27 percent of SMHA resources. This is a major reversal from the 1980s, when SMHAs expended 63 percent of their funds in state psychiatric hospitals and only 33 percent for community mental health services (see figure 17).

Figure 17: SMHA Expenditures for State Psychiatric Hospital Inpatient and Community-Based Mental Health Services, FY 1981 to FY 2007



2.11 Summary

The majority of SMHAs operate as a division within a larger state umbrella agency, most often within the Department of Human Services. Most SMHA commissioners report to a cabinet secretary; however, 17 report to an independent mental health council or board. Almost all SMHAs are responsible for both state psychiatric hospital and community mental health services for both children and adults. Many SMHAs also administer other disability services, including substance abuse treatment, intellectual disability services, and brain impaired and organic brain syndrome services.

Over 6 million consumers were served by the SMHAs in 2008. Forty-eight percent of these consumers were male, whereas 51 percent were female. The majority of consumers (63 percent) were from the ages of 21 to 64, were white (63 percent), and were diagnosed with serious mental illnesses (66 percent) or serious emotional disturbances (68 percent).

In FY 2007, SMHAs expended an estimated $33.5 billion for mental health services. The majority of SMHA-controlled revenues originated from state government sources, including state general revenue funds, Medicaid matching funds, and other special funds. A third of SMHA funds came from the federal government through Medicaid, Medicare, and the MHBG. In 2007, Medicaid (federal share and state match) became the largest single source of funding, replacing state general revenue funds.

III. SMHA Policies

3.1 Eligibility for Mental Health Services

Each state determines the eligibility criteria a person must meet to receive services from the SMHA. The criteria can be inclusive or restrictive, based upon decisions made largely by each state's legislature. The differences in the eligibility criteria are reflected in subsequent data about numbers of clients, expenditures, and types of services provided. The majority (44 SMHAs for adults and 46 for children/adolescents) do not have strict eligibility requirements, meaning that either they have no eligibility requirements (11) or any adult (32) or children/adolescent (31) with a mental illness is eligible. Some SMHAs (9 for adults and 11 for children/adolescents) have strict eligibility requirements; that is, only those with serious mental illnesses or serious emotional disturbances are eligible.

3.2 Collaboration With Other State Agencies

In the last decade, there has been an increased emphasis on the connections between mental health and primary health. Of the 49 SMHAs reporting, 35 collaborate with the state health department to increase the recognition and treatment of persons with mental illnesses by primary care providers.

Fifty reporting SMHAs collaborate with other state agencies to reduce the fragmentation of services. Forty-four SMHAs have representatives from other state agencies participate as members of a mental health planning council. Planning councils in most states (32) plan for the delivery of services across state agencies, and the mental health plans of most states (32) address the health and support services provided by other agencies. SMHAs were most likely to coordinate with agencies such as substance abuse, housing, and Medicaid (see table 13).

Table 13: SMHA Collaboration With Other Agencies

Agency	Reduce Fragmentation	Coordinate Funding Streams	Coordinate Service Delivery	Determine Client Eligibility
Substance Abuse	47	36	46	23
Housing	44	38	38	24
Medicaid	44	38	38	32
Juvenile Justice	43	22	36	14
Criminal Justice	41	22	36	18
Employment	19	26	34	19
Education	39	22	33	12
Child Welfare	39	29	36	14
National Guard	29	7	20	7

3.3 Consumer- and Family-Driven Care

Nearly all reporting SMHAs (48) have some statutory or regulatory mandate for consumers or family members to participate in the planning and oversight of mental health services. Consumers and family members must serve on the boards of 46 SMHAs; must participate in policymaking (28), program evaluation and quality assurance monitoring (21), and internal review boards for research protocols (11); and must participate in licensing and credentialing providers (6).

Forty-eight SMHAs involve consumers and family members in policymaking, quality assurance, and evaluation/research activities. In most SMHAs (48), they participate in statewide and regional planning and in the SMHA's governing/advisory boards (48); in public forums (47); in local governing/advisory boards of SMHA-funded, community-based agencies (45); in focus groups (42); in developing and promulgating rules and regulations and in providing legislative testimony (41), in serving on SMHAs' advisory boards for program evaluation (39); on process action teams and quality councils (33); and in the SMHA's quality assurance activities (30). In some SMHAs, they participate in research and evaluation (22), on quality assurance monitoring teams (24), in internal review boards for research and evaluation (20), and in the SMHA's contracts for research and evaluation awarded to consumer-run organizations (15). Most SMHAs have Offices of Consumer Affairs (39), and some (16) have consumer advisors outside the agency.

Forty-five SMHAs have initiatives to ensure every consumer receives individualized, person-centered treatment plans that meet their unique needs. In most SMHAs, these treatment plans are required, by legislation, regulation, or contract. Technical assistance or training is provided in 39 SMHAs, and program monitoring and quality assurance are conducted by 22 SMHAs to promote these plans.

Mental health consumers in 32 SMHAs and family members in 28 SMHAs were involved in the selection of client outcome measures. The results of these outcome measures are made available to the public by 38 SMHAs and are published on the Web sites of 26 SMHAs. Consumer perception of care is routinely monitored by hospitals in 28 SMHAs and by community mental health providers in 44 SMHAs. Family involvement/satisfaction is regularly monitored by hospitals in 11 SMHAs and by community mental health centers in 37 SMHAs. Of the reporting SMHAs, only the Connecticut Adult Division and the SMHAs in Delaware and West Virginia do not routinely monitor family involvement/satisfaction. Twenty-seven SMHAs survey consumers to assess the extent to which services achieve the self-defined goals of service recipients; of these, 22 SMHAs make the results public, and 20 use the data to inform policy decisions.

All reporting SMHAs support consumer-operated services, expending $50.8 million to fund 551 programs. Most SMHAs (43) support consumer-operated services through direct funding, technical assistance (41), and conference sponsorship (41). Some SMHAs (22) support these services by providing office space. A few SMHAs also support these services through conference calls, funding to counties or community mental health agencies, offices of consumer relations, peer specialist programs, and employment. Consumer-run services are covered under the state's managed behavioral healthcare benefits package in nine SMHAs, and peer support programs are covered by 14 SMHAs.

3.4 Elimination of Disparities in Mental Health Services

Half the SMHAs (28) have at least one initiative to identify disparities in the provision of mental health services. Identifying disparities by age (26), race/ethnicity (26), gender (20), and other cultural groups (22) is the subject of initiatives by nearly all of these SMHAs. The SMHAs choose to address disparities by focusing on the cultural competence of the services and the accessibility of their services, especially to persons living in rural areas, and by addressing the needs of persons with needs beyond just mental health.

3.4.1 Cultural Competency

Thirty SMHAs have a cultural competence plan to address disparities in mental health services. Nearly all of these plans (28) cover the administrative components at every organizational level within the SMHAs. Over half (18) include measurable objectives, but less than half of the SMHAs with plans (15) have achieved the objectives of their plans. Objectives include increasing the SMHA's capacity to provide culturally competent services, developing improvement plans, increasing the use of data to measure the cultural competence of the services provided, convening advisory committees, and increasing the participation of minorities. Most of these plans address linguistic competence (26), including helping organizations obtain educational materials translated into a variety of languages (21), establishing standards for qualified mental health interpreters (17), assisting organizations in obtaining training materials for the use of interpreters by clinical staff (18), addressing the availability of provider and service directories in a variety of languages (15), and addressing the monitoring and updating of staff language skills (10). Most of the SMHAs with cultural competence plans have cultural competence advisory committees (24).

Some SMHAs (16) have conducted an organizational cultural competence assessment. Of these, Arizona, Colorado, Kentucky, and Massachusetts use the NASMHPD/NRI State Mental Health Agency Cultural Competence Assessment Instrument. Other SMHAs use Georgetown University's Promoting Cultural Diversity and Cultural Competency Self-Assessment Checklist, the Consolidated Culturological Assessment Toolkit from Ohio, and the National Center for Cultural Competence Assessment, or an interpretive survey group discussion.

3.4.2 Dual Diagnosis

Most SMHAs have specialized treatment units and programs for persons dually diagnosed with mental illness and substance abuse disorders (41), persons with mental retardation (24), persons with concurrent mental and medical disorders (24), and persons infected with HIV (8).

Forty-four SMHAs have initiatives to cross-train staff for dual diagnosis (mental health and substance abuse) services. Of the reporting SMHAs, Kansas, Massachusetts, Nebraska, New Hampshire, and Utah do not have any initiatives to cross-train their staff. Most initiatives include staff training, and some also create a framework for dual diagnosis services, establish task forces or stakeholder teams, hold conferences, develop Memorandums of Understanding, and integrate mental health and substance abuse service data systems.

Some SMHAs (17) also have initiatives to cross-train staff for medical comorbidity. These initiatives include staff training, the use of peer support specialists, the development of coordinated care models, and holding conferences.

3.4.3 Rural Mental Health Initiatives

Most SMHAs (42) have initiatives to increase access to mental health services in rural and geographically remote areas within their states. Of these, 26 are recruiting and training rural mental

health professionals. Initiatives include expanding coverage, increasing the use of telemedicine and technology, implementing training and rural workforce development, requiring providers to provide coverage in rural and remote areas, improving transportation to services, and developing school-based rural health initiatives. SMHAs are partnering with colleges and universities to recruit and train mental health professionals in rural areas. To accomplish this goal, they are using Web-based training; hosting recruiting events; and offering financial incentives, scholarships, and visa waivers to recruit professionals for underserved areas.

Thirty-one SMHAs provide transportation for mental health clients to ensure that they can access mental health services. Disparities in the availability of services are also being addressed by identifying service gaps, coordinating with primary care providers, increasing the awareness of the SMHA leadership regarding disparities, enhancing cultural competency, implementing workforce development, convening task forces and quality improvement councils, fostering interagency collaboration, increasing the availability and scope of services, and developing new policies.

One of the ways SMHAs can extend the reach of services to rural and frontier areas is through telemedicine, the provision of health services through a variety of technologies, such as telephone, video and Web conferencing, and other uses of the Internet.

3.5 Mental Health Screening, Assessment, and Service Referral

Most SMHAs (43) screen for the early detection of mental health problems. Children are screened by 41 SMHAs, adults by 18, and older adults by 12. SMHAs collaborate with Head Start programs, day care centers, and schools; encourage parents' involvement; work with the Department of Health and with primary healthcare providers for adults and older adults; and provide suicide prevention activities with court systems, with military and veterans organizations, and with geriatric service providers. Most SMHAs (43) work with schools to expand and improve mental health services for children. These SMHAs bill Medicaid for services, provide services directly to clients in schools, collaborate with the Department of Education, participate in workgroups, collaborate with community mental health providers, and provide training to school staff and parents.

3.5.1 Trauma

Thirty-three SMHAs work with mental health providers to screen for histories of trauma in the individuals they serve. Twenty SMHAs require, routinely provide, or make referrals for specialized trauma treatments and services. Of these SMHAs, nine compile information on the numbers of persons receiving mental health services who have a history of trauma.

3.5.2 Older Adults

Twenty-three SMHAs have specialized plans for the provision of mental health services to older adults, ages 65 and up. Most of these SMHAs (22) provide specialized training to providers regarding older adult mental health services and issues of mental illnesses. These plans include practice protocols, collaboration with universities, committees, suicide prevention activities, and enforcement of service requirements for providers. Most SMHAs (36) offer incentives to work with primary care and mental health providers to administer services to older adults with mental health problems. SMHAs help primary care and mental health service providers to recognize symptoms and to treat older adults served in community mental health settings (27), nursing homes (25), primary care settings (24), inpatient psychiatric care (24), and long-term care settings (17). To do these activities, SMHAs train, establish practice protocols for, and collaborate with other state agencies.

3.5.3 Dual Diagnosis

Most SMHAs (47) work with providers to screen for co-occurring mental health and substance abuse disorders. Of those consumers that require screening, many SMHAs (30) compile information on the numbers of persons needing co-occurring services. The early screening, assessment, and referral activities the SMHAs undertake include providing training to a variety of health and nonhealth service providers; collaborating with primary care providers, day care centers, emergency rooms, juvenile and adult corrections, veterans and military organizations, and geriatric service providers; easing access to services by streamlining paperwork; transitioning people away from nursing home care; increasing trauma and autism screening; and promoting the collaboration of mental health, substance abuse, and primary healthcare providers.

3.6 Outpatient Commitment Statutes

The mental health code of most states (37) allows outpatient civil commitments. The length of stay for civil commitments ranges from a high of 5 years in New Hampshire to a low of 21 days in Minnesota. New Jersey allows commitments of 735 days (or just over 2 years). Eight states allow commitments of 365 days, whereas 13 states allow commitments of 180 days. Alabama allows commitments of 150 days. Five states allow commitments of 90 days.

3.7 Awareness of Mental Health Issues

Most SMHAs (41) have public information initiatives to promote a better understanding of the role of mental health in overall health and/or have initiatives to raise awareness of mental illness as a public health or social issue. These initiatives are focused on children and adolescents in 29 SMHAs, adults in 30, the burden of disease in 28, the impact on employment in 29, the impact on housing in 29, and homelessness in 29. Other initiatives focus on African Americans, stigma reduction, mental health first aid, suicide prevention, recovery, and post-partum depression. Forty-one SMHAs also use their Web site to educate the public about mental health treatments, services, and the eligibility criteria to receive services; 18 of these SMHAs also have call centers. California has an ombudsman who assists individuals searching for information on services and treatments. Maine makes presentations to consumer provider organizations, advocates, and family organizations. Michigan produces a customer service handbook that is available at local providers.

3.8 Suicide Prevention

Nearly all SMHAs (46) have a plan to reduce suicide attempts or have suicide prevention activities, whereas only 3 do not. These plans and initiatives are directed at children, adolescents, adults, older adults, and veterans and military personnel. Thirty-four SMHAs also operate, fund, or participate in activities directed at individuals after a suicide attempt. For example, Tennessee has a Suicide Prevention Network that supports two self-help programs, Suicide Anonymous and Survivors of Suicide Attempts. The purpose of these programs is to provide safe environments for people to share their struggles with suicide and to develop strategies for support and healing from the devastating effects of suicidal preoccupation and behavior.

3.9 Services for Armed Forces Veterans and National Guard Members

As a result of the current conflicts in Afghanistan and Iraq, and past conflicts in Europe, Korea, and Vietnam, some individuals who have served in these conflicts and their family members experience mental health problems. These individuals often seek mental health services provided by the SMHAs, and many SMHAs (41) are addressing the need for mental health services for these individuals. SMHAs direct these initiatives toward the Active Duty military (22), veterans (40), National Guard members (37), the Reserve (33), and family members of military personnel (36). Maryland also directs such services toward those less than

honorably discharged from the military. New Jersey has initiatives directed specifically toward combat veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Many SMHAs (31) sponsor, provide, or arrange for the training of mental health professionals and providers to treat the mental health problems of returning veterans and their families. Twenty-nine SMHAs focus specifically on Post-Traumatic Stress Disorder (PTSD) and 21 on traumatic brain injuries (TBIs). Some SMHAs have provided other types of training, including Connecticut's Adult Division (benefits and services available to veterans), Indiana (addiction disorders), Maryland and South Carolina (military cultural competency), Minnesota (problem gambling), New Jersey and North Carolina (the reintegration of military families), and Pennsylvania (depression and resilience). Since 2002, many of these SMHAs (23) have provided outreach to OEF/OIF veterans and family members.

3.10 Use of Medicaid Options To Fund Mental Health Services

All reporting states have adopted at least one Medicaid option for covering mental health services. Most states (48) have adopted the Medicaid Rehabilitation Option for covering mental health services, the under age 21 psychiatric inpatient option (42), the over age 65 inpatient option (38), the targeted case management option (36), the clinic option (33), and the option for drug plans (32). Some (16) states have adopted the Medicaid buy-in option and the 1915(c) waiver for children's mental health (11). Iowa, Oregon, South Carolina, and Wisconsin have adopted the 1915(i) state plan amendment, whereas Montana and Texas have adopted the 1915(a) state plan option. Other options the states have adopted include the 1915(b) waivers, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, psychiatric residential treatment facility, general acute inpatient care, and counseling from licensed professionals.

3.11 Evidence-Based Practices

"Evidence-based practices usually refer to programs or practices that are proven to be successful through research methodology and have produced consistently positive patterns of results. Evidence-based practices or model programs that have shown the greatest levels of effectiveness are those that have established generalizability (replicated in different settings and with different populations over time) through research studies" (Waters, P., 2006, p. 1).

In order to assist states in reducing the gap that exists between services that are based on scientific research and the application of these services, the 1999 Surgeon General's report on mental health identified the steps that states needed to undertake. SAMHSA also has undertaken several major initiatives to assist SMHAs in addressing the difficulties of implementing evidence-based practices (EBPs). CMHS supported the development of six toolkits to help states, providers, clinicians, and consumers and their families implement and use EBP services for adults with SMI. Since the publication of the original six toolkits, additional toolkits for supported housing; consumer-operated services; and a variety of child, adolescent, and older adult EBPs have been under development. SMHAs, in return, have responded to the federal leadership by increasing the number and level of EBPs being provided. In 2009, every reporting SMHA implemented at least one of the EBPs in the CMHS toolkit. The majority of SMHAs (33) have implemented from 6 to 9 different EBPs in their state (see table 14).

3.11.1 Assertive Community Treatment

Assertive Community Treatment (ACT) is a "comprehensive community based model for delivering treatment, support, and rehabilitation services to individuals with severe mental illnesses" (Phillips et al., 2001, p. 771). Multiple studies have demonstrated that ACT services are effective in helping individuals with mental illnesses avoid psychiatric hospitalizations and lead productive lives in the community.

Table 14: Number of SMHAs Implementing or Planning To Implement EBPs

EBP	Promoting Implementation	Implementing Statewide	Implementing Parts of State	Piloting	Planning To Implement
Assertive Community Treatment	39	11	30	0	10
Integrated Mental Health and Substance Abuse	42	15	32	3	16
Supported Employment	40	17	26	1	16
Supported Housing	38	21	24	3	11
Consumer-Operated Services	36	13	26	3	14
Illness Self-Management	32	5	27	2	13
Family Psychoeducation	27	8	19	2	12
Medication Algorithms (Schizophrenia)	13	6	7	2	8
Medication Algorithms (Bipolar)	9	6	3	1	7
Other Adult EBPs	14	6	8	1	4
Multisystemic Therapy (Conduct Disorder)	26	2	22	4	9
Functional Family Therapy	22	5	19	0	9
School-Based Intervention	22	0	19	2	10
Other Child EBPs	23	5	12	3	11

Thirty-nine SMHAs actively promote ACT services through a variety of methods, including endorsing ACT in state plans, directly providing or funding training, providing incentives for providers to adopt ACT, and funding aspects of training or service delivery. In 30 states, ACT services are available in parts of the state, whereas in 11 states, these services are available statewide. Additionally, 10 states are currently planning to implement ACT services in either parts of the state (5 states) or statewide (5 states).

SMHAs use a variety of funding sources to pay for ACT services, including state general funds (35), Medicaid (31), the federal Community Mental Health Block Grant (17), local funds (12), and other funds (5).

3.11.2 Supported Employment

Supported employment programs are designed to help consumers gain competitive employment within the community. Such employment pays at least minimum wage; any person can apply for it, in accord with consumer choices and capabilities; and it does not require 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. These programs do not provide intermediate work experiences, such as prevocational work units, transitional employment, or sheltered workshops, but they actively facilitate job acquisition, often sending staff to accompany clients on interviews, and provide ongoing support once the client is employed.

Forty SMHAs actively promote supported employment services through a variety of methods, including endorsing supported employment programs in state plans, directly providing or funding training, providing incentives for providers to adopt supported employment, and funding aspects of training or service delivery. In 26 states, supported employment services are available in parts of the state, whereas in 17 states, they are available statewide. Additionally, 16

states are currently planning to implement supported employment services in either parts of the state (6) or statewide (10).

SMHAs use a variety of funding sources to pay for supported employment services, including state general funds (31), Medicaid (20), the federal Community Mental Health Block Grant (25), local funds (12), and other funds (10).

3.11.3 Medication Algorithms

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

3.11.3.1 Schizophrenia

Thirteen SMHAs actively promote medication algorithms for schizophrenia through a variety of methods, including endorsing the use of these algorithms in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In eight states, medication algorithms for schizophrenia are available in parts of the states, whereas in six states, they are available statewide. Additionally, eight states are currently planning to implement medication algorithms for schizophrenia in either parts of the state (one) or statewide (seven).

SMHAs use a variety of funding sources to pay for medication algorithms for schizophrenia programs, including state general funds (eight), Medicaid (seven), the federal Community Mental Health Block Grant (one), local funds (two), and other funds (one).

3.11.3.2 Bipolar Disorder

Nine SMHAs actively promote medication algorithms for bipolar disorders through a variety of methods, including endorsing the use of these algorithms in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In three states, medication algorithms for bipolar disorder are available in parts of the state, whereas in six states, they are available statewide. Additionally, seven states are currently planning to implement medication algorithms for bipolar disorders in either parts of the state (one) or statewide (six).

SMHAs use a variety of funding sources for these services, including state general funds (three), Medicaid (five), the federal Community Mental Health Block Grant (one), local funds (two), and other funds (two).

3.11.4 Family Psychoeducation

Family psychoeducation services are offered as part of an overall clinical treatment plan for individuals with mental illnesses. Such services achieve the best outcomes through the active involvement of family members in treatment and management and alleviate the difficulties of family members by supporting them in their efforts to aid the recovery of their loved ones. These services may be focused on either multiple families or single families. The core characteristics of family psychoeducation services include the provision of emotional support, education, and resources during periods of crisis, as well as the development of problem-solving skills.

Twenty-seven SMHAs actively promote family psychoeducation services through a variety of methods, including endorsing the use of such services in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 19 states, family psychoeducation

services are available in parts of the state, whereas in 8 states, they are available statewide. Additionally, 12 states are currently planning to implement family psychoeducation services in either parts of the state (6) or statewide (6).

SMHAs use a variety of funding sources for these services, including state general funds (16), Medicaid (9), the federal Community Mental Health Block Grant (11), local funds (4), and other funds (5).

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

Dual diagnosis treatments combine or integrate mental health and substance abuse interventions at the clinical encounter level. Therefore, 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. For individuals with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The goal of dual diagnosis interventions is recovery from two serious illnesses.

Forty-two SMHAs actively promote integrated mental health and substance abuse treatment services through a variety of methods, including endorsing the use of such treatment services in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 32 states, these services are available in parts of the states, whereas in 15 states, they are available statewide. Additionally, 16 states are currently planning to implement integrated mental health and substance abuse services in either parts of the state (3) or statewide (13).

SMHAs use a variety of funding sources for these services, including state general funds (33), Medicaid (26), the federal Community Mental Health Block Grant (15), local funds (10), and other funds (7).

3.11.6 Illness Self-Management

Illness self-management includes a broad range of health, lifestyle, self-assessment, and treatment behaviors by the individuals with mental illness, often with the assistance and support of others. Such individuals are then able to take care of themselves, manage symptoms, and learn ways to cope better with their illness. Self-management includes psychoeducation, behavioral tailoring, early warning sign recognition, coping strategies, social skills training, and cognitive behavioral treatment.

Thirty-two SMHAs actively promote illness self-management services through a variety of methods, including endorsing the use of such services in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 27 states, these services are available in parts of the state, whereas in 5 states, they are available statewide. Additionally, 13 states are currently planning to implement illness self-management services in either parts of the state (7) or statewide (6).

SMHAs use a variety of funding sources for these services, including state general funds (24), Medicaid (15), the federal Community Mental Health Block Grant (13), local funds (7), and other funds (3).

3.11.7 Supported Housing

Supported housing refers to services to assist individuals in finding and maintaining appropriate housing arrangements. This activity is premised upon the idea that certain consumers 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 in maintaining a link to other essential services provided within the community. The object of supported housing is to help obtain and maintain independent living.

Forty SMHAs actively promote supported housing services through a variety of methods, including endorsing the use of such services in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 24 states, these services are available in parts of the state, whereas in 21 states, they are available statewide. Additionally, 11 states are currently planning to implement supported housing services in either parts of the state (3) or statewide (8).

SMHAs use a variety of funding sources for these services, including state general funds (32), Medicaid (14), the federal Community Mental Health Block Grant (14), local funds (9), and other funds (14).

3.11.8 Consumer-Operated Services

Services and supports delivered from consumer to consumer have become an increasingly integral part of the public mental health services. "Self-help is based on the principle that people with a shared condition come together to help themselves and each other to cope, with the two-way interaction of giving and receiving help seen as therapeutic in itself" (Van Tosh, Ralph, & Campbell, 2000, p. 391).

Thirty-six SMHAs actively promote consumer-operated services through a variety of methods, including endorsing the use of such services in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 26 states, consumer-operated services are available in parts of the state, whereas in 13 states they are available statewide. Additionally, 14 states are currently planning to implement consumer-operated services either in parts of the state (5) or statewide (9).

SMHAs use a variety of funding sources for these services, including state general funds (29), Medicaid (6), the federal Community Mental Health Block Grant (19), local funds (5), and other funds (3).

3.11.9 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 MST approach views individual, family, and extrafamilial (peer group, school, and neighborhood) factors. Interventions may be necessary in any one of a combination of these systems. MST interventions typically aim to improve caregiver discipline practices, enhance family effective 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.

Twenty-six SMHAs actively promote MST through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In 22 states, MST is available in parts of the states, whereas it is available statewide in 1 state. Additionally, nine states are currently planning to implement MST either in parts of the state (seven) or statewide (two).

SMHAs use a variety of funding sources for these services, including state general funds (19), Medicaid (15), the federal Community Mental Health Block Grant (5), local funds (4), and other funds (7).

3.11.10 Functional Family Therapy

"Functional Family Therapy (FFT) is a family-based prevention and intervention program" (Sexton & Alexander, 2000, p. 1). In this phasic program, each step builds on another to enhance protective factors and reduce risk by working with both youth and their families. The phases are engagement, motivation, assessment, behavior change, and generalization.

Twenty-two SMHAs actively promote FFT services through a variety of methods, including endorsing the use of such services in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 19 states, FFT is available in parts of the state, whereas in 5 states, it is available statewide. Additionally, nine states are currently planning to implement FFT in either parts of the state (six) or statewide (three).

SMHAs use a variety of funding sources for these services, including state general funds (17), Medicaid (13), the federal Community Mental Health Block Grant (4), local funds (4), and other funds (4).

3.11.11 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).

Twenty-two SMHAs actively promote school-based interventions through a variety of methods, including endorsing the use of such interventions in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 19 states, school-based intervention programs are available in parts of the state. Additionally, 10 states are currently planning to implement school-based intervention programs in either parts of the state (5) or statewide (5), and 2 states are piloting school-based programs.

SMHAs use a variety of funding sources for these services, including state general funds (13), Medicaid (8), the federal Community Mental Health Block Grant (5), local funds (5), and other funds (6).

3.11.12 Older Adult EBPs

Of the 47 SMHAs responding, only 15 are currently implementing EBPs for older adults. Older adult EBPs being implemented include Psychogeriatric Assessment and Treatment in City Housing (PATCH), Positive Achievement Change Tool (PACT), and Cognitive Behavioral Therapy (CBT). In addition, eight SMHAs are currently planning to implement older adult EBPs including outcome-based treatment planning, the Program to Encourage Active and Rewarding Lives for Seniors (PEARLS), and expansion of certified peer specialists to facilitate screening for older adults.

3.11.13 Training for EBPs

SMHAs use a variety of mechanisms to provide ongoing training to providers related to implementing EBPs. Most SMHAs (45) rely on expert consultants to provide ongoing training to providers, 41 use internal staff, 35 collaborate with universities, 32 use provider-to-provider training, 19 have established research/training institutes, and 8 use outside accreditation organizations.

Most SMHAs organize workforce training for child and adolescent EBPs, whereas some SMHAs provide these trainings for consumers (13) and family members (24). For adult EBPs, the majority of SMHAs (43) provide training for their workforce, whereas a significantly lower number of SMHAs (28) provide such trainings for adult consumers and family members (19).

3.11.14 Barriers to Implementing EBPs

Almost all SMHAs have experienced barriers to implementing EBPs. The most prevalent barriers reported include financing programs (47), experiencing shortages of an appropriately trained workforce (45), attaining or maintaining fidelity to EBP model standards (44), modifying the EBP model to meet local needs (32), and experiencing providers' resistance to implementing EBPs (31).

3.11.15 SMHA Initiatives To Promote the Adoption of EBPs

All reporting SMHAs have initiatives to promote the adoption of EBPs. The most frequently used initiatives include awareness/training (45 SMHAs) and consensus building among stakeholders (44 SMHAs). Other initiatives include monitoring fidelity (38 SMHAs), incorporating EBPs in contracts (29 SMHAs), modifying information systems and data reports (27 SMHAs), providing financial incentives (19 SMHAs), and making budget requests specific to EBPs (19 SMHAs).

3.11.16 Emerging EBPs

Emerging EBPs and innovative practices are practices for which the research evidence base had not been finalized but appear very promising. Most SMHAs (35) are implementing or providing emerging EBPs or other innovative practices.

Emerging EBPs being implemented for children and adolescents include in-home intervention, the matrix model for adolescents, aggression replacement, CBT for depression, risking connections, trauma-informed care, system of care models, Parent-Child Interactive Therapy, motivational interviewing, child psychiatric rehabilitation, wraparound, family-based mental health services, and Aggression Replacement Therapy.

Emerging EBPs being implemented for adults include psychosocial rehabilitation, interpersonal psychotherapy, motivational interviewing, trauma-informed services, Dialectical Behavioral Therapy, supported education, tobacco cessation treatment, crisis intervention training, recovery education, and wellness clinic.

Emerging EBPs being implemented for older adults include the collaborative model of mental healthcare, PATCH, wraparound services, mental health-physical health integration, and CBT.

3.12 Summary

Every state determines the eligibility criteria a person must meet to receive services funded and/or operated by SMHAs. The majority of SMHAs do not have strict eligibility requirements, meaning that they have no restrictions (11 SMHAs) or that any adult (32 SMHAs) or youth (31 SMHAs) with a mental illness is eligible to receive SMHA services. Some SMHAs (9 for adults, 11 for youth) have strict eligibility requirements and limit SMHA services to those who meet the state's criteria of SMI or SED.

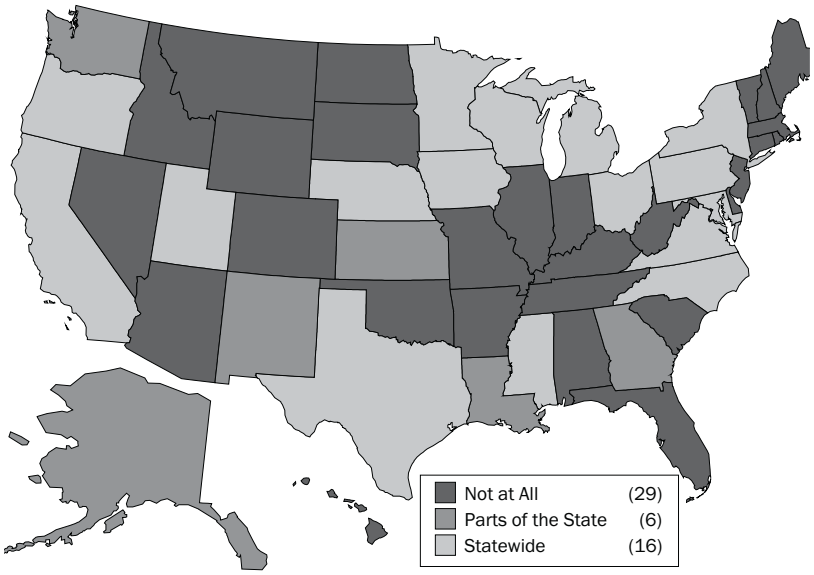
SMHAs have undertaken initiatives recommended by the President's New Freedom Commission on Mental Health to better meet the needs of their consumers. Initiatives include collaborating with other state agencies to reduce the fragmentation of services; working to identify and eliminate disparities in mental health services; cross-training staff for co-occurring mental health and substance abuse disorders; increasing access to services in rural and geographically remote areas; and addressing the mental health needs of the Armed Forces, veterans, and National Guard members.

IV. Community Mental Health Services

Community mental health is driven by the goal of "better access to high-quality care for all Americans and allocation of more resources to community treatment" (Sharfstein, 2000, p. 616). In 2008, 94 percent (5.6 million) of SMHAs' consumers received community mental health services in 49 states, the District of Columbia, and 6 territories. Keeping with the philosophy of devoting resources for community mental health treatment, SMHAs expended 70 percent ($20 billion) of their funds (48 SMHAs reporting) for community mental health services in FY 2007.

SMHAs use a variety of mechanisms to administer funds in support of community mental health services. The most commonly used method of funding stream is to provide funding directly to community-based providers (38 SMHAs). Twenty SMHAs fund city or county governments that, in turn, fund local community-based providers, whereas 16 SMHAs directly provide community mental health services. In 22 states, community mental health services are administered either in whole (16) or in part (6) by city or county authorities (see figure 18).

Figure 18: Extent to Which City/County Authorities Administer Community Mental Health Services



4.1 SMHA Relationships to Community Mental Health Providers

In 2009, 18,942 community mental health providers were funded and/or operated by 50 SMHAs. Of these, the SMHAs operated 336 programs directly providing community services to mental health consumers and funded 18,606 community-based providers.

4.1.1 Controlling Entry to State Psychiatric Hospitals

Community mental health programs in 40 SMHAs perform a gatekeeping function over entry to state psychiatric hospitals through a single portal of entry, screening, or other procedures. Community gatekeeping is required by statutes in 21 states, by SMHA policy in 20 states, and by SMHA regulations in 14 states. In Alabama, by practice, community

mental health centers (CMHCs) work with probate courts to control entry to state psychiatric hospitals. In Colorado, this function is required by the Mental Health Institute; and as part of grant agreements, CMHCs screen commitments in West Virginia.

4.2 Initiatives To Restructure Community-Based Mental Health Service Delivery

Twenty-three SMHAs are restructuring their system of community-based mental health service delivery. Initiatives include providing a better continuum of care, expanding services provided, enhancing clinic options, expanding crisis stabilization programs, expanding the provision of EBPs, expanding services to individuals dually diagnosed with mental illness and either substance abuse or intellectual disability, and reorienting services toward wellness and recovery as well as consumer-oriented care.

4.3 Community Mental Health Services Provided

SMHAs offer a variety of mental health services that are targeted toward specific population groups. Thirty SMHAs require state-funded community mental health service providers to offer a mandated set of services. Emergency and case management services were the most commonly provided services for all population groups (children/adolescents, adults, elderly, forensic, and homeless).

For adult consumers, emergency (48 SMHAs), outpatient (45 SMHAs), and case management (44 SMHAs) were the most frequently provided services. School-based (3 SMHAs) and in-home family services (12 SMHAs) were less commonly provided.

Similar to the services targeted toward adult consumers, emergency (44 SMHAs) and case management (42 SMHAs) services were also most frequently targeted toward childhood/adolescents. Consumer-run services (five SMHAs), supportive employment (four SMHAs), and social clubs (three SMHAs) were the least commonly provided services for childhood/adolescents.

4.4 Consumer-Operated Services

In its discussion about consumer-operated services, the Surgeon General's report on mental health stated, "Consumer staff are thought to gain meaningful work, to serve as role models for clients, and to enhance the sensitivity of the service system to the needs of people with mental disorders" (US DHHS, 1999, p. 290). Echoing the Surgeon General's report, the President's New Freedom Commission (PNFC) report on mental health concluded that "consumers who work as providers help expand the range and availability of services and supports that professionals offer" (US DHHS, 2003, p. 37). Following these recommendations, 32 SMHAs employ or require contracted service providers to employ self-identified consumers/survivors to provide peer services to other consumers/survivors in different settings. Of these, 81 percent specifically require the employment of consumers in community mental health programs. SMHAs support consumer-operated services through direct funding (43), conference sponsorship (41), technical assistance (41), and office space (22).

Thirty-two SMHAs expended a total of $50.8 million for consumer-operated services. The median state spending for these services was $566,442, ranging from a high of $12,348,983 in New York, to a low of $10,000 in Kentucky. These funds were spent on 551 consumer-operated programs, with a median of 6 programs per state, ranging from a high of 138 programs in New York to a low of 1 program in Arkansas, Colorado, Idaho, and North Dakota.

SMHAs also use peer specialists to provide services that are reimbursed by Medicaid. In 25 states, adult peer specialists are reimbursed through Medicaid; however, only Nevada reimburses adolescent consumer peer specialists through Medicaid.

4.4.1 Types of Consumer-Operated Services Funded by SMHAs

SMHAs fund a variety of consumer-operated services. The most commonly funded services are peer/mutual support, advocacy, drop-in centers, promoting positive public attitudes, and leadership skills training. See table 15 for types of consumer-operated services funded by SMHAs.

Table 15: Types of SMHA-Funded Consumer-Operated Services

Services	Number of States
Peer/mutual support	46
Advocacy	40
Drop-in centers	31
Promoting positive public attitudes	32
Leadership skills training	33
Wellness/prevention services	30
Policy development	25
Technical assistance	23
Social services	17
Vocational rehabilitation/employment	15
Client-staffed businesses	13
Research activities	13
Nonresidential crisis intervention	9
Transitional assistance	8
Case management	6
Residential crisis facility	5
Other	7

4.5 Clinical Practice Guidelines

Clinical practice guidelines are "systematically developed statements intended to assist decision-making by practitioners and patients about appropriate health care in specific clinical circumstances" (Institute of Medicine, 1990, p. 8). Although 23 SMHAs have adopted standardized clinical guidelines and treatment recommendations based on research results on the effectiveness or efficacy of particular treatments or medications, few SMHAs use these guidelines. Eight SMHA-operated and 11 SMHA-funded community mental health programs use the guidelines for the treatment of schizophrenia (19 SMHAs), mood disorders (13 SMHAs), bipolar disorder (11 SMHAs), dual mental and addictive disorders (11 SMHAs), major unipolar depression (10 SMHAs), alcohol abuse and dependence (11 SMHAs), and other substance abuse and dependence (9 SMHAs).

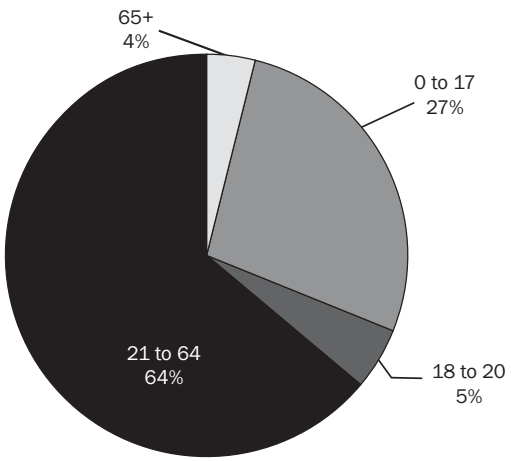
4.6 SMHAs' Relationship to Criminal and Juvenile Justice

The majority of SMHAs have adopted mental health courts to help divert persons with mental illness from the criminal justice (35) and juvenile justice (31) systems into mental health treatment. These SMHAs have 209 mental health courts (with a high of 30 in Ohio and a low of 1 in Iowa, Louisiana, Massachusetts, Maine, Vermont, and Wyoming) serving a total of 3,193 consumers (with a high of 978 in New York and a low of 20 in Maine). In 21 of these SMHAs, the mental health courts have access to dedicated or new resources to provide community-based treatments. Thirty-two SMHAs have adopted, funded, or operated programs designed to provide support for prisoners or jail detainees with mental illnesses and/or with co-occurring mental health and substance abuse disorders prior to their return to the community.

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

SMHAs vary in their responsibility for providing mental health services to juveniles and to inmates of local jails and detention centers. Few SMHAs (in Missouri and Nebraska, these services are provided to adults, and in Maine, Missouri, New Mexico, and North Dakota, these services are provided to children) have the responsibility for the provision of mental health services to persons with SMI in local jails and detention centers; however, in most states (22 provide adults' services and 20 provide children's services), city and county mental health authorities are tasked with providing these services.

Figure 19: Percent Distribution of Consumers Served in Community Settings, by Age Groups



Most SMHAs (32) provide community services to adults in the community corrections population, which includes probation, parole, and alternatives to incarceration; in local jails or detention centers (29 SMHAs); and in the local sheriffs' offices (11 SMHAs). Twenty-six SMHAs provide these services to juveniles in community corrections populations, in local jails or detention centers (19 SMHAs), and in local sheriffs' offices (7 SMHAs).

4.7 Characteristics of Persons Served in Community Settings

In 2008, the vast majority of mental health consumers (94 percent or 5.6 million) received community mental health services in 56 SMHAs. The total number of consumers served in community settings ranged from a low of 8,106 in Delaware to a high of 638,938 in New York. Slightly under half (48 percent) of all consumers served in community settings were male (with utilization rate of 18.6 per 1,000 population), and 52 percent were female (with a utilization rate of 19.6 per 1,000 population).

4.7.1 Consumers Served, by Age Groups

Consumers of all ages received services in community settings. Of the different age groups served, consumers from the ages of 21 to 64 made up the majority (64 percent). See figure 19, above, for the distribution of consumers served in community mental health service settings, by age groups.

4.7.2 Utilization Rates of Consumers Served in Community Settings, by Age and Gender

Although consumers aged 18 to 20 account for only 5 percent of consumers served, they have the highest average utilization rate of 21.4 per 1,000 population. Consumers aged 65 and older account for only 4 percent of all consumers served and have the lowest utilization rate of 6.9 per 1,000. There is no significant difference in the average utilization rates of female (19.6 per 1,000) and male (18.6 per 1,000) consumers. See figure 20 for the utilization rates of persons served in community settings, by age and gender.

Figure 20: Utilization Rates (per 1,000 Population) of Persons Served in Community Settings, by Age and Gender

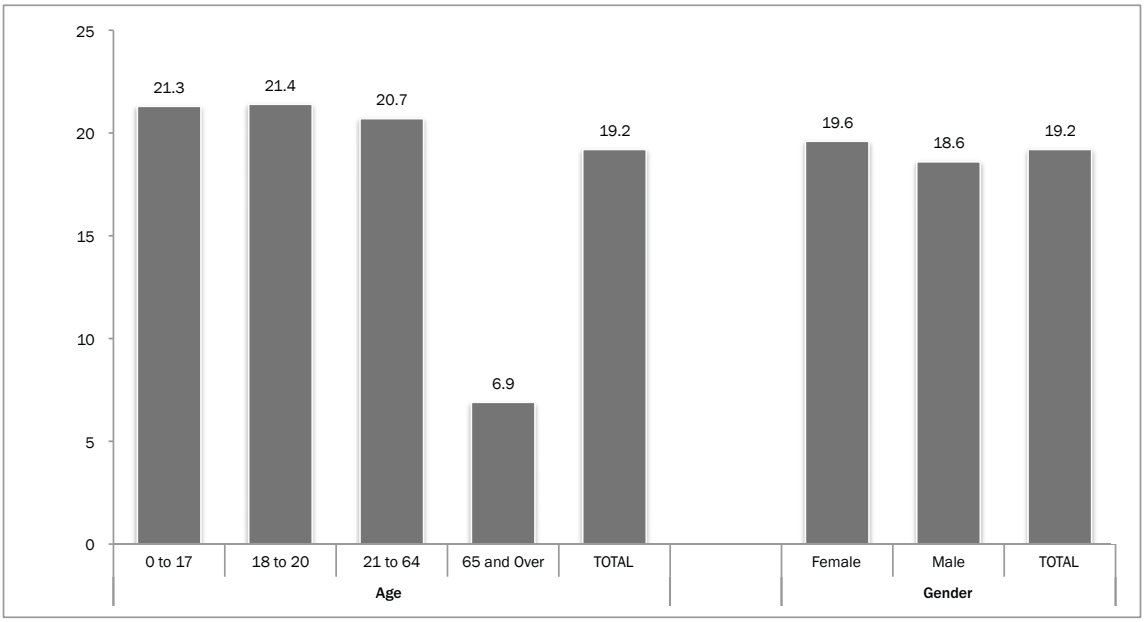
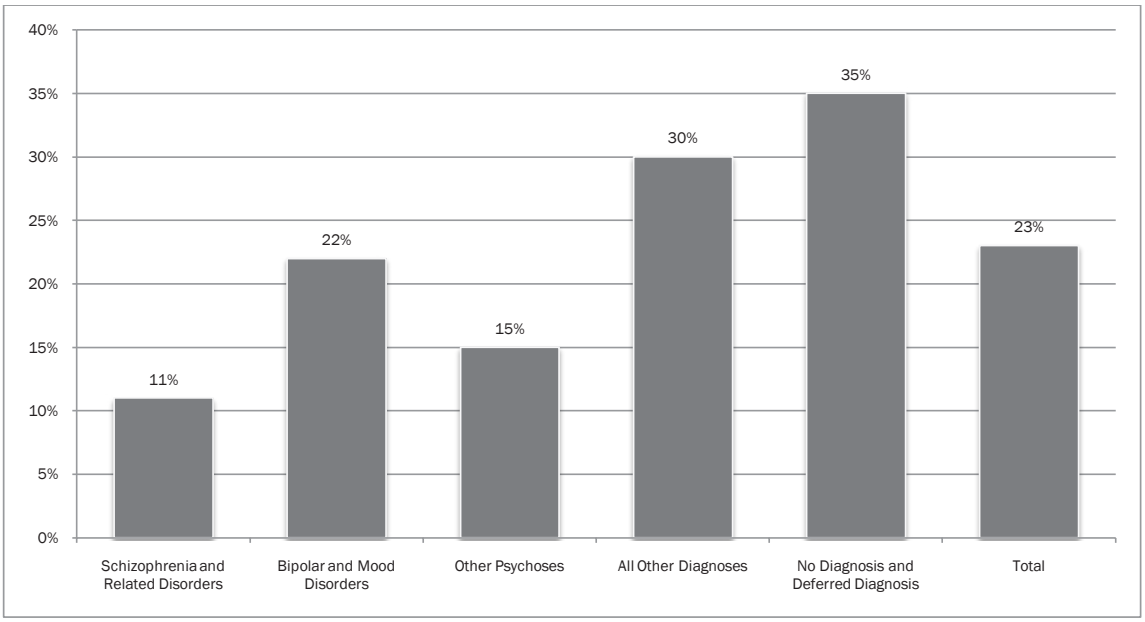


Figure 21: Employment Status of Adult Consumers, by Diagnosis

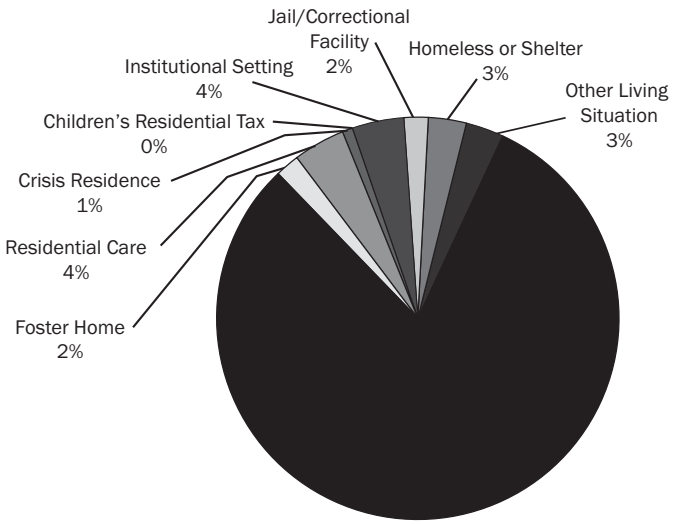


4.7.3 Employment Status of Consumers Served

Twenty-one percent of consumers served in community mental health settings were employed (56 SMHAs reporting). Almost half of adult consumers served (46 percent) are not in the labor force (i.e., not actively seeking employment), whereas 33 percent are unemployed.

In 43 SMHAs, consumers with deferred diagnosis/no diagnosis have the highest employment rate (35 percent), whereas consumers diagnosed with schizophrenia have the lowest employment rate (11 percent). See figure 21, above, for employment status of adult consumers, by diagnosis.

Figure 22: Living Situation of Consumers Served



4.7.4 Living Situation of Mental Health Consumers Served

The majority (81 percent) of consumers served live in private residences (55 SMHAs reporting), with the remainder living in a variety of settings, including foster homes, residential care facilities, crisis residence facilities, residential treatment centers, institutional settings, and jails/correctional facilities. About 3 percent of all consumers were reported as being homeless or living in shelters. See figure 22, above, for the percentage of consumers served who were living in the different settings.

4.8 Financing of Community Mental Health Services

4.8.1 Overall Expenditures for Community Mental Health Services, FY 2007

In FY 2007, SMHAs spent 70 percent ($19.4 billion) of their funds on community mental health services, with New York spending the highest amount ($2.5 billion) and Wyoming the lowest ($24 million). Of the $20 billion expended on community services, 29 percent was spent providing services for children under age 18, 51 percent for adults over age 18, and 19 percent were unallocated by age (see table 16).

SMHAs expended the majority of their mental health services funds ($12.1 billion) on community-based ambulatory (less than 24-hour) services, accounting for 63 percent of community expenditures. In addition, SMHAs expended $2.7 billion (14 percent) on other 24-hour care (residential) services and $2.3 billion (12 percent) on inpatient and other community services (see table 17).

Table 16: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Age, FY 2007 (in millions)

State	Children/Adolescents			Adults/Elderly (18 & over)			Unallocated by Age			Total Community Expenditures	Per Capita
	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita	%		
Alabama	$23.3	$20.8	13%	$117.6	$33.7	66%	$37.3	$8.1	21%	$178.2	$38.63
Alaska (a)	$11.1	$60.7	42%	$15.5	$32.4	58%	$0.0	$0.0	0%	$26.6	$40.22
Arizona	$318.6	$190.2	35%	$588.7	$126.4	65%	$0.0	$0.0	0%	$907.3	$143.27
Arkansas (a)	$4.9	$7.0	12%	$3.7	$1.7	9%	$31.3	$11.1	78%	$39.8	$14.10
California	NR			NR			NR			NR	
Colorado	$84.9	$71.3	32%	$178.7	$49.3	68%	$0.0	$0.0	0%	$263.6	$54.71
Connecticut (ac)	$0.0	$0.0	0%	$362.5	$136.1	100%	$0.0	$0.0	0%	$362.5	$104.10
Delaware (ac)	$0.0	$0.0	0%	$43.4	$66.5	100%	$0.0	$0.0	0%	$43.4	$50.60
District of Columbia	$31.5	$278.6	27%	$86.7	$183.7	73%	$0.0	$0.0	0%	$118.2	$202.07
Florida	$79.2	$19.7	21%	$300.6	$21.3	79%	$0.0	$0.0	0%	$379.7	$20.95
Georgia	$62.7	$24.9	27%	$170.6	$24.6	73%	$0.0	$0.0	0%	$233.3	$24.65
Hawaii	NR			NR			NR			NR	
Idaho	$17.8	$43.8	46%	$21.3	$19.6	54%	$0.0	$0.0	0%	$39.1	$26.21
Illinois	$242.4	$76.1	31%	$527.7	$54.9	69%	$0.0	$0.0	0%	$770.1	$60.21
Indiana	$115.2	$72.7	32%	$248.2	$52.3	68%	$0.4	$0.1	0%	$363.8	$57.46
Iowa	NR			NR			NR			NR	
Kansas	NA	NA	NA	NA	NA	NA	$173.2	$62.7	100%	$173.2	$62.71
Kentucky	$41.3	$41.1	39%	$62.2	$19.4	59%	$1.7	$0.4	2%	$105.2	$24.97
Louisiana	$7.9	$7.2	11%	$61.1	$18.8	89%	$0.0	$0.0	0%	$69.1	$15.86
Maine (b)	$182.6	$653.7	48%	$195.8	$189.6	52%	$1.7	$1.3	0%	$380.1	$289.76
Maryland (b)	$202.4	$149.4	37%	$279.1	$65.9	51%	$63.2	$11.3	12%	$544.7	$97.45
Massachusetts (c)	$91.6	$63.8	15%	$506.9	$100.9	85%	$0.0	$0.0	0%	$598.5	$92.63
Michigan (b)	$129.5	$53.1	15%	$720.0	$94.7	85%	$0.0	$0.0	0%	$849.5	$84.57
Minnesota	$150.3	$119.5	27%	$400.3	$102.1	73%	$0.0	$0.0	0%	$550.7	$106.33
Mississippi (b)	$61.8	$80.7	41%	$88.7	$41.5	59%	$0.0	$0.0	0%	$150.5	$51.80
Missouri	$39.4	$27.6	20%	$155.8	$35.1	80%	$0.0	$0.0	0%	$195.2	$33.32
Montana	$57.5	$261.5	53%	$50.1	$68.4	47%	$0.0	$0.0	0%	$107.6	$112.93
Nebraska (b)	$8.2	$18.5	12%	$62.4	$47.4	88%	$0.0	$0.0	0%	$70.7	$40.09
Nevada	$21.5	$32.6	17%	$101.6	$53.9	83%	$0.0	$0.0	0%	$123.0	$48.35
New Hampshire	$18.9	$63.5	20%	$14.3	$14.2	15%	$61.3	$46.8	65%	$94.6	$72.15
New Jersey	$368.7	$178.9	32%	$762.5	$115.8	67%	$8.3	$1.0	1%	$1,139.4	$131.83
New Mexico	$96.6	$192.8	66%	$49.3	$34.0	34%	$0.0	$0.0	0%	$145.9	$74.68
New York (b)	$0.0	$0.0	0%	$0.0	$0.0	0%	$2,530.4	$130.4	100%	$2,530.4	$130.40
North Carolina	$890.5	$403.2	64%	$488.6	$72.4	35%	$11.5	$1.3	1%	$1,390.6	$155.20
North Dakota	$3.1	$21.9	12%	$23.9	$49.1	88%	$0.0	$0.0	0%	$27.1	$42.95
Ohio	$217.2	$78.9	37%	$374.5	$43.0	63%	$0.0	$0.0	0%	$591.7	$51.60
Oklahoma	$11.2	$12.5	9%	$116.7	$43.5	91%	$0.0	$0.0	0%	$127.9	$35.69
Oregon	$92.1	$106.8	30%	$211.6	$73.7	70%	$0.0	$0.0	0%	$303.7	$81.38
Pennsylvania (b)	$1,434.2	$514.8	53%	$1,042.9	$108.4	39%	$225.1	$18.1	8%	$2,702.2	$217.73
Rhode Island (c)	$0.0	$0.0	0%	$78.7	$96.3	100%	$0.0	$0.0	0%	$78.7	$75.03
South Carolina	$49.0	$46.3	29%	$121.3	$36.7	71%	$1.4	$0.3	1%	$171.7	$39.34
South Dakota	$7.3	$37.0	33%	$12.5	$21.0	56%	$2.5	$3.1	11%	$22.3	$28.08
Tennessee	$134.4	$91.5	32%	$280.4	$60.2	68%	$0.0	$0.0	0%	$414.8	$67.69
Texas (b)	$89.8	$13.6	19%	$373.2	$21.8	81%	$0.0	$0.0	0%	$463.0	$19.51
Utah (b)	$35.7	$43.1	30%	$85.3	$46.5	70%	$0.0	$0.0	0%	$121.0	$45.43
Vermont	$65.5	$499.0	60%	$43.8	$89.6	40%	$0.0	$0.0	0%	$109.3	$176.25
Virginia (b)	$75.2	$41.3	23%	$249.0	$43.2	77%	$0.0	$0.0	0%	$324.2	$42.78
Washington	$93.5	$60.9	21%	$214.8	$44.1	48%	$142.0	$22.2	32%	$450.3	$70.24
West Virginia (b)	$5.6	$14.5	7%	$31.4	$22.1	37%	$46.8	$25.9	56%	$83.8	$46.34
Wisconsin	$0.0	$0.0	0%	$0.0	$0.0	0%	$401.1	$71.7	100%	$401.1	$71.68
Wyoming (a)	$8.4	$66.8	35%	$15.6	$39.7	65%	$0.0	$0.0	0%	$24.0	$46.26
Total	**$5,682.4**	**$76.9**	**29%**	**$9,939.7**	**$43.9**	**51%**	**$3,739.1**	**$38.4**	**19%**	**$19,361.3**	**$74.56**
Average (Mean)	**$113.6**			**$198.8**			**$73.3**			**$379.6**	
Median	**$45.1**	**$45.0**		**$109.1**	**$43.8**		**$0.0**	**$0.0**		**$173.2**	**$51.80**

a = Medicaid revenues for community program 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.
NR = not reported.

Table 17: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Service Type (in millions)

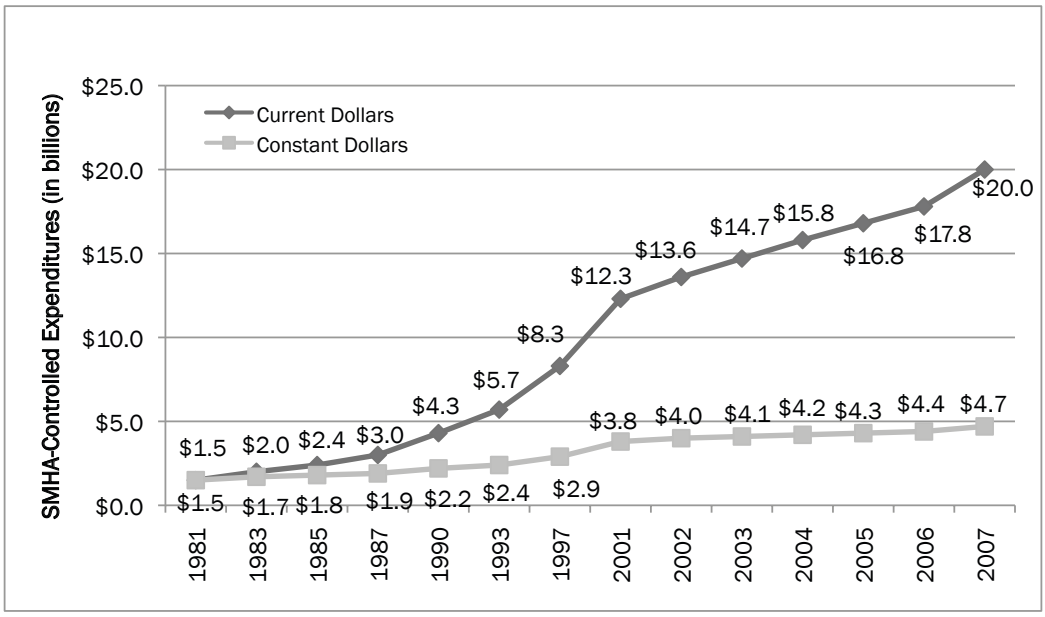
State	Inpatient		Other 24 Hour Care		Less Than 24 Hour Care		Other/Not Available		Community Expenditures
	$	%	$	%	$	%	$	%	$
Alabama	$0.0	0%	$37.1	21%	$114.5	64%	$26.6	15%	$178.2
Alaska (a)	$4.6	17%	$9.6	36%	$12.4	47%	$0.0	0%	$26.6
Arizona	$127.9	14%	$74.9	8%	$704.5	78%	$0.0	0%	$907.3
Arkansas (a)	$0.0	0%	$0.0	0%	$39.8	100%	$0.0	0%	$39.8
California	NR		NR		NR		NR		NR
Colorado	$0.0	0%	$0.8	0%	$0.0	0%	$262.7	100%	$263.6
Connecticut (ac)	$46.9	13%	$86.7	24%	$228.9	63%	$0.0	0%	$362.5
Delaware (ac)	$2.9	7%	$12.8	30%	$21.7	50%	$6.0	14%	$43.4
District of Columbia	$0.0	0%	$5.9	5%	$112.3	95%	$0.0	0%	$118.2
Florida	$0.0	0%	$82.7	22%	$297.1	78%	$0.0	0%	$379.7
Georgia	$0.0	0%	$0.0	0%	$0.0	0%	$233.3	100%	$233.3
Hawaii	NR		NR		NR		NR		NR
Idaho	$0.0	0%	$6.7	17%	$32.4	83%	$0.0	0%	$39.1
Illinois	$262.7	34%	$99.9	13%	$407.5	53%	$0.0	0%	$770.1
Indiana	$0.0	0%	$0.0	0%	$0.0	0%	$363.8	100%	$363.8
Iowa	NR		NR		NR		NR		NR
Kansas	NA	NA	NA	NA	NA	NA	$173.2	100%	$173.2
Kentucky	$0.0	0%	$23.4	22%	$81.7	78%	$0.0	0%	$105.2
Louisiana	$6.6	10%	$1.4	2%	$61.1	88%	$0.0	0%	$69.1
Maine (b)	$68.2	18%	$100.2	26%	$209.7	55%	$2.0	1%	$380.1
Maryland (b)	$90.6	17%	$77.8	14%	$376.3	69%	$0.0	0%	$544.7
Massachusetts (c)	$88.6	15%	$280.6	47%	$229.3	38%	$0.0	0%	$598.5
Michigan (b)	$123.3	15%	$197.9	23%	$528.3	62%	$0.0	0%	$849.5
Minnesota	$143.9	26%	$60.6	11%	$346.2	63%	$0.0	0%	$550.7
Mississippi (b)	$0.0	0%	$0.0	0%	$0.0	0%	$150.5	100%	$150.5
Missouri	$3.5	2%	$22.3	11%	$169.4	87%	$0.0	0%	$195.2
Montana	$6.1	6%	$47.5	44%	$54.0	50%	NA	NA	$107.6
Nebraska (b)	$17.4	25%	$8.6	12%	$44.7	63%	$0.0	0%	$70.7
Nevada	$0.0	0%	$24.2	20%	$98.8	80%	$0.0	0%	$123.0
New Hampshire	$2.2	2%	$12.2	13%	$66.2	70%	$14.0	15%	$94.6
New Jersey	$192.7	17%	$374.6	33%	$520.7	46%	$51.4	5%	$1,139.4
New Mexico	$19.0	13%	$45.1	31%	$81.7	56%	$0.0	0%	$145.9
New York (b)	$545.3	22%	$437.0	17%	$1,548.1	61%	$0.0	0%	$2,530.4
North Carolina	$55.5	4%	$190.9	14%	$1,087.9	78%	$56.3	4%	$1,390.6
North Dakota	$0.4	2%	$4.8	18%	$21.8	81%	$0.0	0%	$27.1
Ohio	$3.6	1%	$67.6	11%	$520.5	88%	$0.0	0%	$591.7
Oklahoma	$17.6	14%	$5.9	5%	$104.4	82%	$0.0	0%	$127.9
Oregon	$16.9	6%	$64.6	21%	$67.3	22%	$154.9	51%	$303.7
Pennsylvania (b)	$203.1	8%	$38.4	1%	$2,235.7	83%	$225.0	8%	$2,702.2
Rhode Island (c)	$4.7	6%	$16.3	21%	$57.7	73%	$0.0	0%	$78.7
South Carolina	$1.7	1%	$32.1	19%	$136.5	79%	$1.4	1%	$171.7
South Dakota	$0.0	0%	$0.0	0%	$22.3	100%	$0.0	0%	$22.3
Tennessee	$117.1	28%	$0.0	0%	$297.7	72%	$0.0	0%	$414.8
Texas (b)	$20.3	4%	$5.5	1%	$0.0	0%	$437.2	94%	$463.0
Utah (b)	$14.3	12%	$20.2	17%	$86.5	71%	$0.0	0%	$121.0
Vermont	$3.4	3%	$18.4	17%	$87.5	80%	$0.0	0%	$109.3

Table 17: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Service Type (in millions) (Continued)

State	Inpatient		Other 24 Hour Care		Less Than 24 Hour Care		Other/Not Available		Community Expenditures
	$	%	$	%	$	%	$	%	$
Virginia (b)	$9.1	3%	$75.3	23%	$239.8	74%	$0.0	0%	$324.2
Washington	$43.6	10%	$14.5	3%	$384.8	85%	$7.4	2%	$450.3
West Virginia (b)	$7.6	9%	$0.0	0%	$76.2	91%	$0.0	0%	$83.8
Wisconsin	$73.5	18%	$54.7	14%	$273.0	68%	$0.0	0%	$401.1
Wyoming (a)	$0.0	0%	$0.0	0%	$24.0	100%	$0.0	0%	$24.0
Total	$2,344.9	12%	$2,739.7	14%	$12,110.9	63%	$2,165.8	11%	$19,361.3
Average (Mean)	$46.9		$54.8		$242.2		$43.3		$379.6
Median	$5.4		$19.3		$87.0		$0.0		$173.2

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.
NR = not reported.

Figure 23: Trends in SMHA-Controlled Spending for Community Mental Health Services, FY 1981 to FY 2007

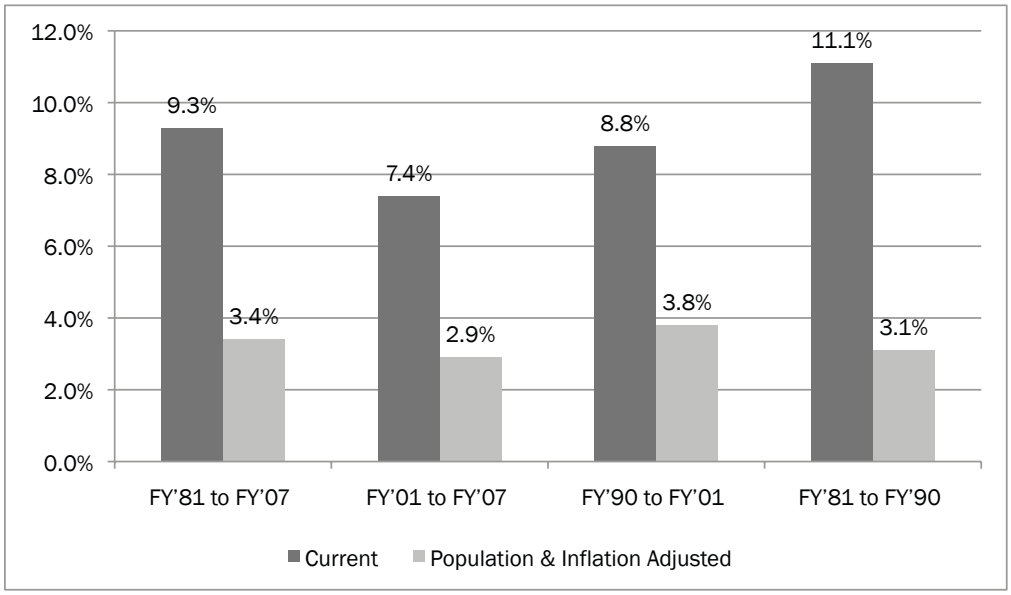


4.8.2 Trends in Community Mental Health Expenditures

From FY 1981 to FY 2007, SMHA-controlled expenditures for community mental health services increased from only $1.5 billion to $20 billion. Adjusted for inflation, expenditures increased from $1.5 billion in 1981 to $4.7 billion in 2007 (see figure 23, above).

From FY 2001 to 2007, community mental health expenditures increased by 7.4 percent per year. However, when adjusted for inflation and population growth, expenditures increased by only 2.9 percent per year. During this time period, 45 SMHAs increased their community mental health expenditures, whereas 3 expended less in 2007 than in 2001. As shown in figure 24, over the 26-year time period from FY 1981 to 2007, SMHA-controlled community services expenditures increased 9.3 percent. When adjusted for inflation and population growth, expenditures increased by only 3.4 percent over this time period. During this decade (the 2000s), SMHA-controlled community expenditures had lower growth rates than those rates in any other decade.

Figure 24: Average Annual Change in SMHA-Controlled Community Mental Health Expenditures, by Decade, FY 1981 to FY 2007



4.8.3 Overall Revenues of Community Mental Health Services, FY 2007

SMHAs controlled $19.4 billion in revenues (67 percent of total SMHA-controlled revenues) dedicated to community mental health services in FY 2007. SMHAs received funding from a variety of sources, including state general funds, Medicaid, Medicare, local government, Community Mental Health Block Grant (MHBG), and other state and federal sources.

In FY 2007, 56 percent of SMHA-controlled funds came from state government sources. The largest share of state funds came from state general funds (31 percent) and the state Medicaid match (24 percent).

The federal government was the second largest funding source (40 percent) of SMHAs' community mental health revenues. Federal Medicaid was the single largest source of revenues, accounting for 34 percent, whereas the MHBG, Medicare, and other federal funds accounted for a total of 5.7 percent of the SMHA-controlled revenues.

In addition, SMHAs received 2 percent of their revenues from local city and county governments and an additional 2 percent from other sources. Those sources included private health insurance reimbursement and consumer copays, as well as donations and all other funding sources (see figure 25 for a breakdown of total revenues, by funding sources, and table 18).

4.8.4 Trends in Financing of Community Mental Health Services

The sources of revenue SMHAs rely on to provide community mental health services have been shifting over time. Traditionally, state government tax dollars appropriated to the SMHA as general or special funds were the largest source of revenue for SMHAs. In FY 1981, state general funds represented 80 percent of SMHAs' community mental health revenues, whereas Medicaid (state and federal) accounted for only 2 percent. Over the years since 1981, state general funds have steadily declined, whereas Medicaid funds have increased, and in FY 2002, Medicaid became the largest single source of revenue, representing 44 percent of community mental health revenues (see figure 26).

Figure 25: Percentage of SMHA-Controlled Revenues for Community Mental Health Services, by Funding Sources, FY 2007

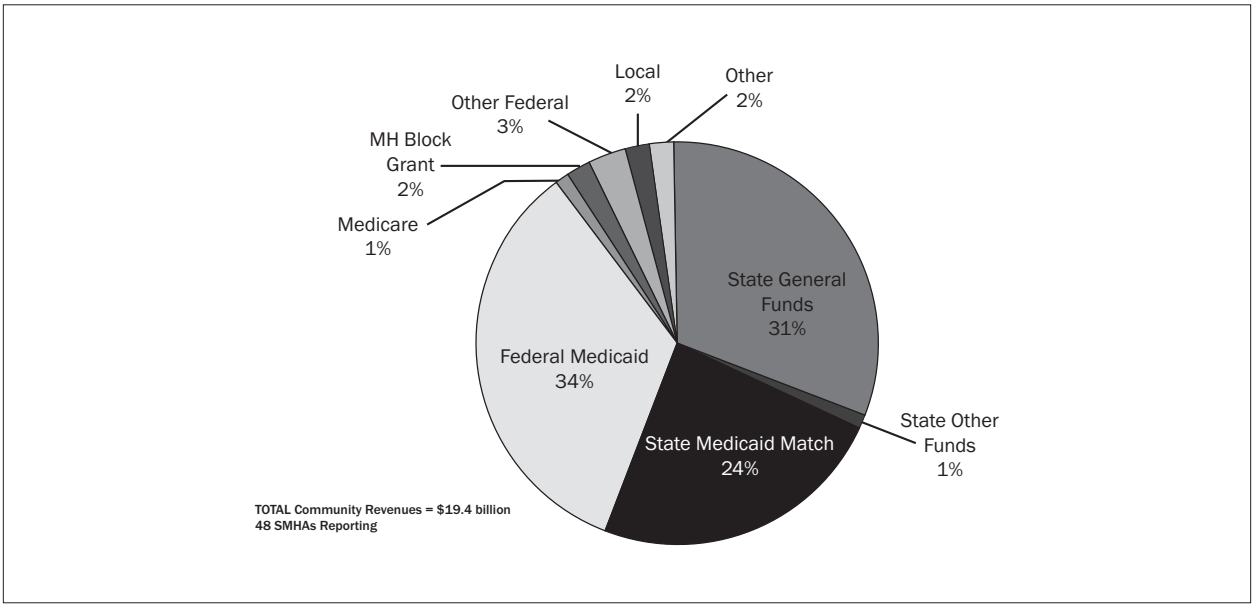


Table 18: SMHA-Controlled Community Mental Health Revenues, by Funding Sources and State, FY 2007 (in millions)

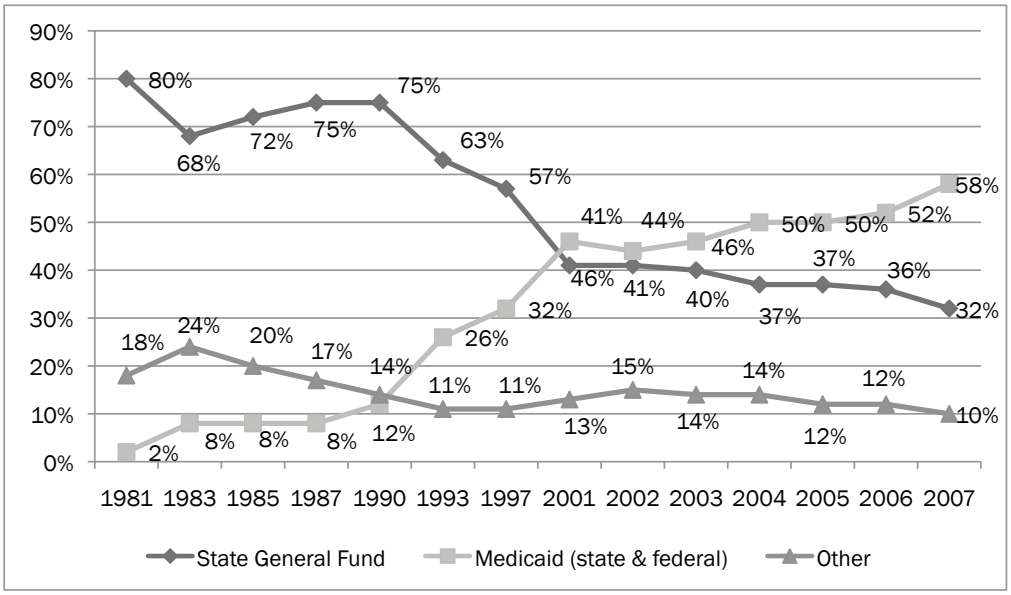
State	State General Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Alabama	$59.7	33%	$110.2	61%	$0.0	0%	$6.0	3%	$1.8	1%	$0.0	0%	$0.0	0%	$2.3	1%	$180.0
Alaska (a)	$23.1	87%	$2.7	10%	$0.0	0%	$0.5	2%	$0.3	1%	$0.0	0%	$0.0	0%	$0.0	0%	$26.6
Arizona	$119.2	13%	$752.7	82%	$0.0	0%	$7.6	1%	$2.5	0%	$0.0	0%	$38.9	4%	$0.0	0%	$920.9
Arkansas (a)	$33.2	83%	$0.0	0%	$0.0	0%	$3.8	9%	$2.9	7%	$0.0	0%	$0.0	0%	$0.0	0%	$39.8
California	NR		NR		NR		NR		NR		NR		NR		NR		NR
Colorado	$37.0	14%	$220.6	84%	$0.0	0%	$5.2	2%	$0.8	0%	$0.0	0%	$0.0	0%	$0.0	0%	$263.6
Connecticut (ac)	$344.2	92%	$11.2	3%	$1.9	1%	$3.9	1%	$11.1	3%	$0.0	0%	$0.3	0%	$3.3	1%	$375.9
Delaware (ac)	$26.8	62%	$14.0	32%	$0.1	0%	$0.6	1%	$1.8	4%	$0.0	0%	$0.0	0%	$0.0	0%	$43.4
District of Columbia	$69.8	66%	$35.2	33%	$0.0	0%	$0.8	1%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$105.8
Florida	$304.1	80%	$17.6	5%	$0.0	0%	$24.1	6%	$33.8	9%	$0.0	0%	$0.0	0%	$0.0	0%	$379.7
Georgia	$203.0	87%	NA		NA		$19.3	8%	$5.0	2%	$0.0	0%	$0.0	0%	$6.0	3%	$233.3
Hawaii	NR		NR		NR		NR		NR		NR		NR		NR		NR
Idaho	$26.9	69%	$3.4	9%	$0.0	0%	$1.5	4%	$7.0	18%	$0.0	0%	$0.4	1%	$0.0	0%	$39.1
Illinois	$320.9	42%	$427.8	56%	$0.0	0%	$15.4	2%	$6.0	1%	$0.0	0%	$0.0	0%	$0.0	0%	$770.1
Indiana	$46.1	13%	$303.5	83%	$0.0	0%	$7.7	2%	$6.6	2%	NA		$0.0	0%	$0.0	0%	$363.8
Iowa	NR		NR		NR		NR		NR		NR		NR		NR		NR
Kansas	$55.7	32%	$115.0	66%	$0.0	0%	$2.5	1%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$173.2
Kentucky	$63.9	61%	$30.6	29%	$0.7	1%	$5.5	5%	$2.6	3%	$0.0	0%	$1.8	2%	$0.0	0%	$105.2
Louisiana	$39.5	57%	$8.1	12%	$0.1	0%	$2.3	3%	$13.7	20%	$0.0	0%	$0.0	0%	$5.3	8%	$69.1
Maine (b)	$37.4	10%	$339.1	89%	$0.0	0%	$1.7	0%	$2.0	1%	$0.0	0%	$0.0	0%	$0.0	0%	$380.1
Maryland (b)	$303.1	56%	$228.6	42%	$0.0	0%	$7.4	1%	$5.6	1%	$0.0	0%	$0.0	0%	$0.0	0%	$544.7
Massachusetts (c)	$586.2	81%	$119.8	16%	$4.2	1%	$8.1	1%	$4.1	1%	$0.0	0%	$0.3	0%	$4.8	1%	$727.5
Michigan (b)	$182.4	21%	$647.5	76%	NA		$9.4	1%	$0.0	0%	$10.2	1%	$0.0	0%	$0.0	0%	$849.5
Minnesota	$188.9	34%	$321.3	58%	$0.0	0%	$5.4	1%	$18.9	3%	$1.4	0%	$5.9	1%	$9.0	2%	$550.7
Mississippi (b)	$17.4	12%	$126.3	84%	$0.0	0%	$3.9	3%	$2.9	2%	$0.0	0%	$0.0	0%	$0.0	0%	$150.5
Missouri	$69.6	34%	$111.5	54%	$12.1	6%	$6.6	3%	$7.4	4%	$0.0	0%	$0.0	0%	$0.4	0%	$207.7
Montana	$14.0	13%	$90.0	84%	NA		$1.2	1%	$2.4	2%	NA		$0.0	0%	$0.0	0%	$107.6
Nebraska (b)	$42.1	60%	$16.1	23%	$0.0	0%	$1.8	3%	$0.6	1%	NA		$5.7	8%	$4.4	6%	$70.7
Nevada	$83.7	68%	$18.5	15%	$4.9	4%	$1.5	1%	$7.9	6%	$0.0	0%	$1.0	1%	$5.5	5%	$123.0
New Hampshire	$4.4	5%	$81.3	86%	$2.8	3%	$1.4	2%	$4.7	5%	$0.0	0%	$0.0	0%	$0.0	0%	$94.6
New Jersey	$554.8	49%	$429.2	38%	$31.8	3%	$15.0	1%	$0.1	0%	$42.7	4%	$36.1	3%	$29.7	3%	$1,139.4
New Mexico	$30.4	21%	$113.0	77%	$0.0	0%	$2.0	1%	$0.5	0%	$0.0	0%	$0.0	0%	$0.0	0%	$145.9
New York (b)	$463.0	20%	$1,345.2	57%	$198.9	8%	$27.0	1%	$77.1	3%	$51.3	2%	$190.6	8%	$0.0	0%	$2,353.1
North Carolina	$106.8	8%	$1,204.3	87%	$0.0	0%	$9.7	1%	$1.8	0%	$67.9	5%	$0.0	0%	$0.0	0%	$1,390.6
North Dakota	$12.5	46%	$7.3	27%	$0.0	0%	$1.2	4%	$4.0	15%	$0.0	0%	$0.0	0%	$2.1	8%	$27.1

Table 18: SMHA-Controlled Community Mental Health Revenues, by Funding Source and State, FY 2007 (in millions) (Continued)

State	State General Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Ohio	$249.4	40%	$339.5	55%	NA		$14.3	2%	$15.3	2%	$0.0	0%	$0.0	0%	$0.0	0%	$618.5
Oklahoma	$99.1	77%	$15.9	12%	$2.0	2%	$5.3	4%	$3.5	3%	$0.0	0%	$0.7	1%	$1.7	1%	$128.2
Oregon	$51.3	17%	$247.4	81%	$0.0	0%	$3.9	1%	$0.6	0%	$0.0	0%	$0.0	0%	$0.5	0%	$303.7
Pennsylvania (b)	$531.2	20%	$1,922.3	71%	$0.0	0%	$14.6	1%	$213.8	8%	$20.1	1%	$0.0	0%	$0.0	0%	$2,702.2
Rhode Island (c)	$12.8	16%	$64.5	82%	NA		$1.1	1%	$0.3	0%	$0.0	0%	$0.0	0%	$0.0	0%	$78.7
South Carolina	$46.2	26%	$96.3	55%	$0.0	0%	$5.6	3%	$9.8	6%	$3.2	2%	$13.4	8%	$0.4	0%	$174.9
South Dakota	$8.1	37%	$11.4	53%	$0.0	0%	$1.0	5%	$1.1	5%	$0.0	0%	$0.0	0%	$0.1	0%	$21.7
Tennessee	$34.8	8%	$367.7	89%	$0.0	0%	$7.6	2%	$3.6	1%	$0.0	0%	$0.0	0%	$1.1	0%	$414.8
Texas (b)	$250.9	54%	$131.0	28%	$0.0	0%	$29.4	6%	$26.0	6%	$21.0	5%	$4.7	1%	$0.0	0%	$463.0
Utah (b)	$4.2	3%	$102.6	85%	$0.0	0%	$2.7	2%	$1.7	1%	$9.8	8%	$0.0	0%	$0.0	0%	$121.0
Vermont	$1.5	1%	$105.3	96%	$0.0	0%	$0.8	1%	$1.7	2%	$0.0	0%	$0.0	0%	$0.0	0%	$109.3
Virginia (b)	$157.6	49%	$156.6	48%	$0.0	0%	$10.0	3%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$324.2
Washington	$130.6	29%	$306.2	68%	$0.0	0%	$7.6	2%	$1.0	0%	$0.0	0%	$0.0	0%	$4.9	1%	$450.3
West Virginia (b)	$34.3	41%	$46.8	56%	$0.0	0%	$2.2	3%	$0.6	1%	$0.0	0%	$0.0	0%	$0.0	0%	$83.9
Wisconsin	$120.4	30%	$137.4	34%	NA		$7.5	2%	$9.3	2%	$126.6	32%	$0.0	0%	$0.0	0%	$401.1
Wyoming (a)	$24.6	72%	$8.1	24%	$0.0	0%	$0.4	1%	$1.2	3%	$0.0	0%	$0.0	0%	$0.0	0%	$34.3
Total	**$6,227.0**	**32%**	**$11,310.8**	**58%**	**$259.4**	**1.3%**	**$324.2**	**1.7%**	**$525.3**	**2.7%**	**$354.2**	**1.8%**	**$299.6**	**1.5%**	**$81.5**	**0.4%**	**$19,382.0**
Average (Mean)	**$122.0**		**$226.2**		**$5.8**		**$6.4**		**$10.3**		**$7.4**		**$5.9**		**$1.6**		**$380.0**
Median	**$51.0**		**$107.8**		**$0.0**		**$3.9**		**$2.5**		**$0.0**		**$0.0**		**$0.0**		**$174.9**

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.
NR = not reported.

Figure 26: Percentage of SMHA-Controlled Revenues for Community Mental Health Services From Major Funding Sources, FY 1981 to FY 2007



4.8.5 Initiatives To Transform Financing of Mental Health Services

Twenty-three SMHAs are planning or implementing changes in how the delivery of mental health services is financed. The changes being planned or implemented include reviews of funding formulas; Medicaid waivers, including 1915(c) and 1915(i), aligning funding with policy practice expectations; and county health plan for collaborative managed care, including physical and behavioral care integration and shifting the provision of acute psychiatric hospitalization to community hospitals from state-funded hospitals.

4.9 Summary

In 2008, 94 percent of consumers served by SMHAs received community-based services. SMHAs provide a wide variety of services in community settings. For adult consumers, emergency (48) SMHAs, outpatient (45), and case management (44) were the most frequently provided services. School-based (3) and in-home family services were less commonly provided. Similar to adult services, community-based providers provide emergency (44) and case management (42) services to children.

SMHAs devote a significant portion of their SMHA-controlled revenues on community mental health services. In FY 2007, SMHAs spent nearly $20 billion, and at least 70 percent of their funds, on community mental health services. The majority (63 percent) of these funds were spent on community-based ambulatory services (less than 24-hour care). Funding for these services come from a variety of sources, including the state general fund, Medicaid, Medicare, local government, the MHBG, and other state and federal sources.

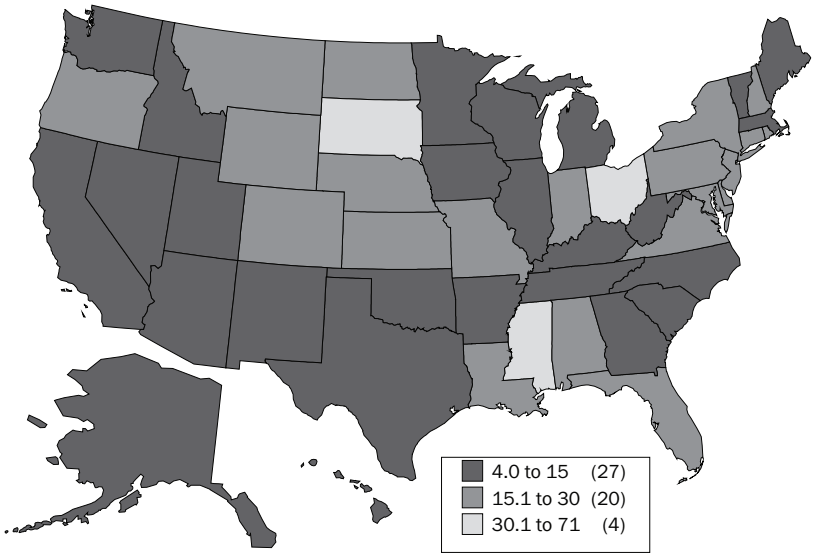
SMHAs organize and fund their community mental health services using several different organizational approaches. The most frequently used approach is for the SMHA to directly contract with local, usually not-for-profit, CMHCs. In larger population states, the SMHA tends to fund county and city governments to organize and deliver community mental health services. A small number of SMHAs directly operate their community mental health service system with state employees working in SMHA owned and operated community providers.

V. Psychiatric Hospitalization and Forensic Services

In 2008, SMHA-operated psychiatric hospitals and wards served approximately 3 percent of all mental health consumers who received services provided by the SMHA. These hospitals had expenditures of $8.6 billion, or 28 percent of all SMHA-controlled expenditures. Fifty SMHAs operate or fund a total of 187 state psychiatric hospitals—hospitals operated and staffed, or funded, by the SMHA that provide specialized inpatient psychiatric care. Rhode Island is the only state that does not have a stand-alone psychiatric hospital; however, Rhode Island's SMHA does operate psychiatric beds within the state's general hospital. In 42 states, the SMHA is responsible for the operation of state psychiatric hospitals; 5 states indicate another agency is tasked with this responsibility. In Colorado, the Mental Health Institutes Division, Office of Behavioral Health and Housing, Department of Human Services, oversees the operation of state psychiatric hospitals, whereas the Department of Health and Human Services oversees the operation of state psychiatric hospitals in Maine, New Hampshire, South Dakota, and Wyoming.

At the beginning of state FY 2008, 50,798 consumers were residents in state psychiatric hospitals in the 50 states and the District of Columbia. States varied widely in the number of hospital residents, ranging from 54 in Vermont to 5,926 in Ohio. The median number of state psychiatric hospital residents was 527. On average, state hospitals had 18 psychiatric residents per 100,000 of the total state population (the median was 15), ranging from a low of 4.3 in Arizona to a high of 70.2 in the District of Columbia (see figure 27 and table 19).

Figure 27: State Psychiatric Hospital Residents per 100,000 Population



Services provided by state psychiatric hospitals include acute care, intermediate care, long-term care, and forensic services. Many states are currently reorganizing their systems to decrease the number of civil status consumers served in psychiatric hospitals while increasing resources to provide expanded forensic mental health services. Civil status consumers are persons who either are voluntarily admitted or are committed to a hospital for treatment under an "involuntary-civil" commitment statute because they were found to be dangerous to themselves or to others and require inpatient psychiatric treatment.

5.1 Characteristics of Persons Served in State Hospitals

In 2008, 180,496 consumers were served in state psychiatric hospitals (3 percent of total population receiving services from SMHAs). Most consumers (82 percent) served in psychiatric hospitals were from the ages of 21 to 64 (see figure 28 for a complete breakdown, by age and gender). Fourteen states do not provide services to children in state psychiatric hospitals. Of the 37 states that do provide services to adults and children, children made up 9 percent of consumers served at the beginning of 2008. Males represented 64 percent of patients in state psychiatric hospitals.

The average length of stay for discharged consumers of all ages was 131 days. Children (ages 0 to 17) spent an average of 64 days in state psychiatric hospitals, ranging from a minimum of 6 days in Wisconsin to a maximum of 347 days in Utah. Adults (ages 18+) spent an average of 166 days in state psychiatric hospitals, ranging from a minimum of 10 days in Wisconsin to a maximum of 751 days in Oklahoma (see table 19).

5.2 Role of State Psychiatric Hospitals

Every state government operates psychiatric inpatient beds that provide services to consumers with high levels of need, including those who are a threat to themselves and/or others. State psychiatric hospitals provide acute care services, long-term treatment, and often forensic services to mental health consumers. Most states use their state psychiatric hospitals to serve adults, elderly consumers, and forensic patients. Approximately half of SMHAs use psychiatric hospital beds to treat children and adolescents. Thirteen SMHAs use their state psychiatric hospitals to provide acute, intermediate, and long-term inpatient care to all population groups (children, adolescents, adults, elderly, and forensic). See table 20 for the number of SMHAs that provide psychiatric inpatient care to particular populations.

Figure 28: Breakdown of Consumers Served in All State Psychiatric Hospitals, by Age and Gender

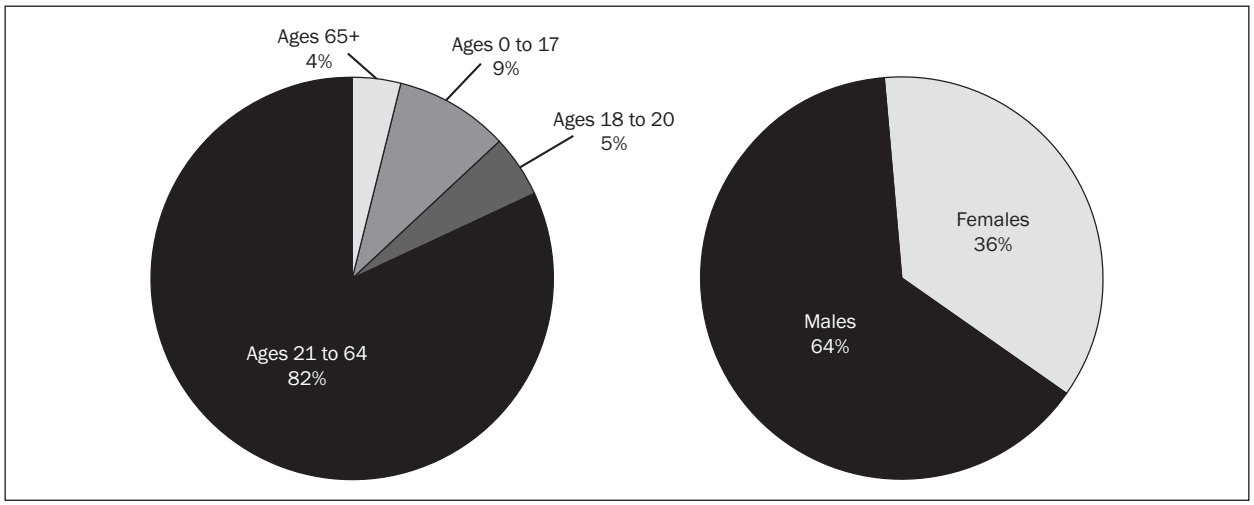


Table 19: State Operated and Funded Psychiatric Hospitals

State	Number of State Hospitals (SMHA operated & funded, 2008)	Number of Residents (start of year)[1]	Number of Children (0 17, start of year)[1]	Number of Adults (18+, start of year) [1]	Population Estimate (May 1, 2007)[2]	Residents per 100,000 Population	State Hospital Admissions (2008)[1]	Average Length of Stay—Children Ages 0 17 (in days, discharged)[1]	Average Length of Stay—Adults Ages 18+ (in days, discharged)[1]
Alaska	1	67	8	59	683,478	9.8	1,270	28	15
Alabama	6	1,144	10	1,134	4,627,851	24.7	2,662	94	140
Arkansas	1	197	20	177	2,834,797	6.9	836	206	89
Arizona	1	270	10	260	6,338,755	4.3	191	100	367
California	5	5,188	32	5,156	36,553,215	14.2	2,813	158	288
Colorado	2	1,090	118	890	4,861,515	22.4	2,457	16	42
Connecticut	5	903	243	659	3,502,309	25.8	1,244	149	184
District of Columbia	1	413	0	413	588,292	70.2	704	Not reported	Not reported
Delaware	1	239	0	239	864,764	27.6	393	0	299
Florida	7	3,169	0	3,169	18,251,243	17.4	2,602	0	353
Georgia	7	1,190	52	1,138	9,544,750	12.5	13,658	12	31
Hawaii	2	191	0	191	1,283,388	14.9	226	0	267
Iowa	4	202	54	148	2,988,046	6.8	1,404	40	53
Idaho	2	167	10	157	1,499,402	11.1	552	58	105
Illinois	10	1,483	9	1,474	12,852,548	11.5	10,364	46	49
Indiana	6	1,000	63	937	6,345,289	15.8	688	339	548
Kansas	3	630	6	624	2,775,997	22.7	4,821	18	37
Kentucky	4	492	0	492	4,241,474	11.6	8,788	0	20
Louisiana	5	923	48	875	4,293,204	21.5	4,753	67	73
Massachusetts	5	719	11	708	6,449,755	11.1	923	220	267
Maryland	9	1,172	24	1,148	5,618,344	20.9	1,820	38	272
Maine	2	140	0	140	1,317,207	10.6	588	0	80
Michigan	5	527	54	473	10,071,822	5.2	1,443	37	120
Minnesota	2	325	32	293	5,197,621	6.3	2,892	39	32
Missouri	9	1,364	35	1,329	5,878,415	23.2	6,648	22	62
Mississippi	4	1,279	70	1,209	2,918,785	43.8	4,191	81	91
Montana	1	211	0	211	957,861	22.0	723	0	102
North Carolina	4	993	105	888	9,061,032	11.0	13,570	28	38
North Dakota	0	148	5	143	639,715	23.1	629	27	62
Nebraska	2	405	47	358	1,774,571	22.8	340	150	392
New Hampshire	0	199	14	185	1,315,828	15.1	2,260	14	35
New Jersey	5	2,429	3	2,426	8,685,920	28.0	3202	0	311
New Mexico	0	141	0	141	1,969,915	7.2	981	0	37

Table 19: State Operated and Funded Psychiatric Hospitals (Continued)

State	Number of State Hospitals (SMHA operated & funded, 2008)	Number of Residents (start of year)[1]	Number of Children (0 17, start of year)[1]	Number of Adults (18+, start of year) [1]	Population Estimate (May 1, 2007)[2]	Residents per 100,000 Population	State Hospital Admissions (2008)[1]	Average Length of Stay—Children Ages 0 17 (in days, discharged)[1]	Average Length of Stay—Adults Ages 18+ (in days, discharged)[1]
Nevada	3	309	43	266	2,565,382	12.0	4,143	64	25
New York	27	5,282	461	4,819	19,297,729	27.4	6,942	101	306
Ohio	7	5,926	6	5,920	11,466,917	51.7	6111	41	191
Oklahoma	6	327	24	303	3,617,316	9.0	2,982	175	751
Oregon	2	728	0	728	3,747,455	19.4	1,097	0	269
Pennsylvania	7	2,069	1	2,068	12,432,792	16.6	1,641	17	694
Rhode Island	0	141	0	141	1,057,832	13.3	863	0	45
South Carolina	4	523	17	506	4,407,709	11.9	2,740	22	154
South Dakota	0	254	49	205	796,214	31.9	2,003	34	32
Tennessee	5	849	23	826	6,156,719	13.8	12,058	Not Reported	Not Reported
Texas	12	2,023	112	1,911	23,904,380	8.5	15,773	45	48
Utah	1	335	62	273	2,645,330	12.7	407	347	283
Virginia	11	1,541	36	1,505	7,712,091	20.0	4,960	18	129
Vermont	1	54	0	54	621,254	8.7	278	0	61
Washington	3	531	16	515	6,468,424	8.2	1,433	254	195
Wisconsin	3	537	86	451	5,601,640	9.6	6,917	6	10
West Virginia	2	247	0	247	1,812,035	13.6	1,688	0	48
Wyoming	1	112	0	112	522,830	21.4	197	39	234
Total	**216**	**50,798**	**2,019**	**48,694**	**301,621,157**	**912**	**172,869**	**3,150**	**8,336**
Average	**4**	**996**	**40**	**955**	**5,914,140**	**18**	**3,390**	**64**	**170**
Median	**3**	**527**	**16**	**492**	**4,241,474**	**14**	**1,820**	**34**	**102**
Maximum	**27**	**5,926**	**461**	**5,920**	**36,553,215**	**70**	**15,773**	**347**	**751**
Minimum	**0**	**54**	**0**	**54**	**522,830**	**4**	**191**	**0**	**10**

Sources:
[1] 2008 Uniform Reporting System (URS) Tables.
[2] U.S. Census 2007 Resident Population (http://www.census.gov/popest/datasets.html) - May 1, 2008, Release.

Table 20: Number of SMHAs Using State Psychiatric Hospitals, by Age and Service, 2009 (55 SMHAs reporting)

Population	Acute Inpatient (less than 30 days)		Intermediate Inpatient (30 90 days)		Long Term Inpatient (more than 90 days)	
	Number of SMHAs	Percent	Number of SMHAs	Percent	Number of SMHAs	Percent
Children (0–12)	26	47%	24	44%	20	36%
Adolescents (13–17)	34	62%	34	62%	27	49%
Adults (18–64)	46	84%	49	89%	50	91%
Elderly (65+)	43	78%	46	84%	47	85%
Forensic	44	80%	46	84%	47	85%

5.3 The Closing and Reorganization of State Psychiatric Hospitals

States have been under pressure to reduce the presence and size of state psychiatric hospitals since before the 1963 Community Mental Health Centers Act, a measure that established a goal of creating a nationwide network of community mental health centers (CMHCs). Twenty-six SMHAs are currently involved in activities to downsize, reconfigure, close, and/or consolidate one or more of their state psychiatric hospitals. Several SMHAs are also privatizing state hospitals to reduce costs.

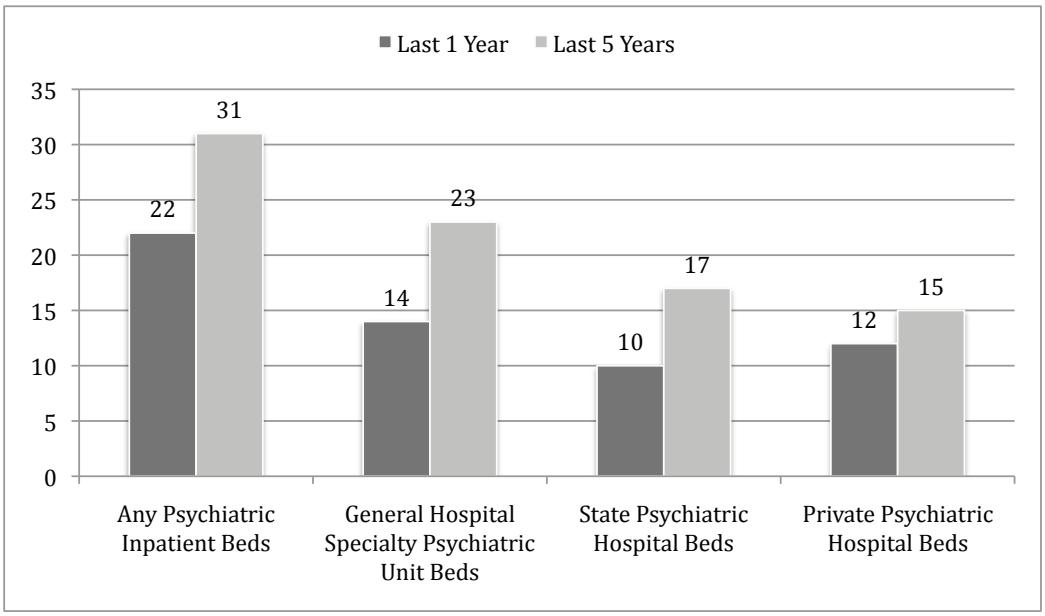
Twenty-six SMHAs indicated that they either have closed, or are planning to reorganize, downsize, or close, a total of 44 state hospitals. Four states have closed a total of seven facilities in the past 2 years, and five states are currently planning to close one or more state psychiatric hospitals. Rather than eliminate state-operated inpatient psychiatric services altogether, many states are opting to reorganize their systems. Of the 26 SMHAs with plans to reorganize, the most frequently cited activities include closing hospital wards (58 percent), significantly reorganizing within one or more state hospitals (46 percent), downsizing one or more hospitals (42 percent), and consolidating two or more hospitals (23 percent). Eleven SMHAs are replacing old state psychiatric hospitals with new hospitals. North Carolina opened Central Regional Hospital in 2008 and has plans to open Cherry Hospital in 2011 and Broughton Hospital in 2014. Oregon plans to replace the old Oregon State Hospital with a new facility in 2012. Tennessee is constructing a new building at Western Mental Health Institute, which will house patient care units and should be completed in early 2010. Seven other states (Alabama, the District of Columbia, Georgia, Kentucky, Massachusetts, New Jersey, and Vermont) have plans to replace old hospitals in the near future; however, details on these projects are not available at this time. SMHAs often report that the cost savings from reduced maintenance and other overhead expenses actually help pay for the new buildings.

Recently, three states privatized operations within seven state hospitals. Missouri privatized the entire Mid-Missouri Health Center along with the emergency room department, emergency operations unit, and the 25-bed acute unit within the Western Missouri Mental Health Center in 2009. In 2006, Kansas privatized the children's services department of KVC Behavioral Health Care and the acute adults department of Via Christi Hospital. In 2002, Maryland privatized civil admissions in the emergency department of the Spring Grove Hospital, the W.P. Carter Center, and the Springfield Hospital Center.

5.4 Shortages of Inpatient Psychiatric Beds

The closing and reorganizing of state psychiatric hospitals, in tandem with a decline in community-based acute care beds, have led to shortages of inpatient psychiatric beds in some states. The closing and reorganizing also have contributed to increased waiting lists for psychiatric beds and to overcrowding in public and privately run inpatient facilities.

Figure 29: Number of States Experiencing Shortages of Psychiatric Beds Over the Last 1 and 5 Years



SMHA, along with clinicians, consumers, and family members) to examine the acute care system and put forth recommendations. Early themes include piloting and evaluating alternative early intervention programs (including peer-delivered options), reorganizing the county-based Systems Review Committee, reviewing funding structures to better maximize Medicaid and other available funding, and improving data collection methods to be more meaningful and informative.

Indiana is attempting to reduce the length of stay in hospitals to decrease wait time for admission into hospitals, whereas Missouri is exploring the development of staffing-enhanced residential facilities and other housing options to free long-term care beds and accelerate discharges. North Carolina is attempting to increase the variety of crisis services and diversion programs to decrease the need for hospitalization. The shortage of inpatient psychiatric beds has led some states, such as Arizona, to require the continued development of bed capacity by its providers, and Florida is converting forensic beds to civil beds to reduce the wait list for civil consumers.

The shortage of forensic beds has also been an issue for several states. The District of Columbia contracts to use beds for the Department of Mental Health (DMH) with local hospitals for a total of 44 psychiatric inpatient beds to accommodate involuntary uninsured commitments. DMH almost always has capacity to refer all appropriate involuntary acute admissions to the community hospitals. West Virginia has also contracted with private hospitals to add forensic beds and has plans to eventually add additional forensic beds to its state hospital. The wait list for forensic beds in Texas is presenting a challenge to the SMHA. On average, more than 175 people are in jails and other correctional facilities waiting to be admitted to a state psychiatric hospital forensic bed. To handle this demand, the Texas Legislature appropriated $82 million in state FY 2008 to the SMHA to redesign the community mental health crisis service system. This redesigned system now includes jail diversion programs for nonviolent offenders to be treated in the community and provides for an "over capacity plan" that allows consumers to be diverted from hospitals that are full to hospitals that have beds available, allowing for full utilization of all beds in the state system. In the long run, Texas plans to implement strategies that will reduce the overall admission rate to state psychiatric hospitals, thus reducing the wait list in jails and other correctional facilities.

5.5 Forensic Mental Health Services

Forensic services provide evaluation and treatment to persons who have a mental illness and come into contact with the criminal justice system. SMHAs vary widely in their responsibilities for providing mental health services to forensic clients. Nearly one-third of all consumers in state hospitals were involuntarily criminally committed. Since 1993, state psychiatric hospital expenditures have increasingly been applied to forensic services, jumping from 10.7 percent of total state psychiatric hospital expenditures in 1993 to 26 percent in 2007. In FY 2007, SMHAs spent $1.99 billion of funds allocated to state psychiatric hospitals on forensic services and an additional $233 million on sex offender services. The amount of funds individual SMHAs spend on each classification varies widely from state to state. New York spent the most ($161.3 million), and Mississippi spent the least ($3.7 million) on forensic services (see table 21).

Table 21: SMHA-Controlled Mental Health Expenditures for Forensic and Sex Offender Services in State Psychiatric Hospitals, FY 2007 (in millions)

State	Forensic	Per Capita	% of Total	Rank	Sex Offenders	Per Capita	% of Total	Rank	Total State Psychiatric Hospital Inpatient
Alabama	$13.10	$2.84	9%	38	$0.00				$152.00
Alaska (a)	$2.94	$4.45	12%	36	$0.00				$24.56
Arizona	$28.70	$4.53	40%	11	$11.30	$1.78	15.7%	6	$72.20
Arkansas (a)	$6.14	$2.17	17%	31	$0.00				$37.04
California	NR				NR				NR
Colorado	$45.51	$9.45	46%	7	NA				$99.20
Connecticut (ac)	$90.30	$25.93	47%	6	$0.00				$190.90
Delaware (ac)	$6.86	$7.99	15%	32	NA				$45.26
District of Columbia	$33.52	$57.31	40%	10	$0.68	$1.16	0.8%	14	$84.21
Florida	$129.56	$7.15	39%	13	$26.24	$1.45	7.9%	7	$330.53
Georgia	$52.05	$5.50	24%	27	$0.00				$214.76
Hawaii	NR				NR				NR
Idaho	$1.32	$0.89	5%	40	$1.70	$1.14	6.5%	9	$26.09
Illinois	$122.90	$9.61	41%	9	$21.60	$1.69	7.3%	8	$297.50
Indiana	$42.40	$6.70	23%	28	$0.00				$183.74
Iowa	NR				NR				NR
Kansas	$24.00	$8.69	28%	22	$17.00	$6.15	20.1%	4	$84.50
Kentucky	$12.30	$2.92	11%	37	$0.00				$115.00
Louisiana	$78.14	$17.95	50%	4	$0.00				$156.25
Maine (b)	$16.75	$12.77	30%	21	NA				$55.84
Maryland (b)	$123.70	$22.13	50%	3	$0.00				$245.20
Massachusetts (c)	$56.80	$8.79	26%	24	$0.00				$216.00
Michigan (b)	NA		NA		NA				$0.00
Minnesota	$69.69	$13.46	33%	19	$68.49	$13.22	32.4%	1	$211.63
Mississippi (b)	$3.70	$1.27	2%	42	$0.00				$191.40
Missouri	$89.10	$15.21	39%	12	$13.61	$2.32	6.0%	10	$225.67
Montana	$9.60	$10.07	38%	15	NA				$25.26
Nebraska (b)	$11.86	$6.73	27%	23	$8.10	$4.60	18.2%	5	$44.52
Nevada	$8.50	$3.34	13%	34	$0.00				$65.48
New Hampshire	NA		NA		NA				$52.18

Table 21: SMHA-Controlled Mental Health Expenditures for Forensic and Sex Offender Services in State Psychiatric Hospitals, FY 2007 (in millions) (Continued)

State	Forensic	Per Capita	% of Total	Rank	Sex Offenders	Per Capita	% of Total	Rank	Total State Psychiatric Hospital Inpatient
New Jersey	$83.60	$9.67	18%	30	$9.10	$1.05	1.9%	13	$475.90
New Mexico	$0.00		0%		$0.00				$20.90
New York (b)	$161.30	$8.31	14%	33	NA				$1,173.20
North Carolina	$7.26	$0.81	2%	41	$0.00				$298.61
North Dakota	$0.00		0%		$3.54	$5.62	20.9%	3	$16.95
Ohio	$141.22	$12.31	66%	1	NA				$215.40
Oklahoma	$18.10	$5.05	36%	16	$0.00				$49.80
Oregon	$60.10	$16.10	52%	2	NA				$116.30
Pennsylvania (b)	$60.37	$4.86	12%	35	$0.00				$503.10
Rhode Island (c)	NA		NA		NA				$31.10
South Carolina	$20.90	$4.79	24%	26	$4.20	$0.96	4.9%	11	$85.70
South Dakota	$0.00		0%		$0.00				$20.72
Tennessee	$41.90	$6.84	25%	25	NA				$168.50
Texas (b)	$112.20	$4.73	34%	17	NA				$331.10
Utah (b)	$15.68	$5.89	31%	20	$0.00				$50.59
Vermont	$8.60	$13.87	45%	8	NA				$19.10
Virginia (b)	$21.40	$2.82	7%	39	$6.30	$0.83	2.1%	12	$306.40
Washington	$39.00	$6.08	18%	29	NA				$217.30
West Virginia (b)	$16.50	$9.13	34%	18	$0.00				$49.10
Wisconsin	$91.70	$16.39	50%	5	$40.70	$7.27	22.2%	2	$183.70
Wyoming (a)	$7.33	$14.09	38%	14	$0.00				$19.20
Total	**$1,986.61**		**25.9%**		**$232.57**		**3.0%**		**$7,657.73**
Average (Mean)	**$41.39**				**$6.29**				**$152.93**
Median	**$21.15**		**26.6%**		**$0.00**		**7.6%**		**$85.70**
States Reporting	**42**				**$14.00**				**47**

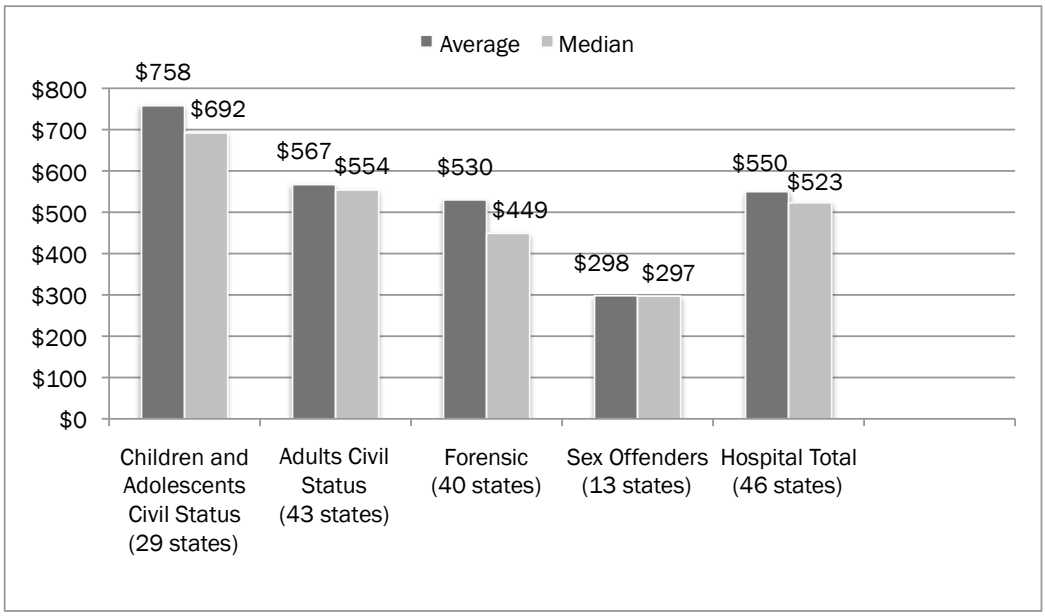
a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.
c = Children's mental health expenditures are not included in SMHA-controlled expenditures.
NA = Services provided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

5.5.1 State Psychiatric Hospital Expenditures per Patient Day

Expenditures in state psychiatric hospitals are often compared on the basis of the average cost of providing care per patient day (how many days total patients were in the hospital divided by total hospital expenditures). In FY 2007, state psychiatric hospitals provided $15.3 million on patient days of care (46 states reporting). In these states, the average expenditures per patient day were $550.48, and the median expenditures were $522.74.

Civil status (both voluntary and involuntary) clients had higher costs per patient day than forensic status clients (see figure 30). Civil status children had the highest average expenditures per patient day at $758.16, followed by civil status adults at $566.80. Forensic status patients and persons in state psychiatric hospitals under sexual offender commitment statuses had the lowest average costs per patient day.

Figure 30: Average and Median State Psychiatric Hospital Expenditures per Patient Day, by Type of Patient, FY 2007



Note: Numbers are rounded.

5.5.2 Organization of State Forensic Mental Health Services

In 25 states, forensic mental health services are the direct responsibility of the SMHA. In 15 states, the SMHA and the Department of Corrections share the responsibility of forensic mental health services. Four SMHAs share the responsibility with the Psychiatric Security Review Board and the Department of Corrections (Oregon), Family and Social Services Administration (FSSA) Legal Services (Indiana), the Human Services Department (New Mexico), and the state hospital/Department of Health (Wyoming).

Only seven SMHAs (California, Maine, Missouri, New Mexico, New York, South Dakota, and Wisconsin) are responsible for providing direct services to consumers within the prison system. The state's corrections agency is most often responsible for administering services and perimeter security for these consumers.

Thirty SMHAs have a central administrative management unit responsible for planning, administration, and/or monitoring forensic services. Twenty SMHAs have a designated mental health

forensic director who has responsibilities for overseeing forensic mental health services, and this person most often reports directly to the SMHA Commissioner (10), the Division Director (7), or the Deputy Assistant Director of Mental Health (6). Four SMHAs report that no person or group within the SMHA is responsible for overseeing forensic services.

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

Forty-four states have a Not Guilty by Reason of Insanity (NGRI) statute, where persons charged with a crime can be found not guilty or not criminally responsible because of their mental illness. Persons ruled NGRI are often sent to state psychiatric hospitals for treatment until they are deemed to be well and safe enough to be discharged into the community. Twenty-seven states reported a total of 1,296 individuals had been found NGRI in 2008. The range of NGRI was from 1 (Delaware, Indiana, New Hampshire, and Nevada) to 147 (Wisconsin), with an average of 48 per SMHA and a median of 23.

Fifteen states have a Guilty but Mentally Ill (GBMI) statute, where criminal defendants can be found guilty of a crime even though they have been diagnosed with a mental illness. Only 13 states have both statutes (Alaska, Florida, Hawaii, Illinois, Indiana, Michigan, Montana, New Mexico, Nevada, Pennsylvania, South Carolina, South Dakota, and Utah). Eight states reported a total of 154 consumers had been found GBMI last year. The range of GBMI was from 1 (Alaska) to 75 (Oregon), with an average of 19 per SMHA and a median of 14.

5.5.4 Sex Offenders

Seventeen states are required by state law to provide specifically for the hospitalization or commitment of sex offenders (such as those classified as sexually violent predators and as sexually dangerous persons). The use of such laws has increased since the 1997 U.S. Supreme Court decision in *Kansas 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 (*Kansas v. Hendricks,* 1997). These laws sometimes require agencies such as the SMHA, the Department of Corrections, or another state agency to provide services to sexual offenders; however, the responsibility of these services is often divided among several agencies. Table 22 displays the breakdown of responsibilities.

SMHAs spent $233 million to provide sex offender services in state psychiatric hospitals in 2007.

Table 22: Responsibilities for Sex Offender Services

Services	SMHA	Department of Corrections	SMHA w/ Corrections or Another Agency	Other	Total
Screening corrections inmates to identify candidates for commitment proceedings	1	9	5	4	19
Evaluating individuals whose commitment someone else has petitioned	9	3	0	7	19
Providing the facility in which the committed individual is served	13	5	0	1	19
Providing for administration of the commitment facility	14	3	1	1	19
Providing or paying for clinical services	12	3	2	3	20
Providing or paying for security services	9	5	4	1	19

On average, SMHAs spent $6.29 million to provide these services. Minnesota spent the most ($68.5 million), and the District of Columbia spent the least ($700,000).

5.6 Financing of SMHA Operated and Funded Psychiatric Hospitals

5.6.1 Overall Expenditures for State Hospitals, FY 2007

In FY 2007, SMHAs expended $8.6 billion, or 28 percent of all SMHA-controlled expenditures, on state psychiatric hospitals. New York spent the highest amount ($1.6 billion, or 37 percent of total SMHA-controlled expenditures), and Vermont spent the least amount ($19 million, or 14 percent of total SMHA-controlled expenditures). South Dakota spent the highest percentage of SMHA-controlled expenditures on state psychiatric hospitals (62 percent), whereas Arizona spent the lowest percentage (7 percent). Of the $8.6 billion state psychiatric hospital expenditures, 91 percent were spent providing services to adults and the elderly over the age of 18, 7 percent for children under age 18, and 2 percent were unallocated by age (see table 23).

The majority (92 percent) of expenditures for state psychiatric hospitals are dedicated to inpatient psychiatric services (see table 24). The remainder of funds is applied to less than 24-hour services (4 percent) and other 24-hour services—a variety of services along a continuum of living arrangements ranging from basic room and board with minimal supervision through 24-hour medical, nursing, and/or intensive therapeutic programs—(3 percent).

Table 23: SMHA-Controlled Mental Health Expenditures for State Psychiatric Hospitals, by Age, FY 2007 (in millions)

State	Children/Adolescents			Adults/Elderly (Over Age 18)			Unallocated by Age			Total State Hospital Expenditures	
	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita
Alabama	$0.00	$0.00	0%	$0.00	$0.00	0%	$152.00	$32.95	100%	$152.00	$32.95
Alaska (a)	$3.43	$18.81	14%	$21.13	$44.11	86%	$0.00	$0.00	0%	$24.56	$37.14
Arizona	$3.80	$2.27	5%	$68.40	$14.69	95%	$0.00	$0.00	0%	$72.20	$11.40
Arkansas (a)	$2.75	$3.93	4%	$65.18	$30.68	96%	$0.00	$0.00	0%	$67.93	$24.05
California	NR			NR			NR			NR	
Colorado	$14.51	$12.19	14%	$87.96	$24.25	86%	$0.00	$0.00	0%	$102.47	$21.27
Connecticut (ac)	$0.00	$0.00	0%	$190.90	$71.68	100%	$0.00	$0.00	0%	$190.90	$54.82
Delaware (ac)	$0.00	$0.00	0%	$45.26	$69.31	100%	$0.00	$0.00	0%	$45.26	$52.75
District of Columbia	$0.00	$0.00	0%	$84.21	$178.46	100%	$0.00	$0.00	0%	$84.21	$143.96
Florida	$0.00	$0.00	0%	$330.53	$23.43	100%	$0.00	$0.00	0%	$330.53	$18.23
Georgia	$13.37	$5.30	6%	$201.39	$28.99	94%	$0.00	$0.00	0%	$214.76	$22.68
Hawaii	NR			NR			NR			NR	
Idaho	$2.08	$5.11	8%	$24.01	$22.15	92%	$0.00	$0.00	0%	$26.09	$17.50
Illinois	$2.20	$0.69	1%	$295.30	$30.74	99%	$0.00	$0.00	0%	$297.50	$23.26
Indiana	$9.86	$6.23	5%	$173.88	$36.62	95%	$0.00	$0.00	0%	$183.74	$29.02
Iowa	NR			NR			NR			NR	
Kansas	$7.10	$10.16	8%	$77.40	$37.51	92%	$0.00	$0.00	0%	$84.50	$30.59
Kentucky	$0.00	$0.00	0%	$115.00	$35.85	100%	$0.00	$0.00	0%	$115.00	$27.30
Louisiana	$23.73	$21.54	15%	$137.04	$42.13	85%	$0.00	$0.00	0%	$160.77	$36.92
Maine (b)	$0.00	$0.00	0%	$55.84	$54.08	100%	$0.00	$0.00	0%	$55.84	$42.56
Maryland (b)	$36.80	$27.16	13%	$243.90	$57.60	87%	$0.00	$0.00	0%	$280.70	$50.22
Massachusetts (c)	$14.60	$10.16	11%	$119.10	$23.70	89%	$0.00	$0.00	0%	$133.70	$20.69
Michigan (b)	$19.10	$7.83	9%	$189.30	$24.89	91%	$0.00	$0.00	0%	$208.40	$20.75
Minnesota	$12.85	$10.21	6%	$205.77	$52.48	94%	$0.00	$0.00	0%	$218.62	$42.21
Mississippi (b)	$19.50	$25.45	10%	$178.50	$83.44	90%	$0.00	$0.00	0%	$198.00	$68.15
Missouri	$21.66	$15.21	9%	$223.53	$50.42	91%	$0.00	$0.00	0%	$245.20	$41.86
Montana	$0.00	$0.00	0%	$27.15	$37.03	100%	$0.00	$0.00	0%	$27.15	$28.49
Nebraska (b)	$2.67	$5.99	6%	$41.85	$31.78	94%	$0.00	$0.00	0%	$44.52	$25.26
Nevada	$9.90	$15.02	14%	$63.33	$33.59	86%	$0.00	$0.00	0%	$73.23	$28.78

Table 23: SMHA-Controlled Mental Health Expenditures for State Psychiatric Hospitals, by Age, FY 2007 (in millions) (Continued)

State	Children/Adolescents			Adults/Elderly (Over Age 18)			Unallocated by Age			Total State Hospital Expenditures	
	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita
New Hampshire	$4.67	$15.66	7%	$66.89	$66.03	93%	$0.00	$0.00	0%	$71.56	$54.58
New Jersey	$0.00	$0.00	0%	$475.90	$72.30	100%	$0.00	$0.00	0%	$475.90	$55.06
New Mexico	$0.00	$0.00	0%	$44.80	$30.84	100%	$0.00	$0.00	0%	$44.80	$22.93
New York (b)	$215.20	$48.34	13%	$1,389.40	$92.91	87%	$0.00	$0.00	0%	$1,604.60	$82.69
North Carolina	$30.35	$13.74	9%	$293.24	$43.43	91%	$0.00	$0.00	0%	$323.59	$36.12
North Dakota	$1.31	$9.15	6%	$21.81	$44.75	94%	$0.00	$0.00	0%	$23.12	$36.66
Ohio	$0.00	$0.00	0%	$215.40	$24.72	100%	$0.00	$0.00	0%	$215.40	$18.78
Oklahoma	$6.60	$7.34	13%	$43.20	$16.10	87%	$0.00	$0.00	0%	$49.80	$13.90
Oregon	$0.00	$0.00	0%	$116.30	$40.53	100%	$0.00	$0.00	0%	$116.30	$31.16
Pennsylvania (b)	$0.00	$0.00	0%	$503.10	$52.27	100%	$0.00	$0.00	0%	$503.10	$40.54
Rhode Island (c)	$0.00	$0.00	0%	$31.10	$38.06	100%	$0.00	$0.00	0%	$31.10	$29.64
South Carolina	$9.90	$9.36	10%	$86.30	$26.10	90%	$0.00	$0.00	0%	$96.20	$22.04
South Dakota	$4.99	$25.28	13%	$15.73	$26.42	41%	$17.37	$21.91	46%	$38.09	$48.05
Tennessee	$9.30	$6.33	6%	$159.20	$34.17	94%	$0.00	$0.00	0%	$168.50	$27.50
Texas (b)	$36.20	$5.48	11%	$304.60	$17.79	89%	$0.00	$0.00	0%	$340.80	$14.36
Utah (b)	$11.63	$14.06	23%	$38.95	$21.23	77%	$0.00	$0.00	0%	$50.59	$19.00
Vermont	$0.00	$0.00	0%	$19.10	$39.07	100%	$0.00	$0.00	0%	$19.10	$30.80
Virginia (b)	$10.20	$5.60	3%	$296.20	$51.45	97%	$0.00	$0.00	0%	$306.40	$40.43
Washington	$10.40	$6.78	5%	$206.90	$42.43	95%	$0.00	$0.00	0%	$217.30	$33.90
West Virginia (b)	$0.00	$0.00	0%	$49.10	$34.55	100%	$0.00	$0.00	0%	$49.10	$27.15
Wisconsin	$21.90	$16.58	12%	$161.80	$37.85	88%	$0.00	$0.00	0%	$183.70	$32.83
Wyoming (a)	$0.57	$4.50	2%	$26.16	$66.42	98%	$0.00	$0.00	0%	$26.72	$51.41
Total	**$593.13**	**$8.03**	**7%**	**$7,831.03**	**$34.61**	**91%**	**$169.37**	**$31.33**	**2%**	**$8,593.54**	**$33.09**
Average (Mean)	**$11.63**			**$153.55**			**$3.32**			**$168.50**	
Median	**$3.43**	**$5.48**		**$86.30**	**$36.62**		**$0.00**	**$0.00**		**$102.47**	**$29.64**

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.
NR = not reported.

Table 24: SMHA-Controlled State Psychiatric Hospital Expenditures, by Service Type, FY 2007 (in millions)

State	Inpatient Services		Other 24 Hour Services		Less Than 24 Hour Services		Total State Hospital Expenditures	Rank
	$	%	$	%	$	%	$	
Alabama	$152.00	100%	$0.00	0%	$0.00	0%	$152.00	22
Alaska (a)	$24.56	100%	$0.00	0%	$0.00	0%	$24.56	46
Arizona	$72.20	100%	$0.00	0%	$0.00	0%	$72.20	31
Arkansas (a)	$37.04	55%	$30.90	45%	$0.00	0%	$67.93	33
California	NR		NR		NR		NR	
Colorado	$99.20	97%	$3.26	3%	$0.00	0%	$102.47	26
Connecticut (ac)	$190.90	100%	$0.00	0%	$0.00	0%	$190.90	17
Delaware (ac)	$45.26	100%	$0.00	0%	$0.00	0%	$45.26	38
District of Columbia	$84.21	100%	$0.00	0%	$0.00	0%	$84.21	29
Florida	$330.53	100%	$0.00	0%	$0.00	0%	$330.53	5
Georgia	$214.76	100%	$0.00	0%	$0.00	0%	$214.76	14
Hawaii	NR		NR		NR		NR	
Idaho	$26.09	100%	$0.00	0%	$0.00	0%	$26.09	45
Illinois	$297.50	100%	$0.00	0%	$0.00	0%	$297.50	8

Table 24: SMHA-Controlled State Psychiatric Hospital Expenditures, by Service Type, FY 2007 (in millions) (Continued)

State	Inpatient Services		Other 24 Hour Services		Less Than 24 Hour Services		Total State Hospital Expenditures	Rank
	$	%	$	%	$	%	$	
Indiana	$183.74	100%	$0.00	0%	$0.00	0%	$183.74	18
Iowa	NR		NR		NR		NR	
Kansas	$84.50	100%	$0.00	0%	$0.00	0%	$84.50	28
Kentucky	$115.00	100%	$0.00	0%	$0.00	0%	$115.00	25
Louisiana	$156.25	97%	$3.09	2%	$1.43	1%	$160.77	21
Maine (b)	$55.84	100%	$0.00	0%	$0.00	0%	$55.84	34
Maryland (b)	$245.20	87%	$35.50	13%	$0.00	0%	$280.70	9
Massachusetts (c)	$127.40	95%	$6.30	5%	$0.00	0%	$133.70	23
Michigan (b)	$208.40	100%	$0.00	0%	$0.00	0%	$208.40	15
Minnesota	$211.63	97%	$6.99	3%	$0.00	0%	$218.62	11
Mississippi (b)	$191.40	97%	$0.70	0%	$5.90	3%	$198.00	16
Missouri	$225.67	92%	$14.34	6%	$5.19	2%	$245.20	10
Montana	$25.26	93%	$1.88	7%	NA	NA	$27.15	43
Nebraska (b)	$44.52	100%	$0.00	0%	$0.00	0%	$44.52	40
Nevada	$65.48	89%	$0.00	0%	$7.75	11%	$73.23	30
New Hampshire	$52.18	73%	$19.38	27%	$0.00	0%	$71.56	32
New Jersey	$475.90	100%	$0.00	0%	$0.00	0%	$475.90	3
New Mexico	$20.90	47%	$23.90	53%	$0.00	0%	$44.80	39
New York (b)	$1,173.20	73%	$98.60	6%	$332.80	21%	$1,604.60	1
North Carolina	$298.61	92%	$24.98	8%	$0.00	0%	$323.59	6
North Dakota	$16.95	73%	$6.17	27%	$0.00	0%	$23.12	47
Ohio	$215.40	100%	$0.00	0%	$0.00	0%	$215.40	13
Oklahoma	$49.80	100%	$0.00	0%	$0.00	0%	$49.80	36
Oregon	$116.30	100%	$0.00	0%	$0.00	0%	$116.30	24
Pennsylvania (b)	$503.10	100%	$0.00	0%	$0.00	0%	$503.10	2
Rhode Island (c)	$31.10	100%	$0.00	0%	$0.00	0%	$31.10	42
South Carolina	$85.70	89%	$3.40	4%	$7.10	7%	$96.20	27
South Dakota	$38.09	100%	$0.00	0%	$0.00	0%	$38.09	41
Tennessee	$168.50	100%	$0.00	0%	$0.00	0%	$168.50	20
Texas (b)	$331.10	97%	$9.70	3%	$0.00	0%	$340.80	4
Utah (b)	$50.59	100%	$0.00	0%	$0.00	0%	$50.59	35
Vermont	$19.10	100%	$0.00	0%	$0.00	0%	$19.10	48
Virginia (b)	$306.40	100%	$0.00	0%	$0.00	0%	$306.40	7
Washington	$217.30	100%	$0.00	0%	$0.00	0%	$217.30	12
West Virginia (b)	$49.10	100%	$0.00	0%	$0.00	0%	$49.10	37
Wisconsin	$183.70	100%	$0.00	0%	$0.00	0%	$183.70	19
Wyoming (a)	$19.20	72%	$7.13	27%	$0.40	1%	$26.72	44
Total	**$7,936.76**	**92%**	**$296.21**	**3%**	**$360.56**	**4%**	**$8,593.54**	
Average (Mean)	**$155.62**		**$5.81**		**$7.21**		**$168.50**	
Median	**$99.20**		**$0.00**		**$0.00**		**$102.47**	

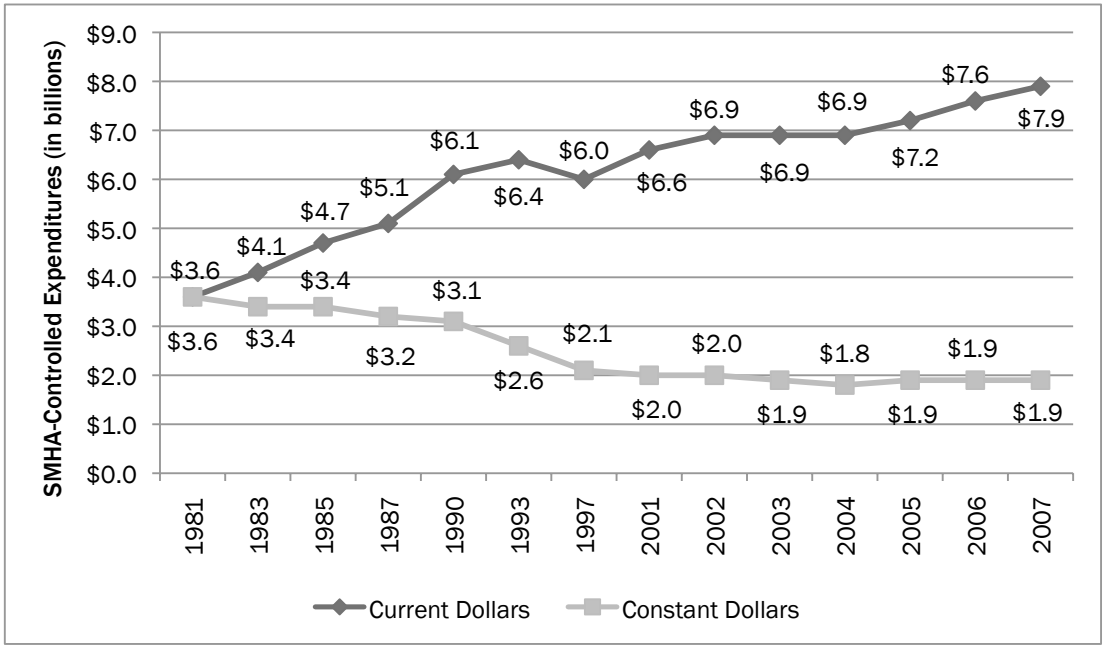
a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.
c = Children's mental health expenditures are not included in SMHA-controlled expenditures.
NR = not reported.

5.6.2 Trends in State Psychiatric Hospital Expenditures

As SMHAs continue to reduce the size and presence of state psychiatric hospitals and more frequently treat consumers in community-based treatment settings, funding for psychiatric hospitals continues to decline. From FY 1981 to FY 2007, SMHA-controlled expenditures for state psychiatric hospitals increased from $3.6 billion to $7.9 billion. However, when adjusted for inflation, expenditures actually decreased from $3.6 billion in FY 1981 to $1.9 billion in FY 2007 (see figure 31).

From FY 2001 to FY 2007, state psychiatric hospital expenditures increased by 2.1 percent per year. However, when adjusted for inflation and population growth, expenditures decreased by 2 percent per year. During the same time period, 39 SMHAs increased their state psychiatric hospital expenditures, whereas 9 expended less in 2007 than in 2001. As shown in figure 32, over the 26-year time period from FY 1981 to FY 2007, SMHA-controlled state psychiatric hospital expenditures increased by 2 percent. When adjusted for inflation and population growth, expenditures actually decreased by 3.5 percent over this time period.

Figure 31: Trends in SMHA-Controlled Spending for State Psychiatric Hospitals, FY 1981 to FY 2007



5.6.3 Overall Revenues of State Psychiatric Hospitals, FY 2007

SMHAs controlled $8.8 billion in revenues (30 percent of total SMHA-controlled revenues) dedicated to state psychiatric hospitals in FY 2007. SMHAs received funding from a variety of sources, including state general funds, Medicaid, Medicare, other federal sources, local government, miscellaneous funding sources, and the MHBG.

In FY 2007, 76 percent of SMHA-controlled funds for state psychiatric hospital services came from state government sources. The largest share of state funds came from state general funds (59 percent) and the state Medicaid match (12 percent).

Funding from the federal government accounted for 20 percent of the total SMHA-controlled state psychiatric hospital revenues. Medicaid was the single largest source of federal revenues, accounting for 16 percent of state psychiatric hospital revenues.

Medicaid's Institution for Mental Disease (IMD) rules restrict payments for inpatient treatment in psychiatric hospitals to children (under age 21) and older adults (over age 65). Services to adult patients between the ages of 21 and 64 in psychiatric hospitals (IMDs) are not eligible for Medicaid reimbursement.

State psychiatric hospitals received over $316 million in Medicare payments (3 percent of revenues) in FY 2007. Medicare payments at state psychiatric hospitals ranged from a high of 11 percent of hospital funding in New Hampshire and 10 percent in Kentucky, to seven states that reported no Medicare payments at their state psychiatric hospitals (California, Florida, Kansas, Maine, Maryland, Oregon, and Wyoming).

In addition, SMHAs received 1 percent of their revenues from local city and county governments and 2 percent from other sources, which include private health insurance reimbursements and consumer copays, as well as donations and all other funding sources. See figure 33 for a breakdown of total revenues, by funding sources, and table 25.

Figure 32: Average Annual Change in SMHA-Controlled State Psychiatric Hospital Expenditures, by Decade, FY 1981 to FY 2007

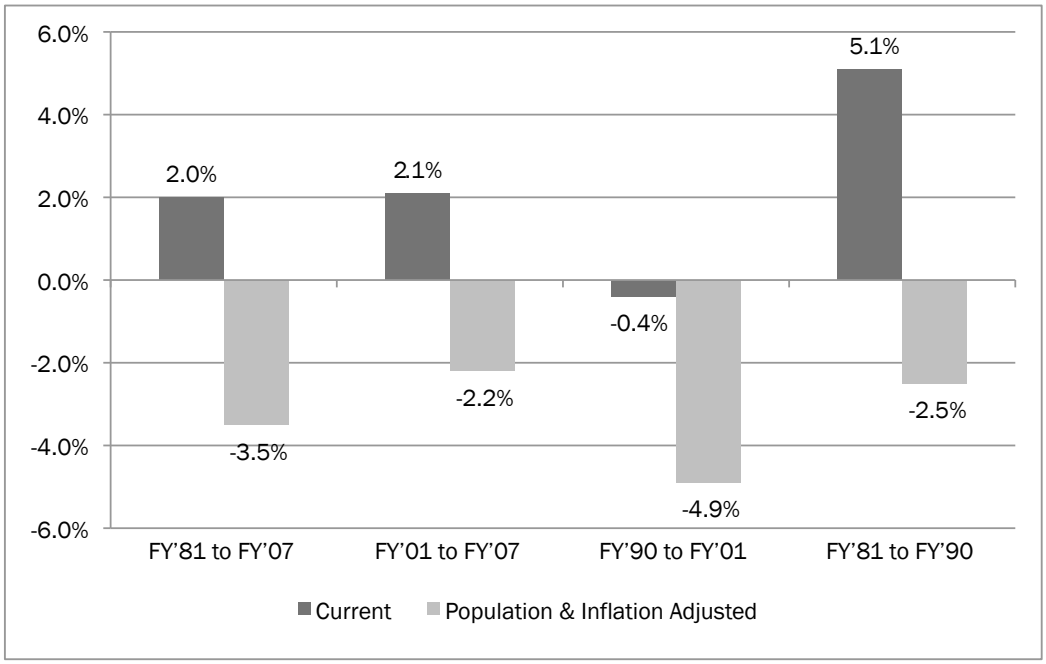


Figure 33: SMHA-Controlled Revenues for State Psychiatric Hospitals, by Funding Sources, FY 2007

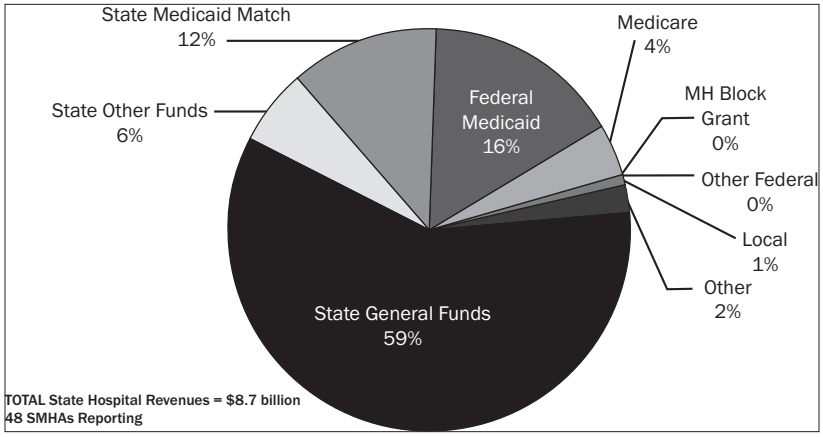


Table 25: SMHA-Controlled State Psychiatric Hospital Revenues, by Funding Sources and State, FY 2007 (in millions)

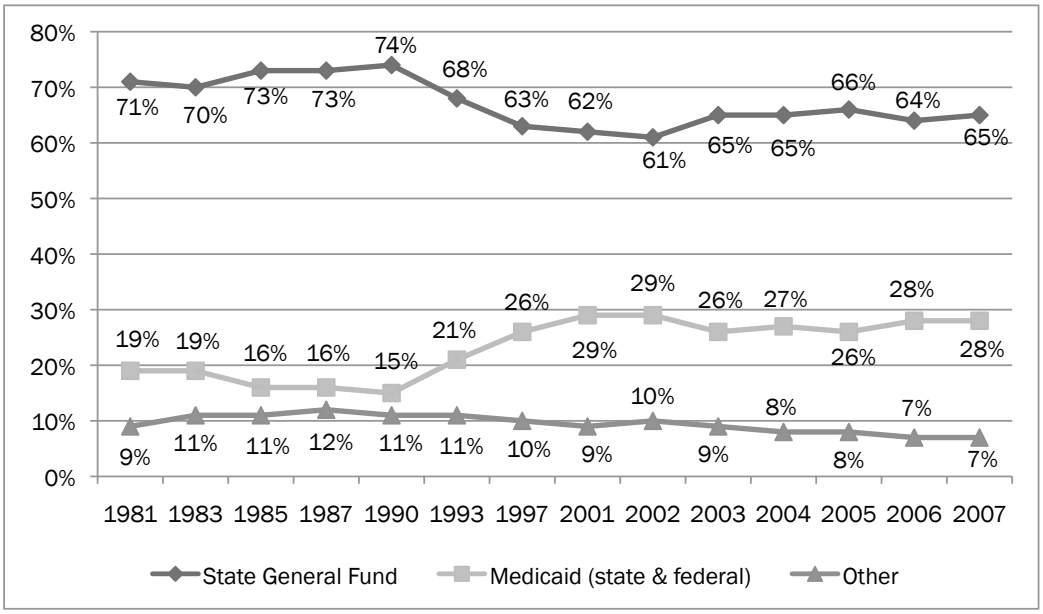
State	State General Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Alabama	$118.2	77%	$19.7	13%	$12.6	8%	$0.0	0%	$0.1	0%	$0.0	0%	$0.0	0%	$3.8	2%	$154.4
Alaska (a)	$6.7	27%	$14.6	59%	$1.3	5%	$0.0	0%	$0.6	3%	$0.0	0%	$1.3	5%	$0.0	0%	$24.6
Arizona	$39.0	53%	$28.5	39%	$0.4	1%	$0.0	0%	$1.7	2%	$0.0	0%	$3.4	5%	$0.0	0%	$73.0
Arkansas (a)	$32.5	48%	$28.9	42%	$2.2	3%	$0.0	0%	$0.0	0%	$0.0	0%	$4.0	6%	$0.4	1%	$67.9
California	NR		NR		NR		NR		NR		NR		NR		NR		NR
Colorado	$78.8	77%	$10.2	10%	$8.7	9%	$0.0	0%	$0.3	0%	$1.0	1%	$3.0	3%	$0.3	0%	$102.5
Connecticut (ac)	$189.7	92%	$5.8	3%	$6.4	3%	$0.0	0%	$0.4	0%	$0.0	0%	$2.0	1%	$0.8	0%	$205.1
Delaware (ac)	$44.1	93%	$0.7	2%	$0.6	1%	$0.0	0%	$1.1	2%	$0.0	0%	$1.0	2%	$0.0	0%	$47.6
District of Columbia	$78.6	93%	$1.7	2%	$1.5	2%	$0.0	0%	$2.4	3%	$0.0	0%	$0.0	0%	$0.0	0%	$84.2
Florida	$223.8	68%	$103.8	31%	$0.0	0%	$0.0	0%	$3.0	1%	$0.0	0%	$0.0	0%	$0.0	0%	$330.5
Georgia	$195.2	91%	NA		$9.1	4%	$0.0	0%	$0.1	0%	$0.0	0%	$0.5	0%	$9.9	5%	$214.8
Hawaii	NR		NR		NR		NR		NR		NR		NR		NR		NR
Idaho	$16.0	61%	$7.2	27%	$2.3	9%	$0.0	0%	$0.0	0%	$0.0	0%	$0.5	2%	$0.2	1%	$26.1
Illinois	$276.4	93%	$8.6	3%	$10.3	3%	$0.0	0%	$0.0	0%	$0.0	0%	$2.2	1%	$0.0	0%	$297.5
Indiana	$128.8	70%	$46.7	25%	$6.5	4%	$0.0	0%	$0.3	0%	$0.0	0%	$0.9	0%	$0.5	0%	$183.7
Iowa	NR		NR		NR		NR		NR		NR		NR		NR		NR
Kansas	$63.2	75%	$21.1	25%	$0.0	0%	$0.0	0%	$0.2	0%	$0.0	0%	$0.0	0%	$0.0	0%	$84.5
Kentucky	$66.3	58%	$35.4	31%	$11.3	10%	$0.0	0%	$0.0	0%	$0.0	0%	$2.0	2%	$0.0	0%	$115.0
Louisiana	$58.9	37%	$88.7	55%	$0.1	0%	$0.6	0%	$5.3	3%	$0.0	0%	$0.0	0%	$7.2	4%	$160.8
Maine (b)	$0.0	0%	$55.8	100%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$55.8
Maryland (b)	$256.9	92%	$23.7	8%	$0.0	0%	$0.0	0%	$0.1	0%	$0.0	0%	$0.0	0%	$0.0	0%	$280.7
Massachusetts (c)	$133.7	91%	$8.9	6%	$3.8	3%	$0.0	0%	$0.0	0%	$0.0	0%	$0.7	0%	$0.1	0%	$147.2
Michigan (b)	$174.2	84%	$19.1	9%	$1.3	1%	NA		$0.1	0%	$11.6	6%	$2.1	1%	$0.0	0%	$208.4
Minnesota	$155.6	71%	$17.9	8%	$5.3	2%	$0.0	0%	$0.0	0%	$26.5	12%	$13.2	6%	$0.0	0%	$218.6
Mississippi (b)	$135.5	68%	$43.4	22%	$7.1	4%	$0.0	0%	$0.0	0%	$0.0	0%	$0.7	0%	$11.3	6%	$198.0
Missouri	$238.4	61%	$149.1	38%	$2.2	1%	$0.0	0%	$0.2	0%	$0.0	0%	$2.8	1%	$0.0	0%	$392.8
Montana	$27.1	100%	$0.0	0%	NA		$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$27.1
Nebraska (b)	$40.2	90%	$0.7	2%	$0.7	2%	$0.0	0%	$2.9	6%	$0.0	0%	$0.0	0%	$0.0	0%	$44.5
Nevada	$59.4	81%	$9.2	13%	$4.1	6%	$0.0	0%	$0.1	0%	$0.0	0%	$0.0	0%	$0.4	1%	$73.2
New Hampshire	$3.1	4%	$54.6	76%	$8.1	11%	$0.0	0%	$0.2	0%	$0.0	0%	$0.0	0%	$5.5	8%	$71.6
New Jersey	$391.7	82%	$25.0	5%	$24.9	5%	$0.0	0%	$0.0	0%	$29.0	6%	$5.4	1%	$0.0	0%	$475.9
New Mexico	$37.6	84%	$4.7	10%	$0.3	1%	$0.0	0%	$0.0	0%	$0.0	0%	$0.4	1%	$1.8	4%	$44.8
New York (b)	$439.8	27%	$1,097.4	68%	$31.9	2%	$0.0	0%	$0.0	0%	$19.1	1%	$16.4	1%	$0.0	0%	$1,604.6
North Carolina	$219.1	68%	$52.0	16%	$29.1	9%	$0.0	0%	$0.0	0%	$3.0	1%	$9.1	3%	$11.3	4%	$323.6
North Dakota	$15.6	67%	$2.3	10%	$1.7	7%	$0.0	0%	$0.0	0%	$0.0	0%	$1.5	6%	$2.1	9%	$23.1
Ohio	$205.0	92%	$1.0	0%	$15.1	7%	NA		$0.0	0%	$0.0	0%	$1.6	1%	$0.0	0%	$222.6

Table 25: SMHA-Controlled State Psychiatric Hospital Revenues, by Funding Sources and State, FY 2007 (in millions) (Continued)

State	State General Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Oklahoma	$41.2	83%	$4.9	10%	$2.4	5%	$0.0	0%	$0.0	0%	$0.0	0%	$0.7	1%	$0.7	1%	$49.9
Oregon	$84.4	73%	$23.8	20%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$8.1	7%	$116.3
Pennsylvania (b)	$403.3	80%	$64.7	13%	$23.7	5%	$0.0	0%	$0.0	0%	$0.0	0%	$11.4	2%	$0.0	0%	$503.1
Rhode Island (c)	$0.0	0%	$31.1	100%	NA		$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$31.1
South Carolina	$62.8	65%	$30.5	32%	$0.5	1%	$0.0	0%	$0.0	0%	$0.0	0%	$1.2	1%	$1.3	1%	$96.3
South Dakota	$25.5	66%	$9.7	25%	$2.7	7%	$0.0	0%	$0.2	0%	$0.0	0%	$0.0	0%	$0.6	2%	$38.6
Tennessee	$109.9	65%	$45.1	27%	$10.5	6%	$0.0	0%	$0.0	0%	$0.0	0%	$1.4	1%	$1.6	1%	$168.5
Texas (b)	$279.4	82%	$29.2	9%	$22.5	7%	$0.0	0%	$0.3	0%	$0.0	0%	$9.4	3%	$0.0	0%	$340.8
Utah (b)	$33.6	66%	$14.2	28%	$1.2	2%	$0.0	0%	$0.1	0%	$0.0	0%	$0.0	0%	$1.6	3%	$50.6
Vermont	$18.8	98%	$0.0	0%	$0.1	1%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.2	1%	$19.1
Virginia (b)	$225.0	73%	$51.0	17%	$18.3	6%	$0.0	0%	$0.0	0%	$0.0	0%	$10.0	3%	$3.0	1%	$307.3
Washington	$46.6	21%	$147.0	68%	$14.9	7%	$0.0	0%	$0.0	0%	$0.0	0%	$8.9	4%	$0.0	0%	$217.4
West Virginia (b)	$19.1	44%	$19.7	46%	$3.4	8%	$0.0	0%	$0.0	0%	$0.0	0%	$0.9	2%	$0.0	0%	$43.1
Wisconsin	$148.8	81%	$16.3	9%	$7.2	4%	NA		$0.0	0%	$0.0	0%	$11.4	6%	$0.0	0%	$183.7
Wyoming (a)	$29.7	100%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$29.7
Total	**$5,677.3**	**65%**	**$2,473.8**	**28%**	**$316.2**	**3.6%**	**$0.6**	**0.0%**	**$19.7**	**0.2%**	**$90.2**	**1.0%**	**$130.0**	**1.5%**	**$72.7**	**0.8%**	**$8,780.3**
Average (Mean)	**$111.3**		**$49.5**		**6.5**		**$0.0**		**0.4**		**$1.8**		**$2.5**		**$1.4**		**$172.2**
Median	**$63.2**		**$19.4**		**2.4**		**$0.0**		**0.0**		**$0.0**		**$0.7**		**$0.0**		**$102.5**

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.
NR = not reported.

Figure 34: Percentage of SMHA-Controlled State Psychiatric Hospital Mental Health Revenues, by Major Sources, FY 1981 to FY 2007



5.6.4 Trends in Financing of State Psychiatric Hospitals

Since FY 1981, state general funds have been the largest source of state psychiatric hospital revenues. While state general funds continue to be the largest source of funding for state psychiatric hospitals, starting in FY 1993, Medicaid funding increased, whereas state general funding decreased. In FY 1981, state general funds represented 71 percent of SMHAs' state psychiatric hospital revenues, whereas Medicaid (state and federal) accounted for 19 percent. By FY 2007, state general funds decreased to 65 percent, whereas Medicaid increased to 28 percent (see figure 34, above).

5.7 Summary

Every state government operates psychiatric inpatient beds that provide intensive services to consumers with high levels of need, including those who are a threat to themselves or others. In 2008, 3 percent of SMHA consumers were served in state psychiatric hospitals. Seventy-seven percent of the consumers served in these hospitals were from the ages of 21 to 64 and had an average length of stay of 125 days.

Psychiatric hospitals often provide forensic services to mental health consumers. Forensic services provide evaluation and treatment to persons who have mental illnesses and are referred to the SMHA after contact with the criminal justice system. Nearly one-third of all consumers in state hospitals were involuntarily criminally committed.

In FY 2007, SMHAs expended $8.7 billion, or 28 percent of all SMHA-controlled expenditures, on state psychiatric hospitals. The majority of expenditures for state psychiatric hospitals were dedicated to inpatient services (92 percent), with the rest spent on less than 24-hour services (4 percent), and other 24-hour services (3 percent). SMHAs expended $2 billion on forensic services and an additional $233 million on sex offender services.

VI. Summary

SMHAs are designated by the state's Governor as the government agencies charged with assuring the provision of mental health services to over 6.3 million persons (just over 2 percent of the U.S. population) each year. The vast majority (94 percent) of persons served by the SMHA systems are served in community settings, whereas 3 percent are served in state psychiatric hospitals and 7 percent in other psychiatric inpatient settings (some consumers are served in more than one service setting during the year).

The organizational location of SMHAs within state government varies. In most states, the SMHA is organized as a division within a larger state umbrella agency, usually the state's Health or Human Services Department. In a few states, the SMHA is an independent stand-alone state agency, where the commissioner reports directly to either the Governor or a mental health oversight board.

Most SMHAs are working with Medicaid and other state government agencies such as substance abuse, health, housing, corrections, juvenile justice, child welfare, aging, and employment, to reduce fragmentation in the funding and delivery of services. SMHAs often collaborate with state health departments regarding the recognition and treatment of mental illnesses within health services and the better recognition and treatment of physical health problems of SMHA consumers.

SMHAs in every state are responsible for funding or operating community mental health services and administering the federal Community Mental Health Services Block Grant. SMHAs are also responsible for developing and implementing comprehensive plans to meet the mental health needs of individuals in their state. Every state government also operates psychiatric inpatient beds, which are part of the SMHA in most states. In states where the state psychiatric hospitals are administered by a separate state government agency, the SMHA works with the state psychiatric hospital to facilitate the transition of consumers between the hospital and SMHAs' community mental health system.

Community mental health services provided by SMHAs include a variety of individual and group therapies, along with residential, crisis, and some inpatient services. Increasingly, SMHAs are providing services identified by SAMHSA and other experts as Evidence-Based Services—including assertive community treatment, supported housing, supported employment, illness self-management, family psychoeducation, medication algorithms, and an array of additional children and adult services.

Although only 3 percent of the consumers were served in state psychiatric hospitals during the year (2008), SMHAs expended almost $8 billion on these intensive services. The financing of state psychiatric hospitals relies much more heavily on state general and other state funds (65 percent) than on Medicaid (28 percent) or Medicare (4 percent).

Almost half (24) of the SMHAs are engaged in some activities to reorganize or downsize their state psychiatric hospital system. In part because of the effects of the recent overall state budget shortfalls, 15 states are currently planning to close, downsize, or consolidate their state psychiatric hospitals. During the last 2 years, seven state psychiatric hospitals have been closed, and five states are currently planning to close one or more additional state psychiatric hospitals. In addition to downsizing, several SMHAs are privatizing the operation of state psychiatric hospitals.

For the last decade, several trends in SMHA financing of mental health services have continued:

- First, although state general funds devoted to SMHAs have not declined, they have grown at a much slower rate (2.6 percent) than Medicaid funds (11.8 percent per year). As a result, over the last 7 years, 75 percent of all new SMHA funds have come from Medicaid.
- Second, SMHAs have continued to shift expenditures from state psychiatric hospitals to community-based mental health systems. In FY 2001, 63 percent of SMHA funds were devoted to community mental health systems, whereas by FY 2007, 70 percent of SMHA funds were devoted to community mental health.
- Third, an ever greater share of state psychiatric hospital expenditures are used to fund patients with forensic and sex offender legal statuses. From FY 2001 to FY 2007, state psychiatric hospital expenditures for forensics and sex offenders grew by over $973 million (an annual increase of 10.1 percent per year) to a total of over $2.2 billion. During this same time interval, total state psychiatric hospital expenditures grew by an average of only 3 percent per year.

SMHAs have identified a number of major policy initiatives that they are addressing to improve mental health services. These initiatives include:

- Performing mental health screening and assessments and making referrals to detect mental illnesses early;
- Developing trauma-informed services;
- Eliminating mental healthcare disparities based on gender, race/ethnicity, age, or other cultural identities;
- Providing culturally appropriate and competent services;
- Providing dual diagnosis services, for individuals with both co-occurring mental health and substance abuse problems, but also with co-occurring mental health and physical health problems;
- Ensuring every mental health consumer receives an individualized treatment plan;
- Ensuring mental health services are consumer and recovery focused;
- Providing diversion programs to keep persons with mental illness out of criminal justice systems; and
- Ensuring returning veterans and military members have access to needed mental health services.

During calendar year (CY) 2009, the U.S. economy experienced a dramatic slowdown that has resulted in major reductions of tax revenues of state governments. Forty-eight of the 50 states have experienced budget shortfalls in their FY 2009 or FY 2010, with estimated cumulative budget shortfalls of $180 billion for FY 2010 (McNichol & Johnson, 2009). The major budget shortfalls facing state governments in CY 2009 and projected to continue for the next fiscal year are potential impediments to the future expansion—or even maintenance—of SMHA services. State budget shortfalls are already causing painful reductions in services and staffing in some SMHAs and may prove a major barrier to states' ability to achieve their goals of improving their public mental health systems.

Glossary

AA	Administrative agent
ABC	Antecedents, Behaviors, and Consequences
ACEC	Arizona Children's Executive Committee
ACRA	Adolescent Community Reinforcement Approach
ACT	Assertive Community Treatment
ADA	Division of Alcohol and Drug Abuse (MO)
ADAD	Alcohol and Drug Abuse Division (HI)
ADE	Arizona Department of Education
ADES/RSA	Arizona Department of Economic Security/Rehabilitation Services Agency
ADOH	Arizona Department of Housing
AHCA	Agency for Health Care Administration
AHP	Advocates for Human Potential, Inc.
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired immunodeficiency syndrome
AKAIMS	Alaska's Automated Information Management System
ALTSD	Aging and Long-Term Services Department (NM)
AMDD	Addictive and Mental Disorders Division (MT)
AMH	Addictions and Mental Health Division
AMHB	Alaska Mental Health Board
AMHD	Adult Mental Health Division (HI)
AMHI	Augusta Mental Health Institute
ANTHC	Alaska Native Tribal Health Consortium
AOC	Administrative Office of the Courts (NM)
API	Alaska Psychiatric Institute
APRN	Advanced practice nurse
ARNP	Advanced registered nursing practitioner
ARRA	American Recovery and Reinvestment Act
ASAP	Arizona Substance Abuse Partnership
ASH	Arkansas State Hospital
ASO	Administrative Service Organization
ASSIST	Applied Suicide Intervention Skills Training
BASIC	Better Attitudes and Skills in Children
BBH	Bureau of Behavioral Health (NH)
BHA	Behavioral Health Administration (HI)
BHHF	Bureau for Behavioral Health and Health Facilities (WV)
BHSD	Behavioral Health Services Division (NM)
BHSN	Behavioral Health Safety Net
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
BTKH	Bring the Kids Home
C&MHSA	Chemical and Mental Health Services Administration (MN)
CalFHA	California Housing Financing Agency
CALOCUS	Child & Adolescent Level of Care Utilization System
CalRHIO	California Regional Health Information Organization
CAMHD	Child and Adolescent Mental Health Division (HI)
CARF	Commission on Accreditation of Rehabilitation Facilities
CBC	Community-Based Care
CBFS	Community Based Flexible Supports
CBT	Cognitive Behavioral Therapy
CCISC	Comprehensive, Continuous, Integrated System of Care
CCS	Comprehensive Community Services
CCSR	Comprehensive Community Service Regions
CDR	Clinical Data Repository
CEPP	Conditional Extension Pending Placement
CEU	Continuing education unit
CFSA	Child and Family Services Agency
CFT	Child and Family Team
CHC	Community health center

CHIP	Children's Health Insurance Program
CHOICES	Consumers Helping Others Improve their Condition by Ending Smoking
CIT	Crisis Intervention Training
CME	Continuing medical education
CMHA	Community mental health agency
CMHC	Community mental health center
CMHD	Children's Mental Health Division (MN)
CMHS	Center for Mental Health Services
CMHSBG	Community Mental Health Services Block Grant
CMHSP	Community Mental Health Services Program
CMS	Centers for Medicare and Medicaid Services
COD	Co-occurring disorders
COSIG	Co-Occurring State Incentive Grant
CPE	Certified public expenditure
CPS	Child Protective Services
CPS	Division of Comprehensive Psychiatric Services (MO)
CPSS	Certified Peer Support Specialists
CPST	Community psychiatric supportive treatment
C-RECS	Consumer Recovery Employment Consultation Service
CSA	Core Service Agency
CSAIG	Commissioner's Strategic Analysis Initiative Group
CSB	Community services board
CSP	Community Support Program
CST	Coordinated Service Team
CSW	Clinical social worker
CTI	Care Transitions Intervention
CY	Calendar year
CYFD	Children, Youth and Families Department (NM)
CYS	Division of Children and Youth Services (MS)
DA	Designated agency
DADS	Department of Aging and Disability Services (TX)
DAODAS	Department of Alcohol and Other Drug Abuse Services (SC)
DBH	Division of Behavioral Health (AK)
DBHDS	Department of Behavioral Health and Developmental Services (VA)
DBHS	Division of Behavioral Health Services (AR)
DBT	Dialectical Behavioral Therapy
DCA	Department of Community Affairs (NJ)
DCF	Department of Children and Families (CT)
DCMHS	Division of Child Mental Health Services (DE)
DCPCA	DC Primary Care Association
DCYF	Department of Children, Youth and Families (RI)
DD	Developmental disabilities
DDD	Developmental Disabilities Division (HI)
DES	Department of Economic Security (AZ)
DFA	Department of Finance and Administration (NM)
DFCS	Department of Family and Children Services (GA)
DFPS	Department of Family and Protective Services (TX)
DH	Designated hospital
DHCD	District's Housing and Community Development
DHCS	Department of Health Care Services (CA)
DHEC	Department of Health and Environmental Control (SC)
DHH	Department of Health and Hospitals (LA)
DHHS	Department of Health and Human Services (ME, NE, NH)
DHIN	Delaware Health Information Network
DHMH	Department of Health and Mental Hygiene (MD)
DHR	Department of Human Resources (GA)
DHS	Department of Human Services (DC, HI, OR)
DHSS	Department of Health and Social Services (AK)
DIAMOND	Depression Improvement Across Minnesota, Offering a New Direction
DIG	Data Infrastructure Grant

DIVERTS	Direct Intervention, Vital Early Response Treatment System
DJJ	Department of Juvenile Justice (GA, SC)
DMA	Division of Medical Assistance (NC)
DMH	Department of Mental Health (AL, CA, DC, MA, MS, MO, VT)
DMH	Division of Mental Health (IL)
DMHA	Division of Mental Health and Addiction (IN)
DMHAS	Department of Mental Health and Addiction Services (CT)
DMHDDAD	Division of Mental Health, Developmental Disabilities and Addictive Diseases (GA)
DMHS	Division of Mental Health Services (NJ)
DMHSAS	Division of Mental Health and Substance Abuse Services (WI)
DOC	Department of Corrections (MT)
DOCR	Department of Corrections and Rehabilitation (ND)
DOE	Department of Education (HI)
DOH	Department of Health (HI, NM, UT)
DOT	Department of Transportation (NM)
DPC	Delaware Psychiatric Center
DPH	Division of Public Health (DE)
DPHHS	Department of Public Health and Human Services (MT)
DSA	Direct service assistant
DSAMH	Division of Substance Abuse and Mental Health (DE)
DSHS	Department of Social and Health Services (WA)
DSHS	Department of State Health Services (TX)
DSM-III-R	Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised
DVR	Delaware Vocational Rehabilitation
DVR	Division of Vocational Rehabilitation (NJ, NM)
DYRS	Department of Youth and Rehabilitation Services (DC)
EBP	Evidence-based practice
ECC	Enhanced Care Clinic
EHR	Electronic health record
EMR	Electronic medical record
EOHHS	Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER/ED	Emergency Room/Emergency Department
ETPS	Enhanced Tier Payment System
F.I.R.S.T.	Families in Recovery Succeeding Together (AZ)
FFS	Fee-for-service
FFT	Functional Family Therapy
FGC	Family Guidance Center
FHK	Foundation for a Healthy Kentucky
FQHC	Federally qualified health centers
FSSA	Family and Social Services Administration (IN)
FTE	Full-time equivalent
FY	Fiscal year
GAIN	Global Appraisal of Individual Needs
GAP	Gamblers Assistance Program
GBMI	Guilty but Mentally Ill
GSA	Geographical service areas
HB	House Bill
HCBS	Home and Community-Based Services
HCPF	Department of Health Care Policy and Financing (CO)
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HIT	Health information technology
HIV	Human immunodeficiency syndrome
HJR	House Joint Resolution
HMO	Health-maintenance organization
HRD	Health Resources Division (MT)
HRSA	Health and Recovery Services Administration (WA)
HRSA	Health Resources and Services Administration
HSD	Human Services Department (NM)
HUSKY	Healthcare for Uninsured Kids and Youth
IAD	Indian Affairs Department (NM)
ICARE	Integrated, Collaborative, Accessible, Respectful and Evidence-based

ICCCY	Interagency Coordinating Council for Children and Youth
ICF-MI	Intermediate care facilities for persons with mental illness
ICSIC	Interagency Collaboration and Services Integration Commission
IDDT	Integrated Dual Disorders Treatment
IDTA	In-Depth Technical Assistance
IGA	Intergovernmental Agreement
IMD	Institution for Mental Disease
IMR	Illness Management and Recovery
IPS	Individual Placement and Support
JCR	Joint Commission Resources
KDBHDID	Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities
KHS	Kansas Health Solutions
KRS	Kentucky Revised Statute
LB	Legislative Bill
LEP	Limited English proficient
LGE	Local governing entity
LIHTC	Low-Income Housing Tax Credit
LMHA	Local mental health authority
LMS	Learning Management System
LOCUS	Level of Care Utilization System
LPN	Licensed practical nurse
MAP	Making A Plan
MBHP	Massachusetts Behavioral Health Partnership
MCO	Managed care organization
MCPAP	Massachusetts Child Psychiatry Access Project
MDCH	Michigan Department of Community Health
MDTV	Mountain Doctor TeleVision
MeHAF	Maine Health Access Foundation
MFA	Mortgage Finance Authority
MFP	Money Follows the Person
MH	Mental health
MHA	Mental Hygiene Administration (MD)
MHBG	Mental Health Block Grant
MHD	Mental Health Division (MN, WA, WY)
MHDDSAS	Mental Health, Developmental Disabilities, and Substance Abuse Services (NC)
MHDS	Mental Health and Developmental Services (NV)
MHOAC	Mental Health Oversight Advisory Council
MHRH	Department of Mental Health, Retardation and Hospitals (RI)
MHSA	Mental Health Services Act
MHSIP	Mental Health Statistics Improvement Program (MHSIP)
MHSP	Mental Health Services Plan
MHTSIG	Mental Health Transformation State Incentive Grant
MIRCI	Mental Illness Recovery Center, Inc.
MIS	Management Information Systems
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
MPD	Metropolitan Police Department (DC)
MR	Mental retardation
MRC	Massachusetts Rehabilitation Commission
MRDD	Division of Mental Retardation and Developmental Disabilities (MO)
MRO	Medicaid Rehabilitation Option
MRSA	Methicillin-resistant Staphylococcus aureus
MST	Multisystemic Therapy
NA	Not applicable
NAMI	National Alliance on Mental Illness
NASMHPD	National Association of State Mental Health Program Directors
NCSACW	National Center on Substance Abuse and Child Welfare
NEP	Non-English proficient
NGRI	Not Guilty by Reason of Insanity
NJ DMAVA	New Jersey Department of Military and Veterans Affairs
NJ DMHS	New Jersey Division of Mental Health Services
NJHMFA	New Jersey Housing and Mortgage Finance Agency
NMCD	New Mexico Corrections Department
NMDDPC	New Mexico Developmental Disabilities Planning Council

NMDWS	New Mexico Department of Workforce Solutions
NOM	National Outcome Measures
NPSY	Department of Neuropsychiatry and Behavioral Science (SC)
NR	Not reported
NRI	National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc.
NSPL	National Suicide Prevention Lifeline
NYS	New York State
OAMHS	Office of Adult Mental Health Services (ME)
OCCIC	Ohio Coordinating Center for Integrating Care
OCHIP	Ohio Children's Health Insurance Program
OCS	Office of Constituency Services (MS)
ODMH	Ohio Department of Mental Health
ODMHSAS	Oklahoma Department of Mental Health and Substance Abuse Services
OEF	Operation Enduring Freedom
OHSU	Oregon Health Sciences University
OIF	Operation Iraqi Freedom
OMAP	Office of Medical Assistance Programs (PA)
OMB	Office of Management and Budget
OMH	Office of Mental Health (LA, NY)
OMHSAS	Office of Mental Health and Substance Abuse Services (PA)
ORHCC	Office of Rural Health and Community Care (NC)
OSA	Other state agency
OSH	Oregon State Hospital
OSHA	Occupational Safety and Health Administration (SC)
OTA	Occupational therapy assistant
PACT	Positive Achievement Change Tool (section 3.11.3); Program of Assertive Community Treatment (MS)
PATCH	Psychogeriatric Assessment and Treatment in City Housing
PATH	Personal Action Toward Health (MI); Projects in Assistance for Transition from Homelessness (MS, MT)
PBHCI	Primary and Behavioral Health Care Integration
PBISAZ	Positive Behavioral Interventions and Supports of Arizona
PCP	Primary care physician (MI); primary care practitioner (NJ)
PEARLS	Program to Encourage Active and Rewarding Lives for Seniors
PED	Public Education Department (NM)
PHIP	Prepaid Inpatient Health Plan
PHR	Personal health record
PLN	Psychiatric licensed nurse
POS	Purchase of Service
PRTF	Psychiatric residential treatment facility
PTSD	Post-Traumatic Stress Disorder
QPR	Question, Persuade and Refer
RBHA	Regional Behavioral Health Authority
RHC	Rural health clinic
RHIO	Regional Health Information Organization
RIP	Regional Intervention Program
RN	Registered nurse
ROSI	Recovery Oriented System Indicators
RSA	Revised Statutes Annotated
RSN	Regional Support Network
RTC	Residential Treatment Center
SAMH	Substance Abuse and Mental Health (FL)
SAMHIS	Substance Abuse and Mental Health Information System
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCDMH	South Carolina Department of Mental Health
SCHIEx	South Carolina Health Exchange
SCHIP	State Children's Health Insurance Program
SCVRD	South Carolina Vocational Rehabilitation Department
SDC	Self-directed care
SDM	Shared Decision-Making
SDMI	Severe disabling mental illness

SE	State entity
SEARHC	South East Alaska Regional Health Consortium
SED	Serious emotional disturbances
SEP	Seniors and People with Disabilities
SFY	State fiscal year
SHIP	Statewide Head Injury Program
SMHA	State Mental Health Agency
SMI	Serious mental illnesses
SOAR	SSI/SSDI Outreach, Access and Recovery (GA); Service Outcome Action Research (MT)
SOC	System of Care
SOS	Signs of Suicide
SPMI	Serious and persistent mental illness
SPS	SMHA Profiling System
SR	Seclusion and restraint
SRP	Subcommittee on Residential Placement
SRS/MH	Social and Rehabilitation Services/ Mental Health
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STD	Sexually transmitted disease
STEPPS	Systems Training for Emotional Predictability and Problem Solving
TANF	Temporary Assistance for Needy Families
TAPP	Transition and aftercare for probationers and parolees
TBH	Tele-Behavioral Health
TBI	Traumatic brain injury
TDMHDD	Tennessee Department of Mental Health and Developmental Disabilities
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TRBHA	Tribal Behavioral Health Authority
TSIG	Transformation State Incentive Grant
TTI	Transformation Transfer Initiative
TWG	Transformation Working Group
UAA	University of Alaska Anchorage
UBHC	University Behavioral Health Care
UMDNJ	University of Medicine and Dentistry of New Jersey
URS	Uniform Reporting System
US DHHS	U.S. Department of Health and Human Services
USC SOM	University of South Carolina School of Medicine
USVA	U.S. Department of Veterans Affairs
VA	Department of Veterans Affairs
VA	Veteran's Administration (state)
VHST	Virginia Human Services Training Center
VISI	Vermont Integrated Services Initiative
VRBHP	Vocational Rehabilitation Behavioral Health Project
VSH	Vermont State Hospital
VWWP	Virginia Wounded Warrior Program
WET	Workforce, Education, and Training
WIG	Wildly Important Goal
WITS	Web Infrastructure for Treatment Services
WMR	Wellness Management and Recovery
WRAP	Wellness and Recovery Action Plan
WSH	Wyoming State Hospital
YES	Youth Empowerment Services
YKHC	Yukon-Kuskokwim Health Corporation

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Appendix to
Funding and Characteristics of
State Mental Health Agencies, 2009

HHS Pub. No. (SMA) XX

Contents

Alabama 2009....1
Alaska 2009....7
Arizona 2009....13
Arkansas 2009....21
California 2009....25
Colorado 2009....31
Connecticut Adults' Division 2009....37
Connecticut Children's Division 2009....43
Delaware 2009....49
District of Columbia 2009....55
Florida 2009....61
Georgia 2009....67
Hawaii Adults' Division 2009....73
Hawaii Children's Division 2009....77
Idaho 2009....81
Illinois 2009....87
Indiana 2009....89
Iowa 2009....95
Kansas 2009....99
Kentucky 2009....105
Louisiana 2009....109
Maine 2009....113
Maryland 2009....119
Massachusetts 2009....125
Michigan 2009....131
Minnesota 2009....137
Mississippi 2009....141
Missouri 2009....147
Montana 2009....151
Nebraska 2009....155
Nevada 2009....161
New Hampshire 2009....165
New Jersey 2009....171
New Mexico 2009....179

New York 2009 185
North Carolina 2009 191
North Dakota 2009 197
Ohio 2009 201
Oklahoma 2009 207
Oregon 2009 211
Pennsylvania 2009 217
Rhode Island 2009 223
South Carolina 2009 227
South Dakota 2009 233
Tennessee 2009 237
Texas 2009 243
Utah 2009 249
Vermont 2009 255
Virginia 2009 259
Washington 2009 265
West Virginia 2009 271
Wisconsin 2009 275
Wyoming 2009 281

Alabama 2009

Department of Mental Health 100 North Union Street Montgomery, AL 36130 www.mh.alabama.gov	The Alabama Department of Mental Health (DMH) is responsible for mental illness, intellectual disabilities, and substance abuse services. DMH is responsible for operating state psychiatric facilities, establishing standards for community services, and is empowered to contract for services.

Statistics:

State Population (2007):	4,627,851
Number of Persons Served (2008):	102,133
Utilization Rate for Adults:	21.8 per 1,000
Utilization Rate for Children:	22.3 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$341.5 million
Revenue From Medicaid	$129.9 million
Expenditures for Community Mental Health Services (52% of Total Mental Health Agency Revenues)	$178.2 million
Per Capita State Mental Health Expenditures	$74.03

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 Services	Part of the SMHA
Brain Impaired Services	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	Part of the SMHA
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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Part of the SMHA
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
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	0	27	27
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is currently not undertaking initiatives to restructure the state's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other Alabama government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Collaborative efforts include: working with the Alabama Housing Finance Authority and with the Governor's Interagency Council on Homelessness; DMH has hired an employment specialist to work with other agencies around employment issues; had a Justice and Mental Health Collaboration Program; collocation of services within school systems; Children's Services Office works with child welfare and education on relevant issues; and Medicaid-approved services for telepsychiatry.

Alabama has initiatives to transform the way it delivers mental health services: hospital census reduction, peer support, supported housing, and other evidence-based practices.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	Yes
Employment	Yes	No	Yes	Yes
Juvenile Justice	Yes	No	Yes	Yes
Criminal Justice	No	No	No	No
Education	Yes	No	Yes	Yes
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	No	Yes	Yes
Substance Abuse	Yes	No	Yes	Yes
National Guard	No	No	No	Yes

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers: discussion in the fall of 2008 with Public Health regarding collocation of services and disparities in mental health.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. Through a grant, regional roundtable discussions were held to promote improved collaboration. The agency has a state-level advisory group.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: Child and Adolescent Psychiatric Institute is cosponsored with the Department of Health and the Academy of Pediatrics. Both psychiatrists and pediatricians attend. DMH also supports Adult Psychiatric Institutes and invites primary care physicians. Additionally, DMH cochairs the Alabama Department of Public Health's Mental Health Task Force on Health Disparities.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	20
Supported Employment	Parts of the state	6
Integrated Mental Health/Substance Abuse Services	Parts of the state	NR
Illness Self-Management	Parts of the state	8
Supported Housing	Parts of the state	8
Consumer-Operated Services	Parts of the state	29

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
In-Home Intervention	Available statewide	22
Supported Employment	Available in parts of the state	6

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing a shortage of psychiatrists, other physicians, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, clinical specialists (master's level and above), and registered nurses in state psychiatric hospitals and community mental health programs. The SMHA has the following initiatives to address staffing shortages: special university-based training initiatives, training at mental health programs/providers, and increased salaries. Other initiatives to reduce staff shortages include contracts for six new residency slots and telemedicine.

The SMHA has initiatives to improve the quality of the mental health workforce. Adult and child adolescent psychiatric institutes provide numerous technical assistance and training events.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings and video conferencing.

The SMHA has relationships with professional schools to provide training in disciplines including social, work, psychology, psychiatry, and nursing. These relationships include providing practice training opportunities and providing scholarship opportunities at Bryce Hospital.

Alabama reimburses adult consumer peer specialists through Medicaid for providing mental health services. Peer support is not covered, but peer support specialists can bill for "Basic Living Skills." DMH also collaborates with the Department of Public Health on an application for a student loan repayment program as a workforce development measure.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Alabama 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, that is, the piloted use of telemedicine for child and adolescent psychiatry and pediatric interface. The SMHA also has increased the use of telemedicine in locations or areas.

Electronic Health Records (EHRs):

Local providers use a variety of EHR systems.

The SMHA has proposed a Health Information Exchange (HIE) through stimulus funding that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all contract community providers.

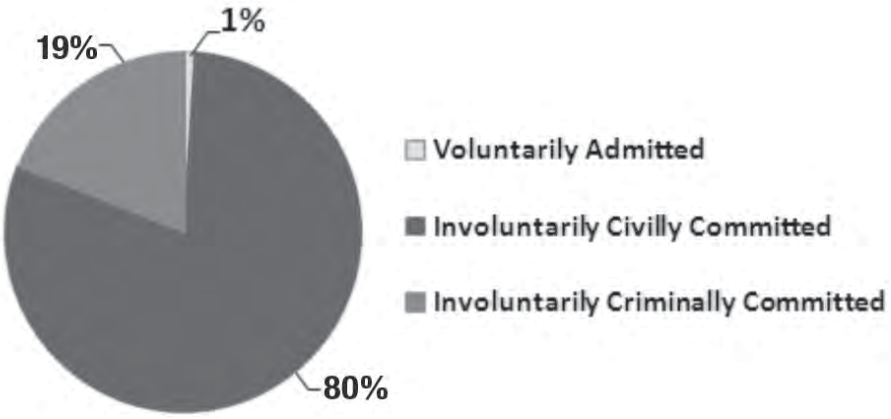
State Psychiatric Hospitals:

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 six SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

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:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, the Reserve, and family members of military personnel. One initiative is the work of the State of Alabama Returning Veterans Task Force, which developed and distributed to returning veterans and their families a self-help handbook, "Reintegration Action Plan."

Alabama has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Alaska 2009

Division of Behavioral Health Department of Health & Social Services 3601 C Street, Suite 878 Anchorage, AK 99645 www.hss.state.ak.us/dbh/	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 (API), 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 API, Alaska 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 (2007):	683,478
Number of Persons Served (2008):	15,256
Utilization Rate for Adults:	10.3 per 1,000
Utilization Rate for Children:	28.5 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$54.7 million
Revenue From Medicaid	$18 million
Expenditures for Community Mental Health Services (47% of Total Mental Health Agency Revenues)	$26.6 million
Per Capita State Mental Health Expenditures	$82.68

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
Housing Agency	Same umbrella department as the SMHA
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
Private Psychiatric Hospitals	NA	1	1
General Hospitals With Separate Psychiatric Units	0	3	3

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives to restructure Alaska's community-based system of mental health service delivery. DBH continues work on achieving its overall mission to manage an integrated and comprehensive behavioral health system based on sound policy, effective practices, and partnerships. DBH's continued work on achieving its mission brings with it several major challenges facing its leadership and staff and a focus on change. DBH is focusing on changes to its Accessible, Effective, and Efficient Continuum of Behavioral Health Services: sustained need for increased grant support, capacity expansion, and decrease in stable workforce without budget increases. In addition, DBH is working on Effective and Efficient Management and Administration: new business practices, performance-based funding, and Alaska's Automated Information Management System (AKAIMS), a powerful Web Infrastructure for Treatment Services (WITS) electronic health records system for both mental health and substance abuse client data; national accreditation; and its Behavioral Health Integration Project to integrate systems and services for individuals with co-occurring disorders.

Interagency Collaboration:

The SMHA is working with other Alaska government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams to the provision of appropriate mental health services:

- **Housing** – The Affordable Appropriate Housing Focus Area increases the availability of housing options.
- **Employment** – The SMHA is working on a supported employment project in partnership with the Council of Disabilities and the Division of Vocational Rehabilitation to increase supports to SMI and SED clients who are hoping to or are working.
- **Juvenile Justice** – Efforts are focused on Bring the Kids Home (BTKH) and the initiative to return kids to Alaska, maintain them safely, and treat them at home with their families.
- **Criminal Justice** – Therapeutic courts are located in multiple local communities.
- **Education** – School-based treatment options are being expanded.

Agency	Combine or Coordinate Service Delivery
Housing	Yes
Employment	Yes
Juvenile Justice	Yes
Criminal Justice	Yes
Education	Yes
Child Welfare	Yes
Medicaid	Yes
Substance Abuse	Yes
National Guard	No

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The SMHA is working with Tribal Health Organizations, the AMHB, and the Alaska Mental Health Trust Authority to develop primary care options and also options for Early Childhood Services.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Supported Employment	Parts of the state	3
Family Psychoeducation	Statewide	NA
Integrated Mental Health/Substance Abuse Services	Statewide	65
Illness Self-Management	Parts of the state	2
Supported Housing	Parts of the state	20
Consumer-Operated Services	Parts of the state	2
Multisystemic Therapy (Conduct Disorder)	Parts of the state	1
Therapeutic Foster Care	Statewide	9
Functional Family Therapy	Parts of the state	NA

NA = Data are not available.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing a shortage of psychiatrists, registered nurses, and direct service workers in state psychiatric hospitals and community mental health programs. Initiatives to reduce staff shortages at the state psychiatric hospital include: (1) All student nurses enrolled at the University of Alaska Anchorage (UAA) rotate through the hospital during the course of their education; (2) the state psychiatric hospital serves as a clinical rotation for 3rd year medical students from the University of Washington Medical School; and (3) the state psychiatric hospital serves as an internship site for doctoral-level interns and physician assistants. The state psychiatric hospital has recently proposed to establish a psychiatric residency training program.

The SMHA has initiatives to improve the quality of the mental health workforce including the Children's Mental Health Conference, workshops for grantee managers, and a training clearinghouse.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings and video conferencing.

The SMHA has relationships with professional schools to provide training in disciplines including psychiatry. API has a relationship with the University of Washington and sponsors rotations for medical students.

Alaska reimburses neither adult nor adolescent consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Alaska 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:

Over the course of the Tele-Behavioral Health (TBH) program at API, DBH has provided over 1,000 psychiatric encounters. API's TBH program continues to present the project at conferences such as Pathways to Health and the Change Agent training. The TBH program also provided a class on Tele-Behavioral Medicine in partnership with the Social Work Department of UAA and the Alaska Native Tribal Health Consortium (ANTHC) during the summer of 2009. DBH offers technical assistance to organizations beginning telehealth projects. DBH also has launched work with Chugachmiut and South East Alaska Regional Health Consortium (SEARHC) for the Impact-Evidence Based Model of Treatment of Depression (www.impact-uw.org/). DBH's TBH psychiatric staff are performing as psychiatric consultants for hospitals and communities across Alaska. API continues to serve clients throughout Alaska including Maniilaq, Seaview Community Services, YKHC's McCann Treatment Center, Cultural Peninsula Hospital, and Fort Yukon through the TBH program.

Electronic Health Records (EHRs):

The SMHA is installing an EHR in state hospitals. The state uses a single EHR system for all community mental health providers. Local providers do not use a variety of EHR systems.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

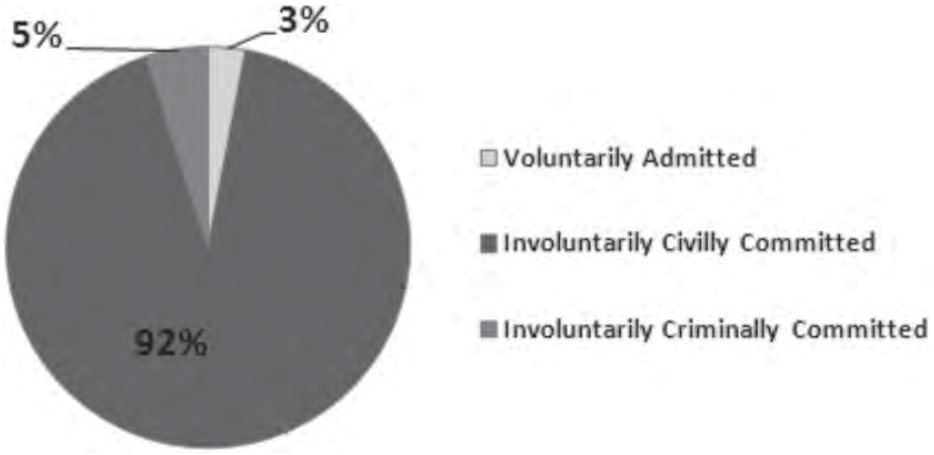
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospitals beds for:

Target Population	Acute Inpatient (less 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	No	No

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There have been declines in state psychiatric hospital beds in the last 5 years; however, the state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Initiatives have addressed Active Duty military and family members of military personnel. The State of Alaska has taken steps to inform provider agencies of the resources available to help serve returning veterans and their families. These agencies have been made aware of the issues surrounding returning veterans and have been encouraged to provide modified services in order to better meet their needs.

Arizona 2009

Division of Behavioral Health Services Department of Health Services 150 North 18th Avenue, Suite 240 Phoenix, AZ 85007 www.azdhs.gov/bhhs	The organizational structure for Arizona s system of care is divided into six geographical regions (geographical service areas, or 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 forprofit 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 the Gila River Indian Community, who operate as Tribal Behavioral Health Authorities (TRBHAs); the Colorado River Indian Tribe, who is contracted to provide Subvention (state only) funded services; and the Navajo Nation, previously a TRBHA but now operates as a case management provider.

Statistics:

State Population (2007):	6,338,755
Number of Persons Served (2008):	141,492
Utilization Rate for Adults:	21.3 per 1,000
Utilization Rate for Children:	25.2 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$l billion
Revenue From Medicaid	$796.7 million
Expenditures for Community Mental Health Services (91% of Total Mental Health Agency Revenues)	$907.3 million
Per Capita State Mental Health Expenditures	$158.07

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 Services	Part of the SMHA
Brain Impaired Services	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	Shared with another agency

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Part of the SMHA
Housing Agency	Different state department
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	7*	7*

*The total consists of four RBHAs and three TRBHAs.

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives to restructure Arizona's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other Arizona government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services, described below.

Housing: Housing is not a service covered by Title XIX; therefore, Arizona must provide 100 percent of the housing funding using state general funds. The general fund appropriations are targeted to housing adults with serious mental illnesses (SMI) and to expand housing programs through a combination of purchase, rental units/apartments, and rental subsidies. The SMHA has been innovative in its approach to providing affordable housing for persons with SMI and combines resources with the Arizona Department of Housing (ADOH). Through an Intergovernmental Agreement (IGA), the SMHA and ADOH have implemented a bridge subsidy program. This program assists mental health recipients in sustaining their housing by contracting with Public Housing Authorities and housing providers to provide subsidized rent for a 5-year period with funds from the SMHA and ADOH, as well as from local public and private community development organizations. Programs and funding sources of the SMHA include: property acquisition – State housing dollars to purchase permanent housing stock; community placement – State rent subsidy funds used to cover housing-related expenses for individuals with SMI; and startup program – Bridge Subsidies.

Employment: The Vocational Rehabilitation Behavioral Health Project (VRBHP) was developed to provide customized employment services to individuals with a SMI who have a vocational goal to become financially independent. The VRBHP was developed through an IGA between the Arizona Department of Economic Security/Rehabilitation Services Agency (ADES/RSA) and the SMHA. This project is funded by an annual share from the SMHA of $1,837,914 and a federal match from RSA of $6,790,790, totaling $8,628,704. The IGA ensures (1) that mental health staff and vocational staff are cross-trained; (2) that clients are found eligible for vocational services in an expedited manner; and (3) that a continuum of services is provided when transitioning from prevocational services, through vocational services, to non-time-limited follow-along supports. The project ensures that the highest level of care is provided to individuals with a SMI while adhering to evidenced-based practices in supported employment.

Recovery for individuals with a SMI is dependent on a philosophy within both the mental health and vocational rehabilitation systems. The philosophy states that work and economic self-sufficiency are an integral part of an individual's treatment and that meaningful work provides opportunities for community integration and reduces the need for expensive mental health interventions. The mission of the VRBHP is to increase the number of employed Arizonans with a SMI who are satisfied with their vocational roles and environments, and who are financially independent and no longer receiving Social Security Disability Insurance.

Juvenile Justice: Through the leadership of the Governor's Office, the Child Welfare and Juvenile Justice Integration Initiative was launched to elicit better coordinated responses to and improved outcomes for youth who are dually involved, or at risk of dual involvement, in the child welfare and juvenile

justice systems. The Court, ADES, the Arizona Department of Juvenile Corrections, and the SMHA signed a Letter of Agreement supporting dually adjudicated youth and their families in Arizona and have agreed to work together to eliminate systemic barriers. Through their efforts, individualized services can be delivered to youth and families in need.

Education: In December 2007, a training subcommittee was formed under the Arizona Children's Executive Committee, which was tasked with developing a systematic process to ensure that the education of children with behavioral health needs is addressed through the Child and Family Team (CFT) practice model statewide. Facilitated by the SMHA, subcommittee members include representatives from the Arizona Department of Education (ADE), local school districts including charter schools, RBHAs, child welfare, the Division of Developmental Disabilities (part of the Department of Economic Security, or DES), community family organizations, and behavioral health providers. The subcommittee is currently designing a curriculum for educating the behavioral health system (and other state systems) about educational processes and the role of educators on CFTs. The curriculum outlines the components of the education system's structure, enrollment processes, federal and state requirements, goals and functions, intervention strategies in the school setting, transition points, language and terms, organizational structure and school culture, collaborative communication, and disciplinary processes. A description of how to facilitate school involvement with behavioral health and an explanation of joint planning will be additional components of the curriculum.

The SMHA has participated on the Positive Behavioral Interventions and Supports of Arizona (PBISAZ) statewide planning committee for over 2 years. The PBISAZ promotes the implementation of the use of positive behavior support practices in school settings statewide through funding from the Creating Disciplined Schools Grant. Districts and schools work with coordinators from the three Arizona universities (Arizona State University, Northern Arizona University, and the University of Arizona) that provide technical assistance and evidence-based methods to assist schools in creating sustainable, positive teaching and learning environments for all staff and students. This committee is supported by the ADE/Exceptional Student Services office. The SMHA has participated in several annual conferences sponsored by ADE, presenting information to educators and school administrators about the behavioral health system.

Child Welfare: Arizona Families in Recovery Succeeding Together (F.I.R.S.T.) is a community substance abuse, prevention, and treatment program. ADES and the SMHA are joint administrators of F.I.R.S.T. This program offers a continuum of community-based substance abuse treatment services to the parent, guardian, or custodian of a child who is named in a report to Child Protective Services (CPS) as a victim of abuse or neglect, and whose substance abuse is a significant barrier to maintaining, preserving, or reunifying the family; or to a person whose substance abuse is a significant barrier to maintaining or obtaining employment and is a recipient of Temporary Assistance for Needy Families (TANF).

Arizona has recently been chosen to participate in the National Center on Substance Abuse and Child Welfare's (NCSACW's) program of In-Depth Technical Assistance (IDTA). The IDTA is designed to facilitate cross-system collaboration between the participating agencies: the Administrative Office of the Courts, the Division of Children, Youth and Families (located within DES), and the SMHA. The principal goal is to improve outcomes for families affected by substance use disorders and ultimately to have a more efficient system of care that includes improvements in communication/collaboration efforts, development of funding strategies to improve timely treatment access, and improvement in cross-system data collection.

Substance Abuse: The Arizona Substance Abuse Partnership (ASAP) was established by Executive Order 2007-12 in June 2007. Chaired by the Governor's Chief of Staff, ASAP is composed of representatives from state government entities, federal entities, and community organizations. ASAP serves as the single statewide council on substance abuse prevention, enforcement, and treatment. ASAP's mission is to ensure community-driven, agency-supported outcomes to prevent and reduce the negative impacts of alcohol, tobacco, and other drugs by building and sustaining partnerships between prevention, treatment, and enforcement. Through coordination among its members and their agencies/organizations, ASAP strives to ensure that substance abuse funding is spent in the most efficient and efficacious manner.

On January 14, 2008, Executive Order 2008-01: Enhanced Availability of Substance Abuse Treatment Services for Families Involved with Child Protective Services was signed by the Governor. This Executive order prioritized access to substance abuse treatment services for families involved in the child welfare system, because substance abuse was shown to be a common factor when a child's safety was at risk. The Governor's order ensures better collaboration between the SMHA and other executive branch agencies and helps provide critical access to services that promote safety and stability for children and their families. The goals of these expanded collaborative efforts are expedited services for this population, prevention of duplication and/or redundancy in services, and improvements in the effectiveness of the service delivery system.

The Arizona Children's Executive Committee (ACEC) strives to create an integrated system of care among all of Arizona's child-serving systems through representation from all the participating agencies. Through ACEC, partners collaborate and collectively ensure that behavioral health services are provided to children and families according to the Arizona Vision and Principles. Further, the committee's purpose is to improve coordination and collaboration efforts, to discuss and resolve any system barriers to care, and to address any related efforts in the delivery of behavioral health services to children and families. A Memorandum of Understanding (MOU), signed in April 2002, formed the ACEC. The MOU contents were reaffirmed in September 2006.

Arizona has initiatives to transform the way it delivers mental health services. As a result of the J.K. lawsuit, Arizona has undertaken a complete transformation of the children's behavioral health system in an effort to promote consumer choice and eliminate barriers to care. This effort includes the Meet Me Where I Am campaign, a statewide initiative, to increase the number of trained and available direct service professionals. The Arizona Vision and Arizona 12 Principles also drive system transformation for the children's system and put family and consumer choice at the forefront of care.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	Yes	No	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	Yes	No	NR
Child Welfare	Yes	NR	Yes	Yes
Medicaid	Yes	Yes	Yes	No
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	No	No	No	No
Arizona Children's Executive Committee	Yes	No	No	Yes

NR = not reported.

The SMHA collaborates with the state Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers.

The SMHA currently has the following initiatives to promote the understanding that mental health is essential to overall health: For FY 2010, the SMHA plans to incorporate the concept of "whole health" in the systems of care.

Evidence-Based Services:

Evidence-Based Practices	Implementation
Assertive Community Treatment (ACT)	Parts of the state
Supported Employment	Statewide
Medication Algorithms (Schizophrenia)	Parts of the state
Medication Algorithms (Bipolar Disorders)	Parts of the state
Family Psychoeducation	Statewide
Integrated Mental Health/Substance Abuse Services	Statewide
Illness Self-Management	Parts of the state and a pilot program
Supported Housing	Statewide and a pilot program
Consumer-Operated Services	Statewide
Multisystemic Therapy (Conduct Disorder)	Parts of the state
Functional Family Therapy	Parts of the state

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Matrix Model for Adolescents	Parts of the state	5
Adolescent Community Reinforcement Approach (ACRA)	Parts of the state	6
White Bison Native American Substance Abuse Wellness (Child and Adult)	Parts of the state	5
Extensive Use of Peer Support in Substance Abuse Treatment	Parts of the state	20

Staffing and Workforce Development Initiatives:

The SMHA has initiatives to improve the quality of the mental health workforce through contractually required Workforce Development Plans.

The SMHA is currently experiencing a shortage of psychiatrists, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners and clinical specialists (master's level and above), registered nurses, and behavioral health technicians in community mental health programs. The SMHA has the initiatives to address staffing shortages including special university-based training initiatives, training at mental health programs/providers, and recruitment bonuses or other financial incentives (state hospital only). Other initiatives to reduce staff shortages include conducting an annual statewide inventory of the workforce including some defined "specialty clinicians" who meet a minimum expectation for education and experience. The specialty areas include: Developmental Disabilities, Treatment for Children Who Act Out Sexually, Sexual Abuse Trauma, Dialectical Behavioral Therapy, Infant and Early Childhood Mental Health, and Substance Abuse. Each year, expansion targets are set to meet the needs of children and adolescents.

In addition, initiative areas have been identified for expansion for FY 2009. Statewide, approximately $1.6 million was added to increase the number of full-time equivalents (FTEs) providing support and rehabilitation services. This allocation funds an additional 43 FTE positions. The second initiative area is case managers, with a 1:15 caseload ratio to serve children/adolescents with high needs. Approximately $9 million was added to the system to fund 129.5 FTE case managers.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including psychiatry. This relationship with professional psychiatry schools includes having residents complete a rotation at the SMHA as part of their residency requirements.

Arizona reimburses consumer peer specialists through Medicaid for providing mental health services to adults. The SMHA is committed to increasing opportunities for individuals to receive peer support and/or become employed as peer support specialists/recovery support specialists to provide guidance in all aspects of recovery. Approximately 700 peers are working in the behavioral health system statewide. They contribute in various roles at providers, consumer-run organizations, RBHAs, and the SMHA.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization.

Custody Relinquishment:

Arizona 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 to obtain mental health services.

Telemedicine:

The SMHA promotes the use of telemedicine.

Electronic Health Records (EHRs):

The SMHA is 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.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

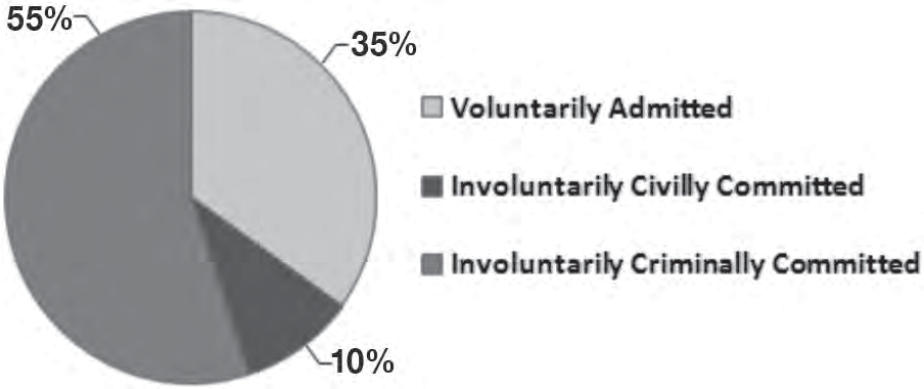
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Arizona is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric and private psychiatric hospital beds in the last 5 years.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, and the Reserve. Another initiative is the SMHA's work with the Department of Veterans Affairs (VA) to develop a statewide training for traumatic brain injury services.

Arizona has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. However, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Arkansas 2009

Division of Behavioral Health Services Department of Human Services 305 South Palm Street Little Rock, AR 72205 www.arkansas.gov/dhs/dmhs	The Division of Behavioral Health Services (DBHS) is Arkansas s 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 14 local, private nonprofit community mental health centers (CMHCs), and by certifying 3 private nonprofit specialty Community Mental Health Clinics.

Statistics:

State Population (2007):	2,834,797
Number of Persons Served (2008):	72,896
Utilization Rate for Adults:	24.3 per 1,000
Utilization Rate for Children:	30.1 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$112.2 million
Revenue From Medicaid	$28.9 million
Expenditures for Community Mental Health Services (63.1% of Total Mental Health Agency Revenues)	$70.7 million
Per Capita State Mental Health Expenditures	$39.72

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 Services	Part of the SMHA
Brain Impaired Services	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	Part of the SMHA
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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of SMHA
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
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	14	14
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is not undertaking initiatives to restructure Arkansas's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other Arkansas government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services.

Arkansas has initiatives involving coordination across multiple agencies to transform the way it delivers children's mental health services and a Co-Occurring State Incentive Grant (COSIG) to develop infrastructure to support integrated treatment of mental illness and substance abuse.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	No	No	No	No
Employment	No	No	No	No
Juvenile Justice	Yes	No	No	Yes
Criminal Justice	No	No	No	No
Education	Yes	No	Yes	Yes
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	No	Yes	Yes
Substance Abuse	Yes	No	Yes	Yes
National Guard	No	No	No	No

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The Medication Management Program develops preferred drug lists and includes primary care physicians.

The SMHA works with public health providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The SMHA is working on a pilot project to provide health education to persons with schizophrenia to help manage their diabetes.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	4
Supported Employment	Parts of the state	5
Family Psychoeducation	Parts of the state	3
Integrated Mental Health/Substance Abuse Services	Parts of the state	6
Illness Self-Management	Parts of the state	5
Supported Housing	Parts of the state	8
Consumer-Operated Services	Pilot program	1
Therapeutic Foster Care	Parts of the state	8

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), and registered nurses in state psychiatric hospitals and community mental health programs. The SMHA has initiatives to address staffing shortages, including increased salaries and recruitment bonuses or other financial incentives.

The SMHA has initiatives to improve the quality of the mental health workforce, including an Annual Mental Health Institute, a Psychiatry Residency program, and a Psychology Internship program.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Its relationships with professional schools include working with the University of Arkansas for Medical Science for psychiatry resident rotations.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Arkansas 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. It is working with Medicaid to expand telemedicine coverage to children's services. It has used grant funding to expand infrastructure to support telemedicine.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in its state hospital.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings.

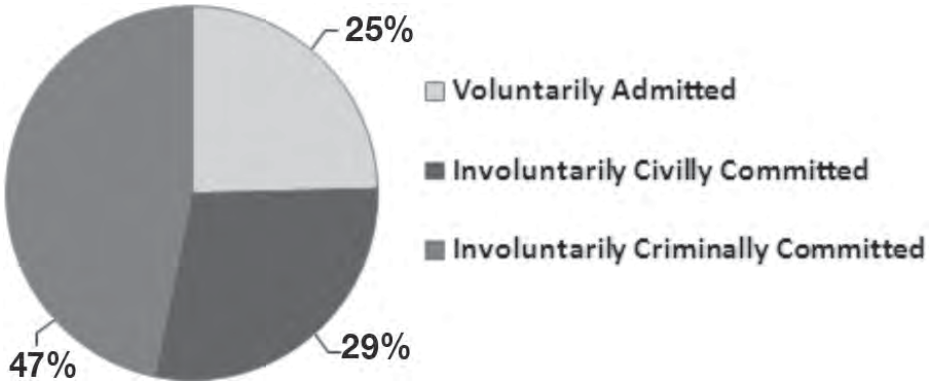
State Psychiatric Hospitals:

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 (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Note: Percentage may not total 100 because of rounding.

Psychiatric Inpatient Bed Shortages:

Arkansas is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, the Yellow Ribbon Task Force is charged with identifying the needs of and resources for returning veterans and their families. It is also noteworthy that a specific subcommittee on Health/Disabilities is chaired by the SMHA medical director.

Arkansas has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. However, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

California 2009

Department of Mental Health 1600 9th Street, Room 151 Sacramento, CA 95814 www.dmh.ca.gov	The California Department of Mental Health (DMH) 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 two city agencies (Berkeley and Tri city), the majority run by county government.

Statistics:

State Population (2007):	36,553,215
Number of Persons Served (2008):	583,374
Utilization Rate for Adults:	14.2 per 1,000
Utilization Rate for Children:	21 per 1,000

New Financing Initiatives:

California is planning or implementing a change in how the delivery of mental health services is financed. Subject to approval by the Centers for Medicaid and Medicare, the Department of Health Care Services (DHCS) will be submitting a State Plan Amendment to authorize the establishment of a CPE-based supplemental payment program for uncompensated care costs.

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
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
State Psychiatric Hospitals	5	0	5
Community Mental Health Providers	0	2,484	2,484

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county or city mental health authorities statewide.

Interagency Collaboration:

The SMHA is working with other California government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. There is a statewide housing initiative through the Mental Health Services Act (MHSA) housing program and the California Housing Financing Agency (CalFHA) to increase housing options for mental health clients that are SMI/SED and who are at risk for homelessness. In addition, through the MHSA, counties are encouraged to leverage funds with existing housing resources to increase housing options. DMH has an interagency agreement with the Department of Rehabilitation for a co-op. This co-op works to increase workforce capacity for mental health clients.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	No	No	Yes	Yes
Employment	No	No	No	Yes
Juvenile Justice	No	No	No	Yes
Criminal Justice	No	No	Yes	Yes
Education	No	No	No	Yes
Child Welfare	No	No	No	Yes
Medicaid	No	No	No	Yes
Substance Abuse	No	No	No	Yes
National Guard	No	No	No	Yes

California has initiatives to transform the way it delivers mental health services. The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. There is a collaborating project between the SMHA and DHCS to improve both the prescribing of psychotropic drugs and the primary care/mental health interface.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. Through the MHSA, DHCS is actively engaged with physical healthcare providers to get their input into requirements for local plans. Many counties have established programs to address this critical need.

Evidence-Based Services:

Evidence-Based Practices	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
Illness 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
Functional Family Therapy	Parts of the state

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
Aggression Replacement	Available statewide
Wraparound	Available statewide
Self-Help Centers	Available in parts of the state
Wellness and Recovery Centers	Available in parts of the state
Tribal Integration (in planning)	Available in parts of the state
Integrated Mental Health Primary Care	Available in parts of the state

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), registered nurses, rehab therapists, and psychiatric technicians. The SMHA has initiatives to address staffing shortages including: training at mental health programs/providers, increased salaries, recruitment bonuses or other financial incentives, and hiring above minimum rates, pay differentials, and alternative work schedules. Other initiatives to reduce staff shortages include: advertizing in magazines, newspapers, and colleges; yearly job fairs at various sites (colleges); and implementation of clinical psychology internship programs, clinical dietitian internship programs, and psychiatric technician apprenticeship programs. DMH's Workforce, Education, and Training (WET) initiative, with funding from California's MHSA, developed a partnership with other public agencies to assist counties in bringing mental health professionals to designated shortage areas and to improve the distribution of such professionals. The many and varied benefits include student loan repayment, scholarships and scholar placement programs, visa waiver programs, bonuses to psychiatrists, and a drug discount program.

The SMHA has initiatives to improve the quality of the mental health workforce including continuing medical education, continuing education units, in-house training, and a quality improvement committee. The SMHA also is bringing staff up to compliance per their individual disciplines to ensure compliance with job requirements along with Department of Justice requirements.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Its relationships with professional schools include Association of Psychology Post-doctoral and Internship Centers, in conjunction with the National Matching Services Incorporated, for the appointment of psychology interns; recruitment and internships for clinical hours to assist students with licensure (clinical dietitians, social workers, psychologists, physicians, rehab therapists, and psychiatric technicians); and working with the University of California at Davis.

Managed Behavioral Healthcare:

Mental health services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization.

Custody Relinquishment:

California 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. California allows for 12 months of voluntary placement through the county's child welfare system, which meets the need of their type of parent/family crisis. Also, Assembly Bill (AB) 3632 ensures that special education children who require mental health services 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 DMH funding.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs. The SMHA is installing and operating an EHR 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.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. The California Regional Health Information Organization (CalRHIO) is preparing a state plan.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

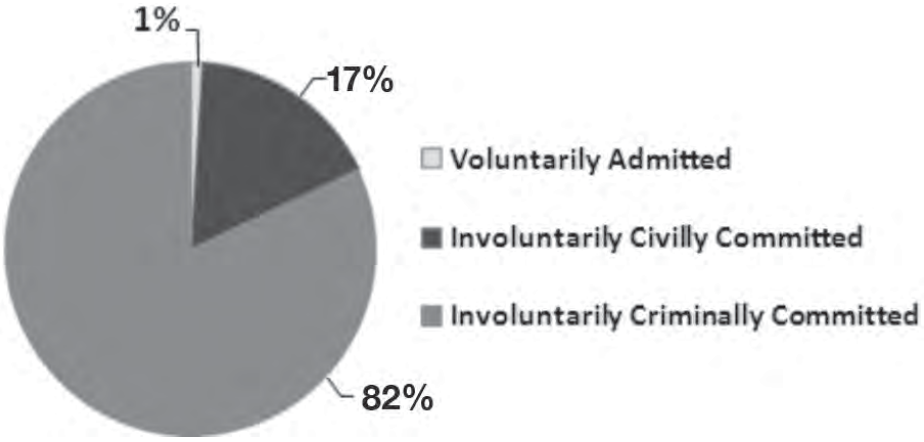
State Psychiatric Hospitals:

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 five SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

California is experiencing a shortage of psychiatric beds. There have been declines in private psychiatric hospital beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel.

California has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Colorado 2009

Division of Behavioral Health Department of Human Services 3824 West Princeton Circle Denver, CO 80236 www.cdhs.state.co.us/dmh/	Colorado s public mental health system comprises community-based mental health programs overseen by the Division of Behavioral 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:

State Population (2007):	4,861,515
Number of Persons Served (2008):	86,273
Utilization Rate for Adults:	15 per 1,000
Utilization Rate for Children:	26.1 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$367.8 million
Revenue From Medicaid	$231.1 million
Expenditures for Community Mental Health Services (73% of Total Mental Health Agency Revenues)	$266.8 million
Per Capita State Mental Health Expenditures	$76.33

New Financing Initiatives:

Colorado is planning or implementing a change in how the delivery of mental health services is financed. It is moving toward a new unit costing system, which will, in future years, influence rate setting for both the State Medicaid Authority and the SMHA.

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Same division as the SMHA
Housing Agency	Same state department (supportive housing and homeless programs) and different department (Department of Local Affairs)
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	2	0	2
Community Mental Health Providers	0	23	23

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly funds, but does not operate, local community-based agencies. The SMHA is undertaking initiatives to restructure the state's community-based system of behavioral health services delivery. The SMHA is participating in the Governor's Behavioral Health Cabinet, examining statewide behavioral health integration and system alignment.

Interagency Collaboration:

The SMHA is working with other Colorado government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Some collaborative efforts are Colorado House Joint Resolution (HJR) 07-1050; House Bill (HB) 1451, Collaborative Management Program; Senate Bill (SB) 006, Suspension of Medicaid for Individuals Who Are Incarcerated; SB 07-97, Offender Mental Health Services in Community Mental Health Centers (CMHCs); and the Department of Education Grant "Building Bridges."

Colorado has initiatives to transform the way it delivers behavioral health services: (1) Governor's Behavioral Health Cabinet with the supporting SAMHSA Transformation Transfer Initiative (TTI) grant (January 2009); and (2) HB 1451, Community Collaborative Management program to blend state and local funds to serve children and youth and to eliminate service barriers.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	No	Yes	Yes
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	No	Yes	Yes
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	No	Yes	Yes
National Guard	Yes	No	Yes	Yes

The SMHA collaborates with Colorado's health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. Collaborative efforts include Screening, Brief Intervention, and Referral to Treatment (SBIRT) and the Governor's Behavioral Health Cabinet.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The SMHA implements these related programs: Early Childhood; Suicide Prevention; and Emergency Mental Health (27-10) Data Collection.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: In accordance with Colorado HJR 07-1050, the Behavioral Health Task Force was established to examine the statewide behavioral health system across all state agencies and provider networks. The task force made system recommendations to coordinate state efforts, streamline services, and manage resources. In 2008, the Governor convened a Behavioral Health Cabinet to implement recommendations of HJR 1050.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	7
Supported Employment	Parts of the state	7
Family Psychoeducation	Parts of the state	7
Integrated Mental Health/Substance Abuse Services	Parts of the state	10
Illness Self-Management	Parts of the state	8
Supported Housing	Parts of the state	11
Consumer-Operated Services	Parts of the state	NA
Multisystemic Therapy (Conduct Disorder)	Parts of the state	3
Therapeutic Foster Care	Parts of the state	NA
Functional Family Therapy	Parts of the state	8

NA = not available.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
Cognitive Behavioral Therapy (CBT) for Depression	Parts of the state
Incredible Years: Kids With Disruptive Disorders	Parts of the state
Trauma-Focused CBT	Parts of the state

Staffing and Workforce Development Initiatives:

The SMHA has initiatives to improve the quality of the mental health workforce. The Colorado Mental Health Institutes provide continuing medical education (CME) to employees. In addition, staff training opportunities for employees include competency assessments, (ongoing) training and development in seclusion and restraint, Verbal Judo, Care Transitions Intervention (CTI), suicide risk assessment, infection control, and an ongoing patient safety program. The SMHA also uses the Agency for Healthcare Research and Quality (AHRQ) surveys on patient safety culture, as well as Lilly/Joint Commission Resources (JCR) tools for the medication safety program, performance evaluation, medical staff credentialing, medical staff CME presentations, and grand rounds.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, DVD training, and state-hosted Webinars.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Specifically, the SMHA has relationships with schools of pharmacy, schools with occupational therapy, schools of speech therapy, schools of recreational therapy, and schools of forensic psychology.

Managed Behavioral Healthcare:

Medicaid mental health services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Approximately 53,000 persons received behavioral health services under the managed care plan in 2008.

Custody Relinquishment:

Colorado 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 (Child Mental Health Treatment Act, Colorado HB 1116).

Electronic Health Records (EHRs):

The SMHA is operating an electronic health record (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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

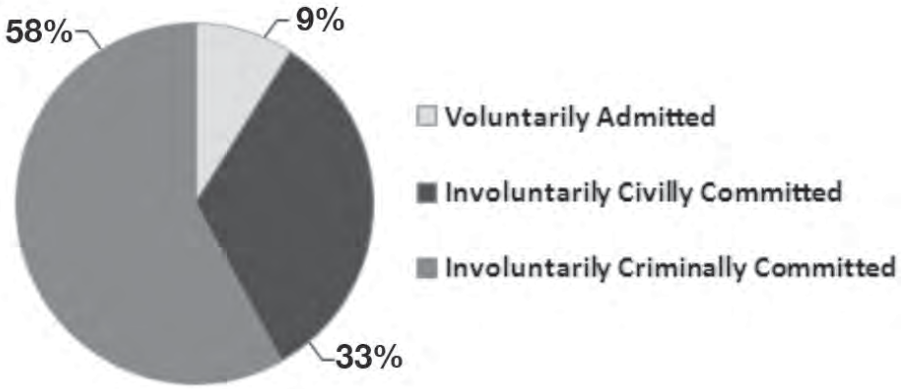
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Colorado is experiencing a shortage of psychiatric beds. There have been declines in private psychiatric hospital beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. An example is SB 07-146, Veterans and Family Mental Health Services Program in Colorado Springs, for families of recently discharged veterans of Iraq or Afghanistan. There is also the Jail Diversion and Trauma Recovery—Priority to Veterans Grant awarded to the SMHA by SAMHSA in May 2008 (pilot in Denver and Colorado Springs).

Colorado has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Connecticut Adults' Division 2009

Department of Mental Health & Addiction Services 410 Capitol Avenue Hartford, CT 06134 www.ct.gov/dmhas	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 they continue to plan and implement effective transitional services for youth moving from DCF to the adult system of care. DMHAS, through a network of 14 community based Local Mental Health Authorities, provides a full range of treatment and recovery support services to adults (ages 18 and older). DMHAS is also responsible for adult forensic services in Connecticut. 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 (2007):	3,502,309
Number of Persons Served (2008):	81,620
Utilization Rate for Adults:	19.6 per 1,000
Utilization Rate for Children:	34.8 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$636.8 million
Revenue From Medicaid	$17 million
Expenditures for Community Mental Health Services (60% of Total Mental Health Agency Revenues)	$362.5 million
Per Capita State Mental Health Expenditures	$174.94

New Financing Initiatives:

Connecticut is planning or implementing a change in how the delivery of mental health services is financed through a 1915(c) waiver and the Money Follows the Person (MFP) demonstration project.

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Part of the SMHA
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
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	9	110	119
Private Psychiatric Hospitals	NA	1	1
General Hospitals With Separate Psychiatric Units	0	11	11

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly operates community-based programs and funds private nonprofit community-based services.

The SMHA is undertaking initiatives to restructure Connecticut's delivery of community-based mental health services. This restructuring is being accomplished through implementation of the Medicaid Rehabilitation Option Waiver for people served in group homes and the Nursing Home Waiver and MFP demonstration project for persons able to transition to community life. Also, bed reconfiguration planning is being considered to ensure appropriate and optimal utilization of state-operated inpatient beds.

Interagency Collaboration:

The SMHA is working with other Connecticut government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The services provided under the Medicaid Home and Community-Based Waiver promote consumer choice and the supports needed to live in the community. These supports include peer support services, which are offered throughout the service system.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	No	No	Yes
Juvenile Justice	No	No	No	No
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	No	No	Yes
Child Welfare	No	No	No	No
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	No	No	Yes

Enhanced Care Clinics (ECCs) have been established under the state Healthcare for Uninsured Kids and Youth (HUSKY) plan (Connecticut's State Children's Health Insurance Program, or SCHIP) with collaboration between DCF and the state Medicaid agency. The ECCs are required to have memorandums of agreement with at least two primary care practices to facilitate consultation, collaboration, and referral. This model is now being replicated in the adult service system with ECCs to be included in the adult fee-for-service population. Standards have been drafted and include increased access to care, integration of primary care and mental healthcare, and treatment of co-occurring disorders. The state Medicaid agency will oversee claims reimbursement, and the SMHA will monitor access to care and quality assurance.

The SMHA works with public and private providers to increase the identification and treatment of the physical health needs of persons with mental illnesses. Two pilot programs will be initiated with the goal of educating pediatric and primary care practitioners about mental illness and referrals for services.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: Connecticut has initiated a statewide multifaceted Social Marketing Campaign aimed at eliminating stigma and increasing awareness of mental health issues. The major components of the campaign include implementing a community awareness/antistigma media campaign; developing and disseminating materials and information on Connecticut's Mental Health Transformation State Incentive Grant (MHTSIG) and continuing development of Connecticut's Network of Care for Behavioral Health Web site (www.ct.networkofcare.org); and creating marketing materials for distribution at public events. In 2008 to 2009, Connecticut added public television to its media and community education activities.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	28
Supported Employment	Parts of the state	6
Family Psychoeducation	Parts of the state	NR
Integrated Mental Health/Substance Abuse Services	Parts of the state	20
Illness Self-Management	Parts of the state	NR
Supported Housing	Statewide	31
Consumer-Operated Services	Statewide	4

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Family Psychoeducation	Parts of the state	5
Wellness and Recovery Action Plan (WRAP)	Parts of the state	NR

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of mental health staff, including psychiatrists, other physicians, psychologists, social workers, advanced practice nurses (APRNs), registered nurses (RNs), and occupational therapists in both the state psychiatric hospitals and community mental health programs, as well as pharmacists in state hospitals.

The SMHA has initiatives to improve the quality of the mental health workforce including:

- **Commissioner's Strategic Analysis Initiative Group (CSAIG) –** This workforce development workgroup consists of a diverse group of individuals from human resources, labor relations, recruitment, workforce development, equal employment opportunity, training, the Co-Occurring State Incentive Grant (COSIG), and the MHTSIG workforce collaborative, who will develop recommendations to recruit, retain, and train a highly competent DMHAS workforce and identify associated measures of performance, efficiencies, and progress.
- **MHTSIG Activities –** Connecticut is implementing several initiatives through the MHTSIG designed to improve the quality of the workforce. These include establishing the Connecticut Workforce Collaborative on Behavioral Health composed of staff from multiple state agencies, providers, academic institutions, and persons in recovery and their family members; a Parent Leadership training initiative to prepare family members to take a more active role in the behavioral health system; a Supervision Competency initiative offering training and ongoing consultation related to

staff supervision, as well as the development of Supervision Standards; an Intensive In-Home Training initiative that includes the development of a graduate-level curriculum that is currently being offered in Social Work, Marriage and Family Therapy, and Psychology programs at three universities across Connecticut; the Consumer Recovery Employment Consultation Service (C-RECS) providing persons in recovery with training, support, and assistance in obtaining employment in the behavioral health workforce; and educating employees of other health and human services agencies about mental health to assist them with their daily work.

- **COSIG Activities –** The Co-Occurring Academy offers free workshops throughout the year through DMHAS's Education and Training Division. In addition, the Dartmouth Medical School provides training and technical assistance to staff for the ongoing implementation of the Integrated Dual Disorders Treatment (IDDT) model within the DMHAS system. In the fall of 2008, DMHAS forged a partnership with Southern Connecticut State University for a new weekend Master of Social Work program that focuses on co-occurring disorders.

Managed Behavioral Healthcare:

The SMHA was approved to begin operation of a Medicaid 1915(c) waiver to assist with the diversion and discharge of people with serious mental illness from nursing homes (April 1, 2009). The waiver will use an Administrative Service Organization (ASO) for claims payment and some credentialing functions; however, managed care (utilization management) decisions will be made by the SMHA with oversight from the State Medicaid Authority. Services covered include psychological rehabilitation, treatment planning, intensive in-home services, medication administration and monitoring, peer support, wraparound services (rental assistance and apartment setup), assertive community treatment, transitional case management, personal care assistance, companion, homemaker, supported employment, short-term crisis stabilization, nonmedical transportation, home accessibility adaptations, and specialized medical equipment. In addition, the SMHA also operates a behavioral health managed care carve-out for the state's general assistance population.

Electronic Health Records (EHRs):

The SMHA is in the process of installing an EHR in state hospitals and community mental health programs. Connecticut does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

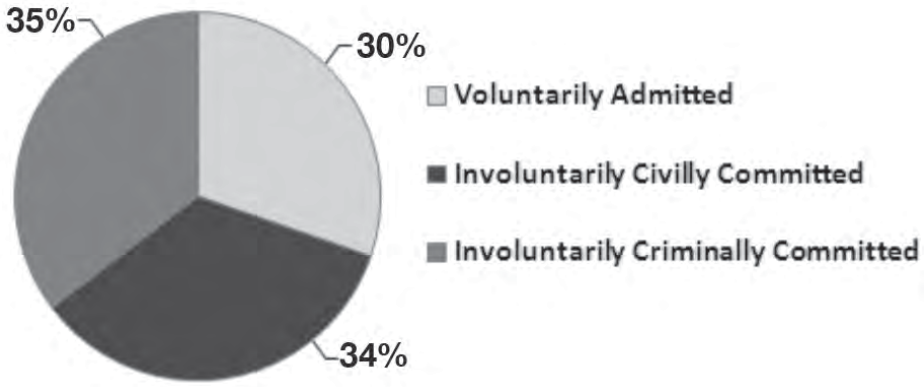
State Psychiatric Hospitals:

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 four SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:



Note: Percentage may not total 100 because of rounding.

Psychiatric Inpatient Bed Shortages:

Connecticut is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. Connecticut has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans and their families who do not have access to military reimbursed or provided services. These initiatives have addressed veterans, National Guard members, the Reserve, and family members of military personnel. Other initiatives are the following: With state funding support, DMHAS provides, statewide, an array of outpatient behavioral health services to Reserve component soldiers and their family members through the Connecticut Military Support Program. The department also provides outpatient and residential treatment to veterans with mental health and substance use disorders. In addition, with federal funding, DMHAS provides jail diversion and trauma recovery support services for veterans.

Connecticut Children's Division 2009

Department of Children & Families 505 Hudson Street Hartford, CT 06106 www.ct.gov/dcf/site/default.asp	The Department of Children and Families (DCF) is a comprehensive, consolidated agency serving children younger than age 18 and their families. DCF is legislatively mandated to provide a spectrum of behavioral health services, child protection and family services, juvenile justice services, substance abuse related services, education services specifically acting in the capacity of a school district for committed children, and prevention services. Although mental health services for children and adults are administered by two departments in Connecticut, these entities work closely together 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 (2007):	3,502,309
Number of Persons Served (2008):	81,620
Utilization Rate for Adults:	19.6 per 1,000
Utilization Rate for Children:	34.8 per 1,000

Responsibilities of the DCF in Administering Specific Mental Health Services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of DCF
Elderly Mental Health Services	No responsibility
Adult Forensic Services	No responsibility
Brain Impaired Services	No responsibility
Alzheimer Disease and Organic Brain Syndrome Services	No responsibility
Court Evaluation of Mental Health Status	Part of DCF
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Part of DCF

Location of Other State Agencies in Relation to DCF:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Child/adolescent substance abuse (DCF)
Housing Agency	Different state department
Health Department	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	0	1
Community Mental Health Providers	0	60*	60*

*This number is estimated.

Primary Mechanism Used To Deliver Community Mental Health Services:

DCF does not directly operate community-based programs, but does fund these programs through grants and fee-for-service methodologies.

Interagency Collaboration:

DCF is working with other Connecticut government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Fourteen state agencies and the Judicial Branch, through a signed Memorandum of Understanding, are working together through the Mental Health Transformation State Incentive Grant (MHTSIG) on a wide variety of initiatives, including workforce development, different utilization of waivers, sharing of data, and collaborating on models of treatment.

Connecticut has initiatives to transform the way it delivers mental health services. DCF is utilizing the learning collaborative approach to disseminate community-based evidence-based practices including Trauma-Focused Cognitive Behavioral Therapy for child guidance clinics. This approach was also used for an Engaging Families in Services initiative for the statewide extended-day treatment providers.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	No	No	No	No
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	No	No	No	No
Education	Yes	No	Yes	Yes
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes

DCF collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. DCF and the Department of Social Services (Connecticut's Medicaid agency), through the state's Behavioral Health Partnership, work collaboratively to increase the recognition and treatment of persons with mental illness by primary care providers. Enhanced Care Clinics (ECCs), which are outpatient psychiatric clinics for children, have been established to increase access to and availability of services. An increase of 25 percent above the traditional Medicaid rate is reimbursed for meeting a set of criteria that includes, but is not limited to, timeliness of service, service utilization rates, and use of evidence-based practices.

DCF works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. These include ongoing consultations and problem-solving to address these needs. For example, one of the criteria to become an ECC is the establishment of two formal agreements with primary care providers. These agreements cover identification, referral, and ongoing consultation.

DCF has several initiatives to promote the understanding that mental health is essential to overall health. A multimedia campaign focused on stigma reduction and mental health education is underway, funded by the MHTSIG. The "Opening Doors, Opening Minds" series has been launched and includes televised panel discussions and print ads.

Evidence-Based Services:

Evidence-Based Practices	Implementation
Supported Housing	Statewide
Multisystemic Therapy	Parts of the state
Therapeutic Foster Care	Statewide
Functional Family Therapy	Statewide
Trauma-Focused Cognitive Behavioral Therapy	Parts of the state
Dialectical Behavior Therapy	Parts of the state
Multidimensional Family Therapy	Statewide

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Intensive In-Home Child and Adolescent Psychiatric Services	Statewide	NA
Risking Connection	Parts of state	NA
Trauma Adaptive Recovery Group Education and Training	Parts of state	NA
Family Engagement Protocols (Dr. Mary McKay)	Parts of state	22

NA = not available.

Staffing and Workforce Development Initiatives:

DCF is currently experiencing shortages of psychiatrists, advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), and registered nurses in state psychiatric hospitals and community mental health programs. DCF has special university-based training initiatives, training for mental health providers, and recruitment bonuses or other financial incentives to address staffing shortages.

DCF has initiatives to improve the quality of the mental health workforce. Connecticut is implementing several initiatives through the MHTSIG designed to improve the quality of the workforce. These include establishment of the Connecticut Workforce Collaborative on Behavioral Health composed of staff from multiple state agencies, providers, academic institutions, and persons in recovery and family members; a Parent Leadership training initiative to prepare family members to take a more active role in the behavioral health system; a Supervision Competency initiative offering training and ongoing consultation related to staff supervision, as well as developing Supervision Standards; an Intensive In-Home Training initiative including the development of a graduate-level curriculum that is currently being offered in Social Work, Marriage and Family Therapy, and Psychology programs at three universities across Connecticut; the Consumer Recovery Employment Consultation Service (C-RECS) providing persons in recovery with training, support, and assistance in obtaining employment in the behavioral health workforce; and educating employees of other health and human services agencies about mental health to assist them with their daily work. Trainings, grand rounds, presentations, and professional conferences also occur.

DCF is using technology (e-learning) to improve the training of the workforce while limiting travel through DVD training.

DCF has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Its relationships with professional schools include providing psychiatry residency placements for Yale University and the University of Connecticut, two postdoctoral fellowships, and internship placement for social work students and Ph.D. psychology students.

Connecticut reimburses adult consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services in the second 1915(b) waiver are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 40,000 persons received behavioral health services under the second 1915(b) waiver last year, and 330,000 persons were covered under the plan. Services in the third 1915(b) waiver are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization.

Custody Relinquishment:

Connecticut has laws or policies designed to avoid parents' having to relinquish custody of children (to DCF, child welfare, or juvenile justice systems) in order for them to obtain mental health services. A variety of services, including voluntary services, are available to assist families in resolving problems and remaining intact.

Telemedicine:

DCF promotes the use of telemedicine. A multidisciplinary planning and advisory committee is exploring the implementation of telemental health technology to access mental health services for rural citizens in the northwestern part of the state. Resources are limited and may impact the future directions of this initiative, which are now being determined.

Electronic Health Records (EHRs):

DCF has no EHR activities or plans for 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.

DCF does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

DCF maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

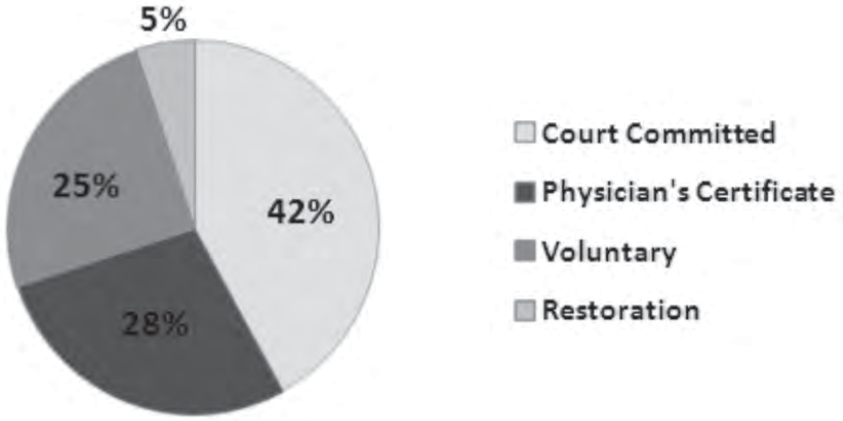
State Psychiatric Hospitals:

The operation of state psychiatric hospitals for children is within the same agency responsible for the funding and/or delivery of community-based mental health services, specifically DCF. There is one state-operated psychiatric hospital for children.

DCF uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes

Status of Admissions to Children's Psychiatric Hospital on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There appears to be a shortage of psychiatric beds in the northwestern part of the state.

Delaware 2009

Division of Substance Abuse & Mental Health Delaware Health & Social Services 1901 North DuPont Highway New Castle, DE 19720 http://dhss.delaware.gov/dhss/dsamh/index.html	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). DSAMH is responsible for meeting the treatment, rehabilitation, and support needs of adults, ages 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 younger than 18 years of age.

Statistics:

State Population (2007):	864,764
Number of Persons Served (2008):	9,343
Utilization Rate for Adults:	9.6 per 1,000
Utilization Rate for Children:	12.8 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$93.1 million
Revenue From Medicaid	$14.8 million
Expenditures for Community Mental Health Services (48% of Total Mental Health Agency Revenues)	$43.4 million
Per Capita State Mental Health Expenditures	$105.75

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 Services	Shared with another agency
Brain Impaired Services	Shared with another agency
Alzheimer's Disease and Organic Brain Syndrome Services	Some responsibility/state hospital
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Persons With Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Some responsibility/state hospital

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
Housing Agency	Located in a different state department
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	13	17
Private Psychiatric Hospitals	0	3	3
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly funds state-operated clinics and other local community-based agencies.

The SMHA is undertaking initiatives to restructure Delaware's community-based system of mental health service delivery. The SMHA is making all state-run outpatient mental health programs capable of providing services to individuals with co-occurring mental health and substance use disorders. In addition, the SMHA is exploring the collocation of primary care, mental health, and substance abuse services in other state-operated centers and in SMHA-funded centers. The SMHA also is planning to implement a specialty mental health/developmental disability outpatient clinic in one county.

The Delaware SMHA's current community mental health system of care has bifurcated funding streams where the community private provider system is certified to bill for Medicaid Services, whereas the state-run system is not. The SMHA is now reviewing this system of care.

Interagency Collaboration:

The SMHA is working with other Delaware government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Through workgroups and Memorandums of Understanding (MOUs), the division is attempting to eliminate barriers and to improve both coordination of care and transition from program to program.

Delaware has several interagency initiatives to transform the way it delivers mental health services. DSAMH is participating in the following activities:

- Collaborating with the Delaware Vocational Rehabilitation (DVR) agency to improve and expand the delivery of supported employment services;
- Also collaborating with Delaware's State Service Centers (15) that provide services such as food stamps, unemployment applications, and TANF to collocate mental health/substance abuse and possibly primary care services in these centers; and
- With Delaware's Developmental Disabilities Agency, with which it has had a long-term relationship, is currently setting up shared treatment plan reviews for persons with mental health/developmental disabilities who are currently admitted to the state hospital. The division also is exploring opening a mental health/developmental disabilities clinic in Newark, DE.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	Yes
Employment	Yes	No	Yes	Yes
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	No	No	No

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	No	No	No

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The SMHA and the Governor's Task Force on Health Disparities are planning efforts to increase the recognition and treatment of mental illness by primary care medical providers. The SMHA collaborated with Medicaid managed care organizations (MCOs) to educate primary care providers about the high prevalence of depression in clients with diabetes.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. DSAMH and the Division of Public Health (DPH) have an ongoing collaborative initiative to provide information about Human Immunodeficiency Virus (HIV)/Auto Immunodeficiency Syndrome (AIDS)/Sexually Transmitted Diseases (STDs). Assertive Community Treatment (ACT) teams provide comprehensive health education and coordination of care with medical providers. The SMHA is working with federally qualified health centers (FQHCs) to increase awareness of comorbid conditions and to collaborate on treatment of comorbid conditions. The SMHA is part of a grant-funded project with an FQHC in southern, rural Delaware to develop outreach and engagement of elders with behavioral health conditions. The SMHA is working with all of its mental health providers to increase assistance.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: The Governor's Task Force on Health Disparities is planning efforts to increase recognition and treatment of mental illness by primary care medical providers, and DSAMH and DPH have an ongoing collaborative initiative to provide information about HIV/AIDS/STDs. The SMHA has assisted the Medical Society of Delaware and DPH with planning a 2009 Health Education Summit on Communicable Diseases. In addition, the SMHA is collaborating with DPH and community providers to develop guidelines for the treatment of individuals in long-term care facilities who have a history of MRSA infection.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
ACT	Statewide	4
Supported Employment	Statewide	NR
Integrated Mental Health/Substance Abuse Services	Statewide	13
Supported Housing	Statewide	NR
Consumer-Operated Services	Statewide	1
Multisystemic Therapy (Conduct Disorder)	Child mental health in another agency	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Six Core Strategies Model for SR Reduction	Sept. 2009	1 state hospital
Trauma-Informed Care	Sept. 2009	1 state hospital

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists and dentists in state psychiatric hospitals and community mental health programs. The SMHA has special university-based training initiatives and is possibly contracting with a staffing company to address staffing shortages. Other initiatives to reduce staff shortages include exploring tuition repayment programs for certain staff positions. Participants provide clinical services during their education period and agree to work a minimum of 1 to 2 years after graduation.

The SMHA has initiatives to improve the quality of the mental health workforce. The SMHA has a federal Co-Occurring State Incentive Grant (COSIG) supporting its efforts to improve service quality throughout the state by integrating mental health and substance abuse providers into "co-occurring capable" providers. The SMHA also is reviewing the use of the National Association of State Mental Health Program Directors (NASMHPD) direct care workforce curriculum to initially train hospital staff.

The SMHA has relationships with a few universities and professional schools to provide training for psychiatry residents (a 4-year program); doctoral-level psychology interns; nursing students; associate's, bachelor's, and master's level counselors; creative arts and therapy students; and social work students (pending).

Managed Behavioral Healthcare:

Delaware mental health and substance abuse services have been delivered through a managed care model since 1996. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. Approximately 15,987 persons received behavioral health services under the Medicaid mental health managed care plan last year. Delaware's Managed Care initiative in 1996 basically carved out the traditional Medicaid fee-for-service plan into a two-party Delaware MCO service. Individuals who require more intensive services are supported by state-funded programs that are designed to provide indepth, wraparound individualized treatment and supports for individuals with serious mental health conditions beyond the basic Medicaid Fee-for-Service system and that include four ACT teams and specialized acute care inpatient services when necessary.

Custody Relinquishment:

Delaware 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. Delaware does not require custody relinquishment in order to receive mental health/substance abuse services. Delaware works extremely hard to keep the family system together.

Telemedicine:

The SMHA does not yet use statewide telemedicine strategies, but it is reviewing this strategy.

Electronic Health Records (EHRs):

The SMHA is currently implementing the installation of an EHR in the state hospital and in the state-run community mental health clinics.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. Delaware Health Information Network (DHIN), its statewide HIE, is a communication system available to healthcare providers.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all contracted community 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 and one inpatient child/adolescent residential facility. The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children and Adolescents	Yes	Yes	No
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

Psychiatric Inpatient Bed Shortages:

Delaware has a population of around 865,000. The state's inpatient bed capacity for people in acute crisis or with long-term needs is 213 state hospital beds and 13 community acute care beds. Delaware manages inpatient utilization with some utilization management, but this service needs to be expanded statewide because it currently is focused only on acute inpatient admissions and discharges. At times, the need for community acute care beds can exceed 13. In 2008, the average utilization was 15 to 17 acute care community beds. It is also important to realize that the state hospital census is slightly misleading, because this state facility also provides maximum security forensic hospital services for the entire State of Delaware (40 beds). In addition, this state facility provides a skilled nursing facility (35 beds) offering long-term care for people with medical and organic brain disorders who cannot be discharged easily. However, even with these programs, the Delaware Psychiatric Center (DPC) has ramped up its discharge rates to about 30 to 35 per month, and discharges now match admission rates.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. Delaware has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services. Also, Front Door Teams have been established at some community mental health centers. 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 Veteran's Administration (VA) hospital, and other outpatient VA-funded providers.

District of Columbia 2009

Department of Mental Health 64 New York Avenue, NE., 4th Floor Washington, DC 20002 http://dmh.dc.gov/dmh/site/default.asp	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 support prevention, resiliency, and recovery for District residents in need of public mental health services. 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 DC 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 (2007):	588,292
Number of Persons Served (2008):	16,257
Utilization Rate for Adults:	27.6 per 1,000
Utilization Rate for Children:	26 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$230.3 million
Revenue From Medicaid	$40.5 million
Expenditures for Community Mental Health Services (52% of Total Mental Health Agency Revenues)	$118.2 million
Per Capita State Mental Health Expenditures	$393.27

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
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
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	1	40	41

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly operates community-based programs. However, during FY 2009 and FY 2010, the SMHA is closing most of the community-based services provided directly by the SMHA. Over 4,000 consumers (adults and youth) are transitioning to privately operated community-based programs. The SMHA will continue to operate the community pharmacy, a physicians' practice group, services for special populations (consumers classified as limited English proficient (LEP) or non-English proficient (NEP), consumers with co-occurring developmental disabilities, and consumers who are deaf or hearing impaired), a restoration to competency program, and a psychoeducational program.

At the same time, the SMHA is undertaking initiatives to restructure the District's community-based system of mental health service delivery. In conjunction with the closure of the District-operated community services agency, the Department of Mental Health (DMH) is beginning a service delivery redesign. The redesign includes expanding community-based clinic services and greater access for uninsured individuals. The planning for the redesign is underway, but implementation will be contingent upon the availability of funds.

Interagency Collaboration:

The SMHA has a number of initiatives underway to better coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. These include, but are not limited to, the following:

- Transferred $14 million of SMHA capital funds to the District's Housing and Community Development (DHCD) to develop 300 new affordable housing units for individuals with a mental illness;
- Implemented a partnership with the Metropolitan Police Department (MPD) to provide 40 hours of training to MPD officers who will serve as crisis intervention officers; and
- Established an urgent care mental health clinic at the Superior Court.

The SMHA has continued to be an active partner in the Interagency Coordinating Committee on Homeless Services. All policy and program issues related to people who are homeless are discussed in this forum. One of the new Districtwide efforts of the past year was the Housing First Initiative. Under the leadership of the Department of Human Services (DHS), a targeted outreach was conducted toward those individuals who were prioritized with the highest special needs. To date, over 400 individuals who were homeless have been placed through this effort.

The SMHA participates with other child-serving agencies within the District on the Interagency Collaboration and Services Integration Commission (ICSIC). The Subcommittee on Residential Placement (SRP) is a standing subcommittee of ICSIC, is made up of all the child-serving agencies in the District, and is chaired by DMH. The focus of the SRP is the development and implementation of a common structure for diversion from and placement of youth at high risk in residential treatment programs.

The SMHA, in collaboration with the DC Primary Care Association (DCPCA), the state Medicaid agency, and George Washington University and Georgetown University working as a provider network, develops initiatives to best meet individuals' primary healthcare and psychiatric needs. Both the District's Public Mental Health System and mainly primary healthcare providers serve these individuals. There are two separate initiatives:

- The first initiative is funded by a grant from the DC Department of Health and is led by a research team from George Washington University working in conjunction with several of the community-based mental health providers. This initiative develops models for how to best provide primary care to persons with severe mental illness.
- The second initiative is a collaboration between DCPCA and Georgetown University; they work with primary healthcare providers to promote the understanding that mental health is essential to overall health. The planning stage is funded.

Evidence-Based Services:

Evidence-Based Practices	Implementation
Assertive Community Treatment (ACT)	Statewide
Supported Employment	Statewide
Medication Algorithms (Schizophrenia)	Statewide
Medication Algorithms (Bipolar Disorders)	Statewide
Integrated Mental Health/Substance Abuse Services	Pilot program
Supported Housing	Statewide
Consumer-Operated Services	Statewide
Multisystem Therapy (Conduct Disorder)	Statewide
Functional Family Therapy	Statewide

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, social workers (master's level and above), advanced practice nurses, nurse practitioners and clinical specialists (master's level and above), and registered nurses in state psychiatric hospitals and community mental health programs. In FY 2008, the District amended its Health Professional Recruitment Program to include nurses, nurse practitioners, dental hygienists, clinical social workers, clinical psychologists, professional counselors, or physician assistants. In addition, the law was amended to include any DMH program or other site designated by the Director of the Department of Health that provides mental healthcare to District residents regardless of ability to pay. This expansion of the recruitment program was intended to help address the shortage of qualified staff.

The SMHA's Training Institute has sponsored or cosponsored a number of ongoing training initiatives and series. Highlights include: (1) Level of Care Utilization System (LOCUS)/Child & Adolescent Level of Care Utilization System (CALOCUS) train-the-trainer initiative; (2) ACT workforce development initiative; (3) Transgender Mental Health training series; and (4) Co-occurring Competency Certificate Training Program and Integrated Treatment Trainings as part of the DC COSIG project. The Training Institute also offers a variety of recurring introductory and overview trainings for providers, consumers, and DMH staff. These trainings occur on a quarterly to biannual basis.

The Training Institute is developing several new initiatives to roll out over the summer and early fall. These initiatives will include a clinical supervision initiative, trauma-informed systems initiative, a worker safety initiative, and a cultural and linguistic competence initiative in mental health service delivery.

In addition, the SMHA has established a unit within the Division of Organizational Development that will focus on developing practice guidelines and providing technical assistance to community-based providers with respect to the DMH practice model.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, and psychiatry.

Currently, the District of Columbia does not reimburse consumer peer specialists (adults or adolescents) through Medicaid for providing mental health services. However, the District has initiated a planning process with technical assistance from the National Association of State Mental Health Program Directors (NASMHPD) to implement a peer specialist program that would qualify for Medicaid reimbursement.

Managed Behavioral Healthcare:

Mental health services are being delivered through managed care.

Custody Relinquishment:

The SMHA does not require the relinquishment of custody in order to receive mental health services; it requires only that the child/youth be enrolled in a provider program (Core Service Agency). The children/youth in the child welfare system (Child and Family Services Agency, or CFSA) are wards of the state, and those in the juvenile justice system (Department of Youth and Rehabilitation Services, or DYRS) are committed. These designations, however, are not a prerequisite for the receipt of mental health services. Although parents in the District do not have to relinquish their custody to access mental health services, the only out-of-home placement option available to families in the mental health system is the psychiatric residential treatment facility (PRTF). In order to access any other community-level, out-of-home placement, the youth and family have to interface with the CFSA or DYRS system.

Telemedicine:

The SMHA does not promote the use of telemedicine.

Electronic Health Records (EHRs):

The District of Columbia is implementing a Regional Health Information Organization through a contract with DCPCA. The SMHA has begun discussions with DCPCA about participating in phase 2 of its implementation, which would integrate information from District hospitals and the SMHA's psychiatric emergency facility. The SMHA has completed phase one of implementing an EHR at Saint Elizabeth's Hospital and the Comprehensive Psychiatric Emergency Program in FY 2008.

The SMHA does not have a statewide EHR. All claims for service are submitted electronically, along with some demographic and limited clinical data.

Client-Level Data:

The SMHA obtains some individual client-level data through its claims processing system for consumers served in community mental health settings.

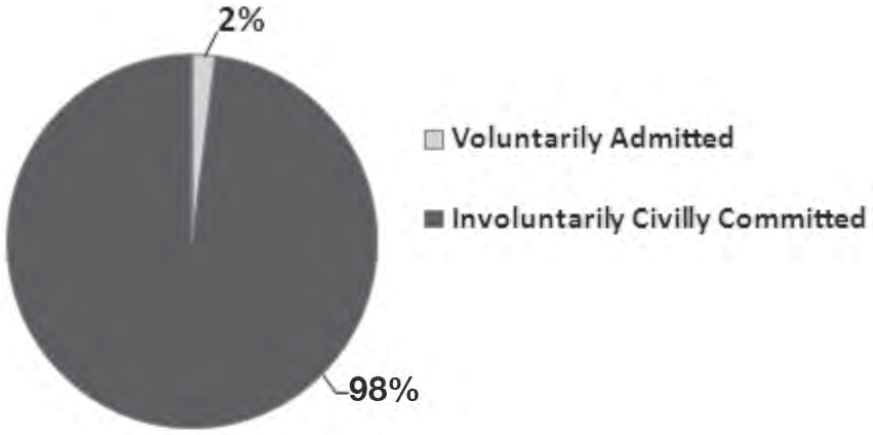
State Psychiatric Hospitals:

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 also contracts with three local hospitals for the provision of acute care services to patients who are involuntary and uninsured.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

The District is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

The SMHA is participating in a Districtwide workgroup focusing on veteran's issues, particularly with respect to the criminal justice system. Other participating agencies include the Office of Veterans Affairs; the Department of Health, Addiction Prevention and Recovery Administration; the Department of Corrections; and the Superior Court, as well as community-based provider representatives.

Mental health services are available to District residents who are uninsured or Medicaid eligible and do not have other insurance benefits. This eligibility includes veterans or family members who do not have access to benefits through the Veterans Administration or the U.S. Department of Defense.

Florida 2009

Department of Children & Families Mental Health Services 1317 Winewood Boulevard Tallahassee, FL 32399 www.dcf.state.fl.us/programs/samh/mentalhealth	The Department of Children & 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 (SAMH) 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 5 regional offices and 20 circuits. Each circuit has a SAMH program office.

Statistics:

State Population (2007):	18,251,243
Number of Persons Served (2008):	262,292
Utilization Rate for Adults:	12.7 per 1,000
Utilization Rate for Children:	20.2 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$772.7 million
Revenue From Medicaid	$125.5 million
Expenditures for Community Mental Health Services (53% of Total Mental Health Agency Revenues)	$379.7 million
Per Capita State Mental Health Expenditures	$39.87

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 Services	Part of the SMHA
Brain Impaired Services	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	Part of the SMHA

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Located in the same umbrella department as the SAMH Program Office
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
State Psychiatric Hospitals	3	4	7
Community Mental Health Providers	0	240	240

Primary Mechanism Used To Deliver Community Mental Health Services:

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

Interagency Collaboration:

The SMHA is working with other Florida government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. It is coordinating care with the following agencies: housing services, employment services, juvenile justice, criminal justice, education, child welfare, Medicaid, substance abuse, and the National Guard.

Florida has initiatives, implemented by its transition workgroups, to transform the way it delivers mental health services:

- **Certified Recovery Peer Specialist Program –** The Mental Health Program Office of Consumer and Family Affairs and the Florida Certification Board developed and implemented the Nation's first systemic, integrated Peer Specialists program. The program offers three different certifications: Certified Recovery Peer Specialist, Certified Recovery Peer Specialists working with adults, and Certified Recovery Peer Specialists for families.
- **Recovery Oriented System Indicators (ROSI) –** This database (soon to be a Web-based entry system) is used to store, analyze, and report on data on consumer satisfaction and services.
- **Substance Abuse and Mental Health Information System (SAMHIS) –** This statewide Web-based system is used to collect, maintain, analyze, and report client-specific information needed by stakeholders at the federal, state, and local levels, including consumers, family members, advocacy groups, providers, managers, and policymakers. The system generates reports showing the sociodemographic and clinical characteristics of the persons served, services provided, service outcomes, service costs, and provider performance.
- **Services to Veterans –** The State of Florida was awarded a 5-year grant to assist veterans who come in contact with the criminal justice system in receiving appropriate treatment, rather than being sent to jail. The purpose of this project is to provide an alternative to jail for veterans, especially those suffering from Post-Traumatic Stress Disorder (PTSD) and other mental health or substance abuse problems. This Jail Diversion and Trauma Recovery project will consist of screening, assessment, treatment, and peer recovery support through community-based services. The project also will offer services for family members and assistance with accessing appropriate veterans benefits.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	No	Yes	Yes
Criminal Justice	Yes	No	Yes	Yes
Education	Yes	No	Yes	No
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	No	No	No

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. All contracted mental health providers screen and refer individuals to Medicaid for eligibility determination.

The SMHA and Medicaid share data to improve Florida's ability to determine access and need for services and to cost share residential treatment services for children. The SMHA reviews and comments on Medicaid rules as well as on requests for proposals.

The SMHA is working with providers to increase the recognition and treatment of physical health needs of persons with mental illnesses. Collocation of mental health and health providers is occurring at limited sites across Florida.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health. The SMHA is working on a cost study for transportation issues for persons with mental illness, working on a cost study for forensically involved consumers on incarceration versus diversion, and working with the Governor's Commission on Disabilities to include mental health issues. The SMHA will deploy use of the ROSI system indicator instrument statewide.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	31
Supported Employment	Statewide	32
Medication Algorithms (Schizophrenia)	Statewide	1
Medication Algorithms (Bipolar Disorders)	Statewide	1
Integrated Mental Health/Substance Abuse Services	Parts of the state	Unknown
Illness Self-Management (SDC)	Parts of the state	2
Supported Housing	Statewide	34
Consumer-Operated Services (Drop In/Clubhouse)	Parts of the state	16
Therapeutic Foster Care	Statewide	30
Functional Family Therapy	Parts of the state	Unknown

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Trauma-Informed Care	Parts of the state	7 (1 per hospital)
Wraparound	Parts of the state	Unknown
CCISC for Co-Occurring Substance Abuse/Mental Health	Parts of the state	60 (average of 3 per circuit) (Community not available)

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing a shortage of psychiatrists, other physicians, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), registered nurses, dietitians, and pharmacists in state psychiatric hospitals and community mental health programs. The SMHA has special university-based training initiatives, offers training at mental health programs/providers, and offers increased salaries as well as recruitment bonuses or other financial incentives to address staffing shortages. Other initiatives to reduce staff shortages include allowing flexed hours, providing on campus housing, allowing educational leave with pay for nursing staff, and implementing cross-training with other social services agencies.

The SMHA has staff training initiatives, mentoring, and leadership institute training to improve the quality of the mental health workforce.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings and video conferencing.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing.

Managed Behavioral Healthcare:

The majority of Florida Medicaid Mental Health services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved in and are provided by either the primary healthcare provider networks or a health-maintenance organization (HMO). Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization.

Custody Relinquishment:

Florida 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. Florida Statute 394.491 states that the system of care should be community based, the mental health programs and services should support and strengthen families, and these services must be delivered in a coordinated manner. Substance Abuse and Mental Health works closely with all child-serving agencies in an attempt to divert children from entering the mental health system. This goal is accomplished through various interagency agreements that provide guidelines to navigate the system of care and provide the most appropriate services and supports to the children and their families.

The Community-Based Care (CBC) providers contracted by the department to provide child welfare services are required by contract to provide diversion and prevention services throughout Florida. This requirement includes linking children to substance abuse and/or mental health services, as needed, to avoid removal. Limited funding is available to families of children who need residential services on a sliding fee scale.

Telemedicine:

The SMHA promotes the use of telemedicine. The SMHA is working in partnership with the Agency for Health Care Administration (AHCA) to facilitate the delivery of telemental health services to rural individuals through a secure telecommunications network connecting rural hospitals, not-for-profit clinics, and mental health and substance abuse providers.

The SMHA is currently developing a statewide policy to address the use of intrastate telemental health services. The SMHA is also currently developing a Rural Mental Health Plan to be incorporated into the Florida Department of Health's Rural Health Plan that will support the use of telemental health services.

Electronic Health Records (EHRs):

The provider that operates three of the four privately operated Adult Mental Health Residential facilities has an electronic medical record (EMR) system in use in one of the facilities and has plans to use it in the other facilities once development has been completed. The three state-operated hospitals are currently exploring EMR programs that can be utilized by all of them.

The SMHA is considering the adoption of an EHR 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.

AHCA has applied for several grants that will involve Regional Health Information Organizations (RHIOs) across Florida in efforts to develop electronic health information systems. The SMHA is working closely with AHCA to ensure that these initiatives include the mental health providers.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in state-contracted community mental health settings and state-funded mental health treatment facilities (state psychiatric hospitals). The SMHA does not receive data from privately funded community providers.

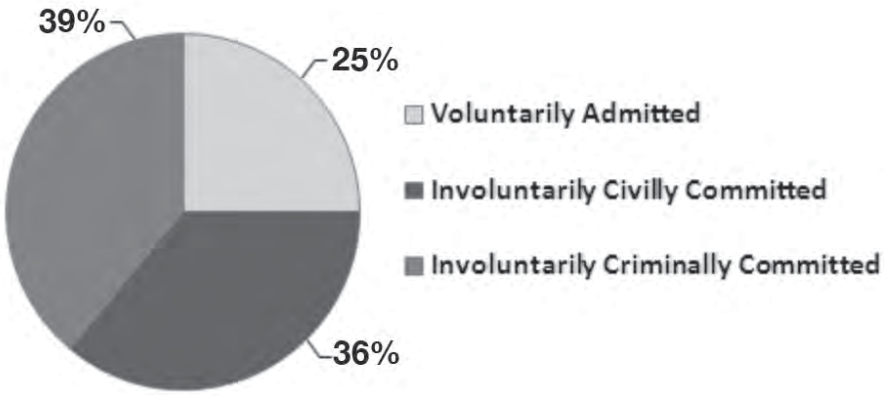
State Psychiatric Hospitals:

The responsibility for the operation of Florida 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 and four state-contracted psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Adults	No	Yes	Yes
Elderly	No	Yes	Yes
Forensic	No	No	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, the State of Florida was awarded a 5-year grant to assist veterans who come in contact with the criminal justice system in receiving appropriate treatment, rather than being sent to jail. The purpose of this project is to provide an alternative to jail for veterans, especially those suffering from PTSD and other mental health or substance abuse problems. This Jail Diversion and Trauma Recovery project will consist of screening, assessment, treatment, and peer recovery support through community-based services. This project also will offer services for family members and assistance with accessing appropriate veterans benefits.

Florida has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is no arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Georgia 2009

Divsion of Mental Health, Developmental Disabilities, & Addictive Diseases Department of Human Resources 2 Peachtree Street, Suite 23 492 Atlanta, GA 30303 http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/	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 (2007):	9,544,750
Number of Persons Served (2008):	134,435
Utilization Rate for Adults:	14.7 per 1,000
Utilization Rate for Children:	12.4 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$448.1 million
Revenue From Medicaid	NA
Expenditures for Community Mental Health Services (52% of Total Mental Health Agency Revenues)	$233.3 million
Per Capita State Mental Health Expenditures	$47.33

NA = Exact revenue is not available.

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Different state department
Housing Agency	Same umbrella department as the SMHA
Health Department	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	7	0	7
Community Mental Health Providers	7	130	137
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly operates local community-based agencies.

The SMHA is undertaking initiatives to restructure Georgia's community-based system of mental health service delivery. Child and adolescent services are provided under a fee-for-service payment system with an expanded provider pool. The Georgia SMHA is participating in the Psychiatric Residential Treatment Facility (PRTF) demonstration grant waiver. In addition, the SMHA will fund Care Coordination and Child and Family Teams for children and adolescents who do not qualify for the waiver but who require intensive services. The SMHA has decreased hospital beds in Savannah and Columbus and has increased crisis stabilization units, Assertive Community Treatment (ACT), mobile crisis services, social detoxification, intensive residential treatment, and transportation services. Georgia is operating some of the community services. Georgia also is evaluating the possibility of merging, privatizing, and redirecting hospital funding over the next 5 years, resulting in a decrease of hospital facilities from seven to three.

Interagency Collaboration:

The SMHA is working with other Georgia government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The SMHA has a Memorandum of Understanding (MOU) to participate in joint requests for procurements; however, budget reductions at the state level have not allowed issuance at this time. The SMHA has successfully utilized the Supplemental Security Income (SSI)/Social Security Disability Insurance (SSDI) Outreach, Access and Recovery (SOAR) program to expedite eligibility determinations for SSI and subsequently Medicaid. Transition and aftercare for probationers and parolees (TAPP) funding was utilized in 2008 to provide case management services to persons leaving correctional facilities; however, this funding was included in the budget reductions in the FY 2009 budget. Correctional facilities are currently utilizing the Georgia Crisis and Access Line to make appointments for persons leaving correctional facilities. The SMHA began funding Consumer Transition Planning for participation by providers in planning for consumers leaving correctional facilities during FY 2009. The SMHA works with Public Health and with Housing in joint programs for persons who are homeless. Education funds teachers in several mental health service programs. The SMHA manages funds from the budget of the Department of Family and Children Services (DFCS) to provide mental health treatment to children in foster care and for intensive services for children in parental custody who require residential services. The SMHA has an MOU with the Department of Juvenile Justice (DJJ) and DFCS to provide outdoor therapeutic services for children in their custody.

Georgia has initiatives to transform the way it delivers mental health services. Extensive planning for children's services is occurring through the State Infrastructure and Substance Abuse Coordination Grants. These grant activities are overseen by a Collaborative of representatives from all child-serving state agencies, provider associations, and family organizations. The focus is on improving the delivery of behavioral health services to youth with serious emotional disturbances (SED) and co-occurring disorders, improving the skills of the workforce, expanding youth and family involvement in systems of care, developing financing

strategies, and supporting development of systems of care at the local level. The SMHA has completed one phase of financial mapping for children's services and is currently engaged in phase 2. Georgia also has obtained the PRTF demonstration grant waiver from the federal Centers for Medicare and Medicaid Services (CMS) and is preparing for its implementation on July 1, 2009. The SMHA is engaged in extensive Olmstead work regarding providing services and supports in communities so that fewer people require institutional care. Additional ACT, mobile crisis, social detoxification, transportation, and intensive treatment programs were funded for FY 2009. Hospital beds were decreased significantly in the two areas of Georgia where these services were added. CMHS is currently providing technical assistance to the SMHA regarding funding streams for intensive services. Georgia amended its Medicaid State Plan in FY 2009, including rate increases, for implementation in FY 2010. The SMHA closed one state-run children's hospital in early FY 2009 and plans to close the one remaining state-operated child and adolescent hospital by the end of the fiscal year.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	No	Yes
Education	Yes	Yes	Yes	Yes
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	Yes	Yes	Yes

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The SMHA also collaborates with Georgia Medicaid (Department of Community Health) to implement disease management and care management. The Division of Public Health is within the same department, that is, the Department of Human Resources, as the DMHDDAD and is working with primary care providers regarding recognition of depression and the potential for suicide. Gateway Community Service Board, a provider funded by the SMHA, is working with federally qualified health centers (FQHCs) to assist primary care physicians in recognizing and treating mental illnesses.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The SMHA funds mental health supports in collaboration with Physical Health Services for persons who are homeless and for collaborations between mental health centers and FQHCs. Mental health providers work in conjunction with public health providers to provide joint treatment for persons experiencing homelessness.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health:

- The SMHA Consumer Relations and Recovery Section Director includes the message that understanding mental health is essential to overall health in all public-speaking engagements.
- The SMHA funded a conference by the Georgia Mental Health Consumer Network Conference focused on whole health.
- A SMHA-funded community provider in southeast Georgia has developed a collaborative with multiple FQHCs that includes screening for mental health disorders and telemedicine to support primary care physicians in providing appropriate treatment.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	7
Supported Employment	Statewide	27
Medication Algorithms (Schizophrenia)	Parts of the state	NR
Medication Algorithms (Bipolar Disorders)	Statewide	NR
Integrated Mental Health/Substance Abuse Services	Statewide	NR
Supported Housing	Statewide	NR
Consumer-Operated Services	Statewide	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
System of Care Models	Available in parts of the state	5
Peer Support	Available in parts of the state	1
Intensive Family Intervention	Available statewide	NR
Psychosocial Rehabilitation	Available statewide	NR
Peer Supports	Available statewide	NR

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA has not indicated whether it is currently experiencing shortages of mental health staff. Other initiatives to reduce staff shortages include concentrated recruitment and hiring fairs.

The SMHA has numerous initiatives throughout the system to improve the quality of the mental health workforce. Many of these initiatives use Covey's Wildly Important Goal (WIG) methodology.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings and video conferencing.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Its relationships with professional schools include making practicums and internships available.

Georgia reimburses adult consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care.

Custody Relinquishment:

Georgia 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. Parents can access all services, including PRTFs and room, board, and watchful oversight without relinquishing custody. The Office of Mental Health administers the funds.

Telemedicine:

The SMHA promotes the use of telemedicine. The SMHA has been working with federal and state Medicaid to expand the telemedicine activities that can be reimbursed. The SMHA is utilizing telemedicine to link physicians at the state hospitals to the Bibb County jail to provide consultation and assessments. One Community Services Board is working with multiple FQHCs utilizing telemedicine to support primary care physicians in assessing for mental health and alcohol and drug issues and in providing appropriate medications.

Electronic Health Records (EHRs):

The SMHA is installing an EHR in state hospitals. The SMHA is operating an EHR 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

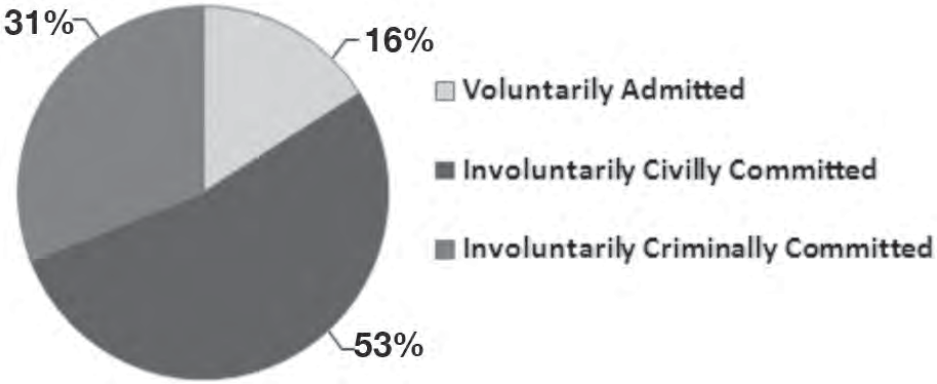
State Psychiatric Hospitals:

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 seven SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Georgia 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 since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans and National Guard members and provide education and treatment services to veterans returning from recent conflicts.

Georgia has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Hawaii
Adults' Division 2009

Department of Health Adult Mental Health Division 1250 Punchbowl Street, Room 256 Honolulu, HI 96813 www.amhd.org/	Hawaii s Mental Health System is located in the Department of Health (DOH), Behavioral Health Administration (BHA). Four divisions compose 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 AMHD both provides services through the community mental health centers (CMHCs) and contracts for services through approximately 35 Purchase of Service (POS) providers.

Statistics:

State Population (2007):	1,283,388
Number of Persons Served (2008):	18,948
Utilization Rate for Adults:	16.6 per 1,000
Utilization Rate for Children:	10.4 per 1,000

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 Services	Part of the SMHA
Brain Impaired Services	Part of the SMHA
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

Location of Other State Agencies in Relation to the SMHA:

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

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly operates community-based programs.

The SMHA is undertaking initiatives to restructure Hawaii's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other Hawaii government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services, as follows:

- **Housing (Mini-Grant) –** Web-based homeless management information system.
- **Employment (Mini-Grants) –** Two clubhouse efforts to support members' work toward finding employment.
- **Juvenile Justice (see Criminal Justice below) –** Juvenile Justice planning track.
- **Criminal Justice –** Specific Criminal Justice Task Group with multiple efforts, including police officer mental health training; mental health court; review and update of Hawaii civil commitment statutes; and Big Island Criminal Justice Work Group.
- **Education –** The department director is a transformation working group (TWG) (steering committee) member; Department of Education (DOE) staff are involved in most Mental Health Transformation State Incentive Grant (MHTSIG) children's planning efforts; and collaboration between DOH, the Department of Human Services (DHS), and the DOE director is underway to promote interagency partnerships.
- **Child Welfare (see Juvenile Justice above) –** In Hawaii, child welfare is part of the DHS, which is involved in the MHTSIG children's planning track; the DHS director is a TWG member.
- **Medicaid –** The DHS director is a TWG member.
- **Substance Abuse –** DOH BHA coordination and reorganization effort; Co-Occurring State Incentive Grant (COSIG) followup evaluation. The Network of Care is a nationally replicated, multi-purpose Web site with Web-based resources (e.g., local services directory and national library) and coordination components (e.g., public announcements and legislation tracking and advocacy), as well as personal health information (Wellness Recovery Action Plan).

Hawaii has initiatives to transform the way it delivers mental health services. The MHTSIG is specifically designed to accomplish this goal, and Hawaii is one of nine national recipients of this SAMHSA grant. In addition, the MHTSIG supports (through a mini-grant) a National Alliance on Mental Illness (NAMI) effort to train healthcare providers to work in effective partnerships with family members.

Agency	Working To Reduce Fragmentation	Combine or Coordinate Service Delivery
Housing Services	NR	Yes
Employment	NR	Yes
Juvenile Justice	Yes	NR
Criminal Justice	Yes	NR
Education	Yes	Yes
Child Welfare	Yes	NR
Medicaid	Yes	NR
Substance Abuse	NR	Yes
National Guard	NR	NR
Network of Care	Yes	Yes

NR = not reported.

The SMHA collaborates with Hawaii's health department to increase the recognition and treatment of persons with mental illness by primary care providers. The state is applying for a SAMHSA Primary and Behavioral Health Care Integration (PBHCI) grant (SM-09-011); this is the secondary goal of the application.

The SMHA works with public providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. Hawaii is applying for a SAMHSA PBHCI Grant (SM-09-011); this is the secondary goal of the application.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health. The MHTSIG effort is underway, carried out by a task group and supervised by the TWG. It includes three objectives and is expected to proceed over the next 2 years: (1) Develop a summary of mental health-related public media campaigns carried out in recent years by state agencies, and collect ideas for initiatives needed; (2) develop a communications plan, approved by the TWG, that will guide implementation of a public media campaign; and (3) carry out a public media campaign that measurably affects the public perception of "mental health."

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	NR	8
Supported Employment	Statewide	2
Integrated Mental Health/Substance Abuse Services	Statewide	3
Illness Self-Management	NR	3
Supported Housing	Statewide	3
Consumer-Operated Services	Statewide	2

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
AMHD Bridge Subsidy to Section 8	Available statewide
Training Consumers To Become Good Tenants	Available statewide
Training Public Housing Staff To Be Good Landlords	Available statewide

Staffing and Workforce Development Initiatives:

The SMHA is not currently experiencing shortages of mental health staff.

The SMHA utilizes behavioral health interventions to improve the quality of the mental health workforce.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including psychology, psychiatry, and nursing. Its relationships with professional schools include: The Psychiatry Department of the University of Hawaii School of Medicine operates a unit at Hawaii State Hospital.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. Services are carved in and are provided by the primary healthcare provider networks or HMO. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 216,900 persons received behavioral health services under the managed care plan in 2008.

Telemedicine:

The SMHA promotes the use of telemedicine. Psychiatrists on the Big Island (Hawaii) utilized telemedicine to provide psychiatric services to consumers in distant areas.

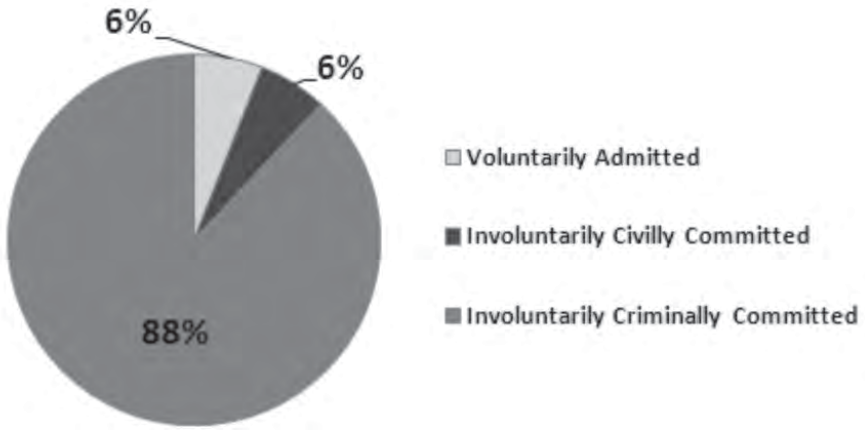
State Psychiatric Hospitals:

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 hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Hawaii is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have not been specific initiatives to address the need for mental health services for Hawaii's returning veterans and their families. However, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Hawaii
Children's Division 2009

Department of Health Child & Adolescent Mental Health Division 3627 Kilauea Avenue, Room 101 Honolulu, HI 96816 www.hawaii.gov/health	Hawaii s Mental Health System is located in the Department of Health (DOH), Behavioral Health Administration (BHA). Four divisions compose 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 AMHD both provides services through the community mental health centers (CMHCs) and contracts for services through approximately 35 Purchase of Service (POS) providers.

Statistics:

State Population (2007):	1,283,388
Number of Persons Served (2008):	18,948
Utilization Rate for Adults:	16.6 per 1,000
Utilization Rate for Children:	10.4 per 1,000

Responsibilities of the SMHA in Administering Specific Mental Health Services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Adult Forensic Services	Part of the SMHA
Brain Impaired Services	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	Part of the SMHA
Sex Offender Services	Part of the SMHA

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Same umbrella department as the SMHA
Housing Agency	Different state department
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
General Hospitals With Separate Psychiatric Units	1	0	1

Primary Mechanism Used To Deliver Community Mental Health Services:

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

Interagency Collaboration:

The SMHA is working with other Hawaii government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services: interagency quality monitoring and quality assurance; regional and state multiagency coordination teams; and memorandums of agreement that specify eligibility, services, and funding arrangements.

Hawaii has the following initiatives to transform the way it delivers mental health services: the Mental Health Transformation Incentive Grant (MHTSIG), in addition to a 13-year reform effort associated with the Felix Consent Decree (about special education services) to develop a statewide system of care; best practices; and comanagement of mental health, school-based behavioral health, and Medicaid services.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Employment	Yes	NR	NR	NR
Juvenile Justice	Yes	Yes	Yes	Yes
Education	Yes	Yes	Yes	Yes
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	NR	NR	NR

NR = not reported.

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers in the following ways: assessment of behavioral health referrals in a provider survey; a Best Practices Conference targeting inclusion of primary care physicians; funding of a medical residency program including pediatrics and psychiatry; and funding of a training program in advanced practice registered nursing for child and adolescent mental health. The latter will result in the ability of more nursing professionals to address mental illness among children and adolescents. In addition, the state Medicaid agency is implementing the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

The SMHA works with public health providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses in several ways: The SMHA corresponds quarterly with primary care physicians of all registered clients to facilitate improved understanding and coordination of care; Family Guidance Center (FGC) care coordinators work with various community professionals to help ensure that youth with mental illnesses or severe emotional disturbances also get their health needs addressed.

The SMHA has initiatives to promote the understanding that mental health is essential to overall health, described below.

Children's Mental Health Awareness Day: Hawaii celebrates Children's Mental Health Awareness Day in May. On this day, volunteers holding "Children's Mental Health Matters" signs wave at commuters as they drive past the State Capitol.

Other May Health Activities: During May, health fairs, marches, and proclamations are held in multiple communities. Hawaii also has been successful in engaging the broadcast media with on-air interviews with healthcare professionals.

Mental Health Awareness at the State Capitol: Because the Hawaii Legislature adjourns prior to May, "Mental Health Awareness at the State Capitol" events have been held for the past 2 years. Informational booths are set up within the State Capitol Building, and legislators are invited to learn more about mental health. Informational booths are set up at multiple shopping centers, and the general public is encouraged to learn more about mental health through selecting and reading written materials, viewing video presentations, and asking questions of the various professionals who man booths for 1 week. The children's Anti-Stigma Workgroup adds to the event with a legislative walkaround, delivering informational packets to each state legislator, city council member, the Governor, the Lt. Governor, and the Mayor.

Children and Youth Day: Hawaii also celebrates Children and Youth Day every October. On this day, organized by the Keiki (children's) Caucus, over a hundred booths surround the State Capitol and adjacent City Hall grounds to provide food, entertainment, and interactive educational activities for young children and teens. The various Anti-Stigma Workgroup members man booths to provide information about mental health and wellness. Every year, about 15,000 children, youth, and families attend Children and Youth Day.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Multisystemic Therapy (Conduct Disorder)	Statewide	9
Therapeutic Foster Care	Statewide	NR
Functional Family Therapy	Statewide	2

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Dialectical Behavior Therapy	Available in parts of the state	NR
Trauma-Informed Care	Available in parts of the state	NR
Transition to Independence Program (TIP)	Available in parts of the state	1

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists and psychologists (doctoral level) in community mental health programs.

The SMHA has initiatives to improve the quality of the mental health workforce. CAMHD introductory and advanced trainings are offered on evidence-based practices in the system of care, transition to adulthood, etc.

The SMHA has relationships with professional schools to provide training in disciplines including social work and psychology.

Managed Behavioral Healthcare:

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

Custody Relinquishment:

Hawaii 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. This is a description of the policies/laws: Provide mental health services regardless of custody status, with no rejection policy. Actively attempt to keep youth with families, and provide services to prevent relinquishment.

Telemedicine:

The SMHA promotes the use of telemedicine. The SMHA contracts with the University of Hawaii's Department of Psychiatry to implement telemedicine in neighbor islands.

Electronic Health Records (EHRs):

The SMHA is installing an EHR 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.

The SMHA did not indicate whether it has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA does not maintain an individual client-level database for consumers served in community mental health settings.

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 hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)
Children	Yes	Yes
Adolescents	Yes	Yes

Psychiatric Inpatient Bed Shortages:

Hawaii is not experiencing a shortage of psychiatric beds.

Idaho 2009

Division of Behavioral Health Department of Health & Welfare 450 West State Street, 3rd Floor Boise, ID 83702 www.healthandwelfare.idaho.gov	Idaho s public Community Mental Health Services are administered by the Division of Behavioral Health within the Department of Health and Welfare. Services are delivered through seven geographically defined regional programs. Regional state staff at community mental health centers provide adult and children's mental health services, with a target of serving those who are not Medicaid eligible. State level programs provide statewide coordination and technical assistance to regional service programs.

Statistics:

State Population (2007): 1,499,402

Number of Persons Served (2008): 12,928

Utilization Rate for Adults: 9.5 per 1,000

Utilization Rate for Children: 6.3 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$71.4 million
Revenue From Medicaid	$10.6 million
Expenditures for Community Mental Health Services (55% of Total Mental Health Agency Revenues)	$39.1 million
Per Capita State Mental Health Expenditures	$47.91

New Financing Initiatives:

Idaho is planning or implementing a change in how the delivery of mental health services is financed.

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 Services	Shared with another agency
Brain Impaired Services	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	Some responsibility

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Located in the same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
Housing Agency	Located in a different state department
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	14	0	14

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly operates community-based programs.

Interagency Collaboration:

The SMHA is working with other Idaho government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The state has initiatives, such as the Children's Mental Health Program described below, to transform the way it delivers mental health services.

The Children's Mental Health Program convened a facilitated workgroup that has been meeting for the last 3 years on issues related to youth with serious emotional disturbances (SED) involved in the juvenile justice system. Workgroup members include county and state juvenile justice, parents, parent advocacy organizations, private providers, state hospital staff, a juvenile court judge, and Medicaid and state children's mental health representatives. This workgroup was instrumental in securing additional funding for mental health services for youth involved in the juvenile justice system, mental health clinicians in all juvenile detention facilities, cross-agency release of information forms, standard mental health assessment reports, training and use of strengths-based assessment and treatment planning, and recommendations on the structure of juvenile mental health courts.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	Yes	Yes	Yes
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes

The SMHA collaborates with Idaho's health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The Division of Behavioral Health presented information on treatment of mental illness to health providers at the Diabetes Alliance of Idaho's Spring Meeting on May 1, 2009, and also at the Idaho Commission on Aging's Long-Term Care Symposium—Understanding and Improving Systems of Care in Idaho, on June 10, 2009.

The Division of Behavioral Health, Children's Mental Health, continues to contract with St. Luke's Regional Medical Center to provide training once a month. The purpose of the training is to enhance the knowledge and skills of primary care practitioners to meet the needs of patients with mental illness. These training sessions focus on the diagnosis and treatment of childhood mental illness, including the use of psychotropic medication and other treatment modalities. Monthly trainings were attended by 33 physicians and 10 other medical professionals during the first 5 months of 2009. Training sessions were recorded on a CD–ROM and made available for checkout.

The SMHA collaborates with courts and corrections to offer Assertive Community Treatment (ACT) to eligible individuals across Idaho referred by the mental health court. Treatment teams composed of representatives from the court, corrections, the judge, vocational rehabilitation, and mental health meet regularly to discuss the need and provision of holistic treatment to the eligible client referred by the mental health court. Such ACT clients attend an assortment of treatment groups, which include those on health and wellness (using an Eli Lilly-sponsored curriculum).

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
ACT	Statewide	NR
Family Psychoeducation	NR	3
Therapeutic Foster Care	Statewide	NR
Functional Family Therapy	Statewide	NR

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), and registered nurses (RNs) in state psychiatric hospitals and community mental health programs.

The SMHA has the following initiatives to address staffing shortages: (1) increased salaries; (2) negotiations began with the University of Washington to establish a shared psychiatric residency program between State Hospital South and Portneuf Medical Center; (3) State Hospital South, State Hospital North, and Region 7 collaborated to develop brochures and a DVD to facilitate shared recruiting efforts of qualified mental health staff; and (4) nursing students (RNs and licensed practical nurses) from local universities are offered experiential opportunities at State Hospital South. In state fiscal year (SFY) 2009, 347 students rotated through units and job shadowed. The hospital uses some of these graduate students as a pool to draw from for employed psych tech (psychiatric technician) trainees. Some of these are recruited for part-time positions and others for full-time positions.

The SMHA has initiatives to improve the quality of the mental health workforce. Efforts include development of policies and procedures and requirements for mandatory training in those policies and procedures. State Hospital South has 63 percent of its nurses credentialed by the American Nursing Credentialing Center as psychiatric and mental health nurse qualified. State Hospital South sponsored a recreational therapy week and conference in SFY 2009. The conference included CEUs through the American Therapeutic Recreation Association.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work and psychology.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Idaho 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. The state law is a voluntary treatment act with provisions for involuntary treatment if parental consent cannot be obtained.

Telemedicine:

The SMHA uses telemedicine to provide mental health services in underserved areas.

Electronic Health Records (EHRs):

The SMHA is implementing an EHR in state hospitals and state-operated community mental health clinics.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that included mental health in its plans to share electronic health information in SFY 2009. The SMHA is considering the inclusion of mental health in the Idaho Health Data Exchange system in the future.

Client-Level Data:

The SMHA does not maintain an individual client-level database for consumers served in community mental health settings. Three of the seven SMHA regions are participating in the federal Client-Level Data Reporting Project.

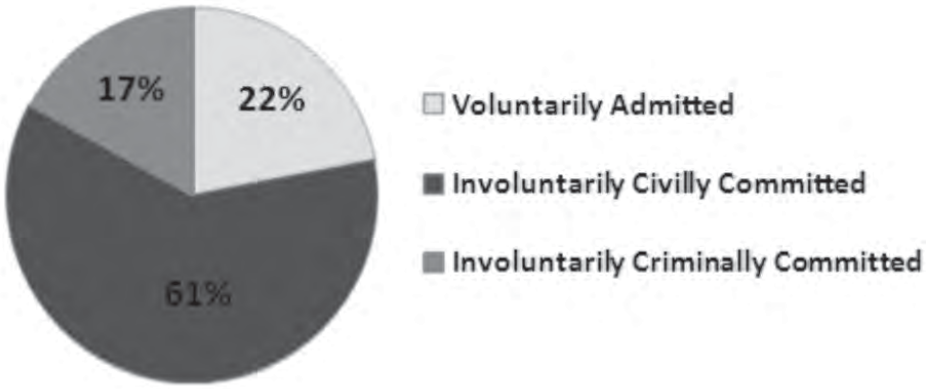
State Psychiatric Hospitals:

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 hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	Yes	Yes	No
Adolescents	Yes	Yes	No
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

In Idaho, there have been declines in general hospital specialty unit psychiatric beds in the last 5 years. The 22 percent of voluntary admissions include adolescents on the adolescent unit with family support and agreement and those who are under guardianship.

Services for Armed Forces Veterans and National Guard Members:

There have been no specific initiatives to address the need for mental health services for Idaho's returning veterans and their families by the SMHA. Although the SMHA will treat eligible veterans, Idaho has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is no formal arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Illinois 2009

Department of Human Services Division of Mental Health 160 North LaSalle Street, 10th Floor Chicago, IL 60601 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 persons who qualify as low income 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 Illinois hospitals and contracts with 162 community mental health providers across the state.

Statistics:

State Population (2007):	12,852,548
Number of Persons Served (2008):	185,158
Utilization Rate for Adults:	15 per 1,000
Utilization Rate for Children:	12.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$1.1 billion
Revenue From Medicaid	$444.3 million
Expenditures for Community Mental Health Services (71% of Total Mental Health Agency Revenues)	$297.5 million
Per Capita State Mental Health Expenditures	$85.06

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Same umbrella department as the SMHA
Housing Agency	Different state department
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	10	0	10
Community Mental Health Providers	0	150	150
General Hospitals With Separate Psychiatric Units	0	28	28

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives to restructure Illinois's community-based system of mental health service delivery: continuing to implement fee for service and continuing to focus on recovery and resilience.

Electronic Health Records (EHRs):

The SMHA has no EHR activities or plans for 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community 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 10 SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Adolescents	Yes	Yes	No
Adults	Yes	Yes	Yes
Forensic	No	Yes	Yes

Psychiatric Inpatient Bed Shortages:

There have been declines in Illinois's psychiatric hospital and private psychiatric hospital beds in the last 5 years; however, the state is not experiencing a shortage of psychiatric beds.

Indiana 2009

Division of Mental Health & Addiction Family & Social Services Administration 402 West Washington Street, Room W353 Indianapolis, IN 46204 www.in.gov/fssa/dmha/	The mission of the Indiana Division of Mental Health and Addiction (DMHA) is to ensure that Indiana citizens have access to appropriate mental health and addiction services that promote individual self sufficiency. As defined by the Indiana Consumer Council, recovery is an intentional and sustained improvement of the quality of life, building on personal hopes and strengths. DMHA s goal is to continue and strengthen its focus on recovery and capitalize on the resiliency of consumers and their families. In light of its mission, a critical role of DMHA is to provide funding and policy oversight for the public mental health and addiction services system. DMHA is responsible for establishing criteria used to determine consumer eligibility, for ensuring that service providers comply with state guidelines, and for assuring the quality of services required by the continuum of care as defined in an Indiana rule. DMHA operates six state psychiatric hospitals and contracts with community mental health centers (CMHCs) and child and addiction treatment providers to offer a full continuum of mental health and addiction treatment services. DMHA also funds community-based alcohol, tobacco, and drug prevention programs.

Statistics:

State Population (2007):	6,345,289
Number of Persons Served (2008):	88,875
Utilization Rate for Adults:	12.2 per 1,000
Utilization Rate for Children:	19.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$552.8 million
Revenue From Medicaid	$352.5 million
Expenditures for Community Mental Health Services (66% of Total Mental Health Agency Revenues)	$363.8 million
Per Capita State Mental Health Expenditures	$87.30

New Financing Initiatives:

Indiana is redesigning how the delivery of mental health and addiction services is financed. SMHA and Medicaid offices are planning to implement a process to align funding with policy and practice expectations. Implementation is expected in July 2010.

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 Services	Shared with another agency
Brain Impaired Services	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	No responsibility

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
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
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	0	31	31

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly funds, but does not operate, local community-based agencies. The SMHA continues to evaluate Indiana's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other Indiana government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. DMHA is working with Indiana's housing agency to implement supportive housing. Several initiatives assist consumers in linking with workforce development. DMHA is working with criminal justice on reentry programs. DMHA works with juvenile justice, education, and child welfare at the local level by developing wraparound services for youth in system of care communities. DMHA has also been working with the VA and the National Guard to develop an initiative to identify returning veterans in need of mental health services.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	No	No
Juvenile Justice	Yes	No	Yes	Yes
Criminal Justice	Yes	NR	NR	Yes
Education	Yes	No	Yes	Yes
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	Yes	NR	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	NR	NR	NR

NR = not reported.

The SMHA collaborates with the Medicaid division and Indiana's health department to increase the recognition and treatment of persons with mental illness by primary care providers. The SMHA is part of an Indiana health department initiative regarding a medical home for children's health. The SMHA is working with Indiana Medicaid pilot sites and federally qualified health centers (FQHCs) to screen all patients for mental health issues.

The SMHA is also working with providers to increase the recognition and treatment of physical health needs of persons with mental illnesses.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: Integration of physical and behavioral health is one of the targeted areas of focus and an initiative within the SMHA System Transformation project. In some areas of Indiana, the CMHCs have specific agreements with private practice physicians or with community health clinics/FQHCs to integrate services. All Indiana hospitals were tobacco free by March 31, 2009.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	NR	33
Supported Employment	NR	27
Family Psychoeducation	Statewide	1
Integrated Mental Health/Substance Abuse Services	Parts of the state	26
Illness Self-Management	Parts of the state	25
Supported Housing	Parts of the state	NR
Multisystemic Therapy (Conduct Disorder)	Parts of the state	NR
Therapeutic Foster Care	Parts of the state	2
Functional Family Therapy	Parts of the state	NR

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), registered nurses, dietitians, behavioral clinicians, and occupational therapists in state psychiatric hospitals and community mental health programs.

The SMHA has several special initiatives underway to address staffing shortages, including university-based training initiatives; training at mental health programs/providers; and increased salaries, recruitment bonuses, or other financial incentives.

Other SMHA initiatives to reduce staff shortages and improve the quality of the mental health workforce include the Workforce Development Task Force and peer-supported recovery, described below.

The Workforce Development Task Force is charged with making recommendations on focus areas. The four priority areas are Licensure, Certification and Clinical Supervision; Culturally Competent and Culturally Diverse Workforce; Behavioral Health Workforce Undergraduate and Graduate Training in Core Disciplines; and Recruitment and Retention. Key stakeholders, consumers, family members, state agency staff, and subject matter experts are involved in this task force.

It has been nationally recognized that peer-supported recovery is making significant contributions to successful outcomes for consumers of services. Peer-supported recovery is a vital component of Indiana's Division of Mental Health and Addiction Transformation. Recipients of mental health treatment have valuable insight and experiences to offer in treatment settings to support and direct the recovery of others.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online training, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, nursing, pharmacy, and chaplaincy. Through professional relationships with institutions of higher education (including Indiana University, Purdue University, Butler University, and Marian University), the state-operated facilities provide training and education to students in those disciplines. Students pursuing professional, graduate, and undergraduate degrees participate in a wide variety of meaningful educational opportunities, contributing to fulfillment of the requirements for their respective degrees.

Relationships with professional schools include the School of Social Work: internships and recruitment of social workers; School of Psychology: internships and serving on boards and committees; School of Psychiatry: medical training/teaching at the facility; School of Nursing: career fairs at nursing schools; utilization of the facilities for clinical training; rotation programs; and the Law Enforcement Academy.

Indiana reimburses neither adult nor adolescent consumer peer specialists through Medicaid for providing mental health services. The State Plan Amendment is in process to allow for such reimbursement.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care for non-Medicaid Rehabilitation Option (MRO) services. These non-MRO behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved in and are provided by the primary healthcare provider networks or by an HMO. Approximately 43,215 persons received behavioral health services under the managed care plan in 2008, although not all of these persons received services through the public mental health and addiction system.

Custody Relinquishment:

Indiana 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. Relinquishment of custody of a child voluntarily placed by parents out of the home for services cannot be made a requirement or condition of receipt of such service.

Electronic Health Records (EHRs):

The SMHA is installing an EHR in state hospitals, and many community mental health programs have installed EHRs. The SMHA is operating an EHR in state hospitals. Indiana does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. The RHIO is working with primary care entities. There have been some very preliminary and sporadic discussions regarding Indiana SMHA data.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

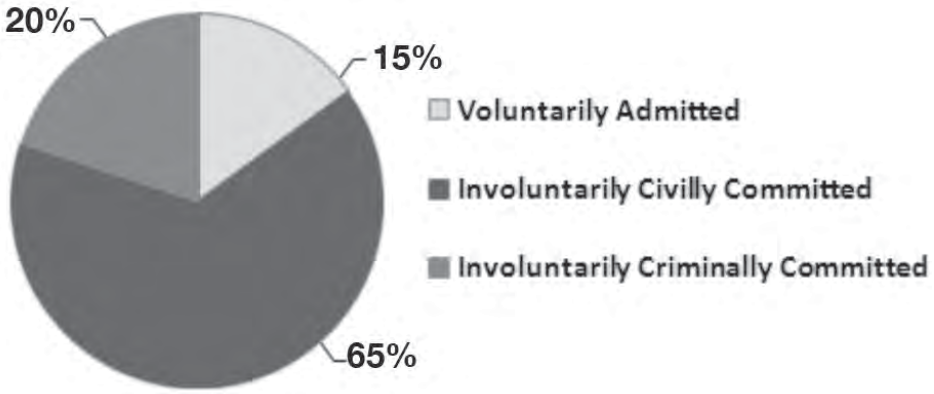
State Psychiatric Hospitals:

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 six SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Indiana is experiencing a shortage of acute psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, the Reserve, and family members of military personnel. For example, the SMHA cosponsored a 2-day training for clinicians in the public mental health system on how to address the mental health and addiction needs of veterans returning from Iraq and Afghanistan and their families. The SMHA also hosted a forum to share information regarding available services and referral options. In addition, the SMHA asked each CMHC to designate a contact person for veterans services to help coordinate services and facilitate appropriate referrals.

Indiana has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Iowa 2009

Division of Mental Health & Disability Services Department of Human Services 1305 East Walnut, Hoover Building, 5th Floor Des Moines, IA 50319 www.dhs.state.ia.us/MHDD/	The Division of Mental Health and Disability Services, within the Department of Human 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 Iowa agencies, including the mental health authority and 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 (2007):	2,988,046
Number of Persons Served (2008):	80,676
Utilization Rate for Adults:	20.6 per 1,000
Utilization Rate for Children:	47.5 per 1,000

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 Services	No responsibility
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
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
State Psychiatric Hospitals	0	4	4
Community Mental Health Providers	0	41	41

Interagency Collaboration:

The SMHA is working with other Iowa government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Iowa has initiatives to transform the way it delivers mental health services. These initiatives include the Money Follows the Person Demonstration Project, Children's Mental Health System of Care, Emergency Crisis Services, transition from the county of legal settlement having responsibility for managing a person's

services to the county of residence having this responsibility, uniform functional assessments to support individual services, the statewide Training Institute, a co-occurring disorder (substance abuse and mental health) academy, Behavioral Health Workforce Initiative, Anti-Stigma Campaign, and the Iowa Peer Support Training Academy.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	No	No	No	No
Employment	No	No	No	No
Juvenile Justice	Yes	No	No	Yes
Criminal Justice	No	No	No	No
Education	Yes	No	No	Yes
Child Welfare	No	No	No	No
Medicaid	Yes	No	No	No
Substance Abuse	Yes	No	Yes	Yes
National Guard	No	No	No	No

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: Mental Health First Aid and Community Emergency Crisis.

Evidence-Based Services:

Evidence-Based Practices	Implementation
Assertive Community Treatment (ACT)	Parts of the state
Supported Employment	Statewide
Family Psychoeducation	Parts of the state
Integrated Mental Health/Substance Abuse Services	Parts of the state
Illness 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
Functional Family Therapy	Statewide

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Parent-Child Interactive Therapy	Available in parts of the state	3
The Incredible Years	Available in parts of the state	8
Trauma-Focused Cognitive Behavioral Therapy	Available in parts of the state	8
Interpersonal Psychotherapy	Available in parts of the state	6
Wellness Recovery Action Program	Available in parts of the state	5
Systems Training for Emotional Predictability and Problem Solving (STEPPS) for Borderline Personality Disorder	Available in parts of the state	NR
Collaborative Model of Mental Health Care for Older Iowans	Available in parts of the state	5

NR = not reported.

Staffing and Workforce Development Initiatives:

Iowa reimburses adult consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

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

Custody Relinquishment:

Iowa 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: Added a children's mental health waiver to Medicaid to reduce the need to use this option to access services.

Telemedicine:

The SMHA does not promote the use of telemedicine.

Electronic Health Records (EHRs):

The SMHA is installing an EHR 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for only some providers. Community provider data are received for those clients who are served by the counties.

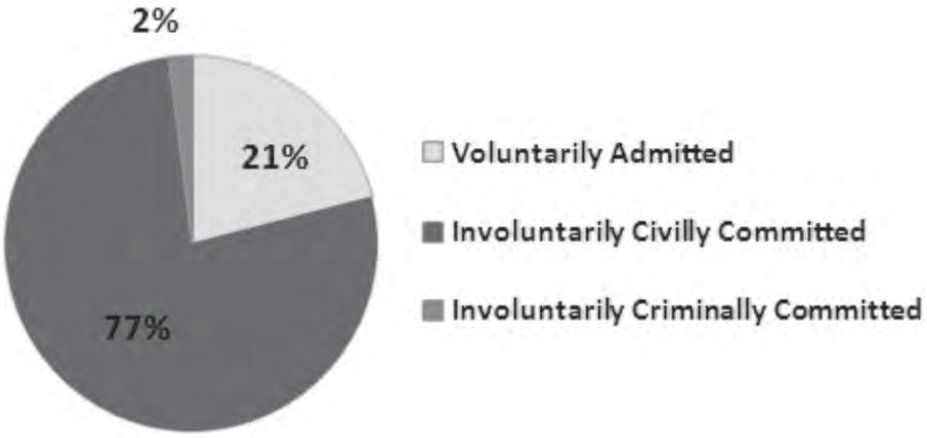
State Psychiatric Hospitals:

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. Iowa has not indicated the number of SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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	No	No

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Iowa is experiencing a shortage of psychiatric beds. There have been declines in private psychiatric hospital beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed National Guard members. For example, volunteer marriage counselors, psychologists, and therapists meet with returning National Guard members and their families.

Iowa has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is no arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Kansas 2009

Division of Disability & Behavioral Health Services Department of Social & Rehabilitation Services 915 SW. Harrison Street, 9th Floor Topeka, KS 66612 1570 www.srskansas.org/main.html	The mission of the Division of Disability and Behavioral Health Services is to promote and ensure high quality mental healthcare, 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 of Kansas, Inc., and is governed by federal managed care requirements and monitored by Social and Rehabilitation Services (SRS)/Mental Health (MH). KHS began its operations on July 1, 2007. In order to afford the same accountability for service to the non Medicaid population and to address unmet needs, SRS/MH has contracted with each community mental health center (CMHC) to meet the same requirements articulated in the managed care contract. In Kansas, the target populations are adults with severe and persistent mental illness and children with serious emotional disturbance. The Division of Disability and Behavioral Health Services also oversees the operation of three state mental health hospitals.

Statistics:

State Population (2007):	2,775,997
Number of Persons Served (2008):	106,014
Utilization Rate for Adults:	35.6 per 1,000
Utilization Rate for Children:	45.4 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$258.6 million
Revenue From Medicaid	$136.3 million
Expenditures for Community Mental Health Services (67% of Total Mental Health Agency Revenues)	$173.2 million
Per Capita State Mental Health Expenditures	$93.62

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 Services	Shared with another agency
Brain Impaired Services	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	Part of the SMHA

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Different state department
Housing Agency	Different state department
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	3	0	3
Community Mental Health Providers	0	27	27
Nursing Homes and Other ICF-MI and SNF Providers	0	11	11

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly funds community mental health providers.

Interagency Collaboration:

The SMHA is working with other Kansas government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Managed care for the Medicaid population combines funding and services with the child welfare pertaining to children who are hard to place in the community.

Kansas has initiatives to transform the way it delivers mental health services. Through its managed care contract, customers can choose any willing provider who participates in the managed care program.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	No	Yes
Employment	Yes	No	No	No
Juvenile Justice	Yes	No	No	Yes
Criminal Justice	Yes	No	No	Yes
Education	No	No	No	No
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	No	Yes	Yes
Substance Abuse	Yes	No	No	Yes
National Guard	No	No	No	No

The SMHA collaborates with the state health department, Medicaid agency, and KHS to increase the recognition and treatment of persons with mental illness by primary care providers.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. Kansas has three federally qualified mental health centers.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Supported Employment	Parts of the state	19
Integrated Mental Health/Substance Abuse Services	Parts of the state	11
Supported Housing	NR	26
Consumer-Operated Services	Parts of the state	20
Functional Family Therapy	Parts of the state	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Parent Support	Available statewide	26
Shared Decisionmaking With Medicine	Available in parts of the state	1
Shared Decisionmaking With Medication	Available in parts of the state	1
Supportive Housing	Available in parts of the state	26

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), and registered nurses in community mental health programs. The SMHA has initiatives to address staffing shortages including special university-based training and training at mental health programs/providers.

The SMHA also has initiatives to improve the quality of the mental health workforce including the use of universities' research and training to improve the skills and retention of providers (the psychiatric residency training program at Kansas University).

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online training, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work and psychiatry. Its relationships with professional schools include several of Kansas's universities that provide training programs for mental health professionals through live training and e-learning. Most of the live training and e-learning are done through a contract with the SMHA.

Kansas reimburses adult consumer peer specialists through Medicaid for providing mental health services. The state used a certified peer support worker who received SMHA-controlled training, and such workers are employed by the local CMHC.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Approximately 56,280 persons received behavioral health services under the managed care plan in 2008.

Custody Relinquishment:

Kansas 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 and child welfare fall under the same umbrella agency. Both systems have committed to ensuring custody relinquishment does not occur. One important component to achieve is a robust Serious Emotional Disturbances (SED) Home and Community-Based Services (HCBS) waiver.

Telemedicine:

The SMHA promotes the use of telemedicine.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is 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.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information (Kansas Health Policy Authority).

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

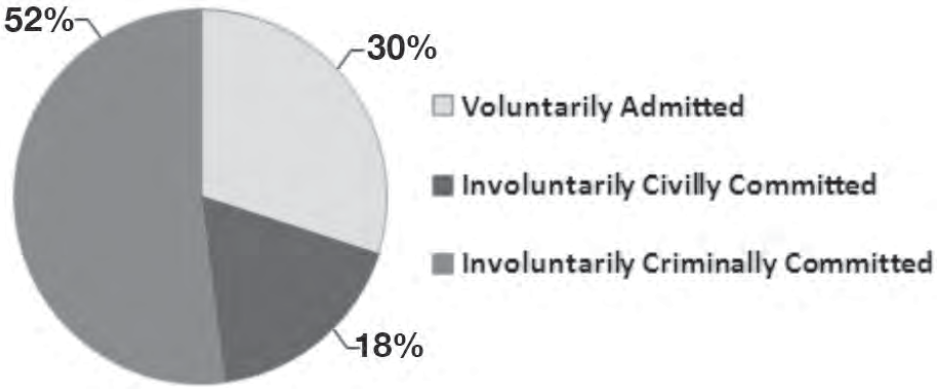
State Psychiatric Hospitals:

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 three SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Kansas is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have not been specific initiatives to address the need for mental health services for returning veterans and their families; however, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Kentucky 2009

Kentucky Department for Behavioral Health, Developmental & Intellectual Disabilities Cabinet for Health & Family Services 100 Fair Oaks Lane, 4E A Frankfort, KY 40621 www.mhmr.ky.gov	The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (KDBHDID) 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 KDBHDID is a department within the Cabinet for Health and Family Services. The commissioner of the department is responsible directly to the Secretary for Health and Family Services, who also oversees the Departments for Public Health and Medicaid Services. Thus, the Secretary of the Cabinet exercises authority over multiple departments that are directly related to both primary and behavioral healthcare.

Statistics:

State Population (2007):	4,241,474
Number of Persons Served (2008):	139,690
Utilization Rate for Adults:	28.1 per 1,000
Utilization Rate for Children:	48.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$230.4 million
Revenue From Medicaid	$66.3 million
Expenditures for Community Mental Health Services (46% of Total Mental Health Agency Revenues)	$105.2 million
Per Capita State Mental Health Expenditures	$54.69

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
Housing Agency	Different state department
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	3	1	4
Community Mental Health Providers	0	14	14
General Hospitals With Separate Psychiatric Units	0	1	1
Nursing Homes and Other ICF-MI and SNF Providers	2	0	2

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly funds, but does not operate, community-based programs.

Interagency Collaboration:

The SMHA is working with other Kentucky government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The SMHA is working with Medicaid on increasing funding for substance abuse services provided when also treating a mental illness. There is a special waiver program for children with serious emotional disturbances (SED) called IMPACT PLUS. The SMHA also revised and updated a Memorandum of Understanding (MOU) with the state Vocational Rehabilitation Agency. The SMHA and juvenile justice representatives review questionable placement issues with clients.

Kentucky has initiatives to transform the way it delivers mental health services. Of these initiatives, payment for peer support specialist services by Medicaid is currently being evaluated.

Agency	Working To Reduce Fragmentation	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes
Employment	Yes	NR	Yes
Juvenile Justice	Yes	NR	Yes
Criminal Justice	Yes	Yes	Yes
Education	No	NR	NR
Child Welfare	No	NR	NR
Medicaid	Yes	Yes	NR
Substance Abuse	Yes	Yes	NR
National Guard	No	NR	NR

NR = not reported.

The SMHA collaborates with the state's health department, Medicaid agency, the Foundation for a Healthy Kentucky (FHK), and Seven Counties Services to increase the recognition and treatment of persons with mental illness by primary care providers. Regional mental health/mental retardation boards are using funding from the FHK to provide integrated services in primary care. The SMHA is providing funding to employ two advanced registered nursing practitioners (ARNPs) at an outpatient clinic serving persons who are homeless.

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

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Illness Self-Management	Parts of the state	10
Supported Housing	Parts of the state	9
Consumer-Operated Services	NR	6
Multisystemic Therapy (Conduct Disorder)	NR	2
Therapeutic Foster Care	Parts of the state	6
Functional Family Therapy	Parts of the state	1

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), and social workers (master's level and above) in community mental health programs. The SMHA has initiatives to address staffing shortages including special university-based training and training at mental health programs/providers.

The SMHA has initiatives to improve the quality of the mental health workforce; for example, CEU trainings are provided to mental health staff.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online training, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Kentucky 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. Funding has been provided to four community mental health centers in western Kentucky for telehealth equipment under the Direct Intervention, Vital Early Response Treatment System (DIVERTS) program to reduce admissions to state hospitals.

Electronic Health Records (EHRs):

The SMHA is operating 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community 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 three SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

Psychiatric Inpatient Bed Shortages:

There have been declines in general hospital specialty unit psychiatric beds since 2008; however, Kentucky is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for Kentucky's returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, suicide prevention staff distribute materials, set up booths at local community events, talk to military personnel regarding suicide prevention initiatives, and provide Question, Persuade and Refer (QPR) training throughout Kentucky at various venues. There is also an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Louisiana 2009

Office of Mental Health Department of Health & Hospitals 628 North 4th Street, 4th Floor P.O. Box 4049 Baton Rouge, LA 70821 www.dhh.state.la.us/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, the Office of Adult and Aging Services, and the Office of Management and Finance (including the state Medicaid agency). The administration of Louisiana mental healthcare is changing from interrelated geographic areas and regions to a system of semi independent, integrated human service districts (local governing entities (LGEs)) under the general administration of DHH.

Statistics:

State Population (2007): 4,293,204

Number of Persons Served (2008): 51,752

Utilization Rate for Adults: 13.2 per 1,000

Utilization Rate for Children: 8.7 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$271.2 million
Revenue From Medicaid	$96.9 million
Expenditures for Community Mental Health Services (27% of Total Mental Health Agency Revenues)	$73.6 million
Per Capita State Mental Health Expenditures	$62.27

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	No responsibility
Adult Forensic Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
Housing Agency	Different state department
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	5	0	5
Community Mental Health Providers	27	15	42
General Hospitals With Separate Psychiatric Units	3	0	3

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly operates community-based programs.

The SMHA is undertaking initiatives to restructure the state's community-based system of mental health service delivery. Community-based services are moving toward the development of 10 locally controlled integrated human service authorities or districts (LGEs). There are currently 4 of 10 previously developed LGEs, and one more is in the development phase.

Interagency Collaboration:

The SMHA is working with other Louisiana government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services in the following areas:

- **Substance Abuse –** The Co-Occurring State Incentive Grant (COSIG) improves coordination or integrates services.
- **Louisiana Rehabilitation Services of the Department of Social Services (DSS) –** This program coordinated with the SMHA to increase employment.
- **School-Based Healthcare –** School-based health centers coordinated with the Office of Public Health to provide care in school settings.

Louisiana has initiatives to transform the way it delivers mental health services. For example, the Cornerstone Quality Management Initiative is designed to improve access to services and to develop more comprehensive and efficient delivery of services.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	No	Yes
Juvenile Justice	Yes	No	No	Yes
Criminal Justice	Yes	No	No	Yes
Education	Yes	Yes	NR	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	NR	Yes
Health	Yes	Yes	Yes	Yes

NR = not reported.

The SMHA collaborates with Louisiana's health department, the Office of Public Health, and the state Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. There are also support and connection with federally qualified health centers (FQHCs), as well as utilization of health and mental health data through the Behavioral Risk Factor Surveillance System (BRFSS).

The SMHA works with public providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The SMHA provides assistance for grants, data management, etc., for community agencies to build in primary care services.

The following SMHA initiative promotes the understanding that mental health is essential to overall health: Louisiana Spirit Hurricane Recovery has assisted with educational campaigns to increase awareness of mental health concerns.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	5
Supported Employment	Parts of the state	2
Medication Algorithms (Schizophrenia)	Parts of the state	NR
Family Psychoeducation	Parts of the state	3
Integrated Mental Health/Substance Abuse Services	Parts of the state	3
Illness Self-Management	Parts of the state	3
Supported Housing	Parts of the state	3
Consumer-Operated Services	Parts of the state	NR
Multisystemic Therapy (Conduct Disorder)	Parts of the state	1
Therapeutic Foster Care	NR	1
Functional Family Therapy	Parts of the state	2

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), and registered nurses in Louisiana psychiatric hospitals and community mental health programs.

The SMHA has initiatives to improve the quality of the mental health workforce. The SMHA uses the Web-based Essential Learning's Learning Management System (LMS) and SMHA-sponsored trainings and workshops establishing competency and credentialing standards as well as privileges.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, DVD training, and audio conferences.

The SMHA has relationships with professional schools to provide training in professional disciplines, including social work, psychology, psychiatry, and nursing. Its relationships with professional schools include one with SMHA-run hospitals that provide internship residency practice training for the disciplines listed.

Managed Behavioral Healthcare:

Mental health services are being delivered through the Medicaid Mental Health Rehabilitation Program that operates under a managed care model.

Custody Relinquishment:

Louisiana 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. The policies of the SMHA do not require custody relinquishment to access outpatient or inpatient mental healthcare. Few children are directly placed in the custody of the SMHA, and many of the residential placements are accessed through other state departments, where this approach might be problematic.

Telemedicine:

The SMHA promotes the use of telemedicine. Video conference sites have been made widely available throughout Louisiana to encourage utilization of this service, especially in rural areas.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in state hospitals and community mental health programs.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings and state psychiatric hospitals, stored as a centralized data warehouse. The SMHA receives information for all community providers.

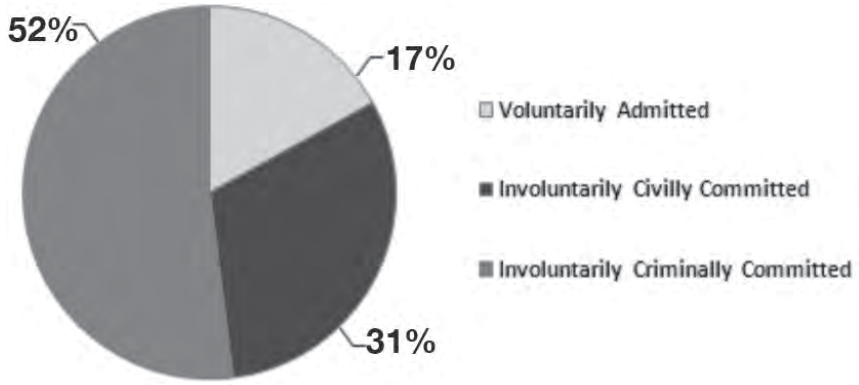
State Psychiatric Hospitals:

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 five SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Louisiana is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There is an arrangement in place to refer or pay for the mental health needs of Louisiana's returning veterans or their families who do not have access to military reimbursed or provided services.

Maine 2009

Department of Health & Human Services Office of Adult Mental Health Services Marquadt Building, 2nd Floor Augusta, ME 04330 www.maine.gov/dhhs/mh/	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 healthcare 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 eight district 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 ages 18 and older. The OAMHS 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, ages birth to 5, who have developmental disabilities or demonstrate developmental delays, and children and adolescents, ages birth to 20, who have treatment needs related to mental illness, mental retardation, autism, developmental disabilities, or emotional and behavioral needs.

Statistics:

State Population (2007): 1,317,207

Number of Persons Served (2008): 51,068

Utilization Rate for Adults: 32.2 per 1,000

Utilization Rate for Children: 63.2 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$451.3 million
Revenue From Medicaid	$394.9 million
Expenditures for Community Mental Health Services (84% of Total Mental Health Agency Revenues)	$380.1 million
Per Capita State Mental Health Expenditures	$343.99

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 Services	Part of the SMHA
Brain Impaired Services	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	Shared with another agency
Sex Offender Services	Shared with another agency

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Different state department (see the definition of a SMHA)
Housing Agency	Same umbrella department as the SMHA
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	1	130	131
Private Psychiatric Hospitals	NA	2	2
General Hospitals With Separate Psychiatric Units	0	7	7
Nursing Homes and Other ICF-MI and SNF Providers	1	3	4

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly funds local community-based agencies.

The SMHA is undertaking initiatives to restructure Maine's community-based system of mental health service delivery. The SMHA continues to be under the Augusta Mental Health Institute (AMHI) consent decree and court-approved settlement agreement for restructuring the Adult Community Mental Health System to improve continuity of care.

Interagency Collaboration:

The SMHA is working with other Maine government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Examples: Collocation of DHHS Children's Behavioral Health Services staff at corrections offices; Thrive System of Care (SOC) initiative located parent partners in Child Welfare and Corrections Region 3 District Office.

Maine has initiatives to transform the way it delivers mental health services. For example, integration of the Office of Child and Family Services' three divisions (i.e., Children's Behavioral Health Services, Child Welfare Services, and Early Child Services) has been a success, resulting in better, faster communication because the offices are collocated.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	NR	Yes
Employment	Yes	Yes	NR	Yes
Juvenile Justice	Yes	No	NR	Yes
Criminal Justice	Yes	Yes	NR	NR
Education	Yes	Yes	NR	NR
Child Welfare	Yes	Yes	NR	NR
Medicaid	Yes	No	Yes	NR
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	Yes	Yes	Yes

NR = not reported.

The SMHA collaborates with the Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. For children, there are telemedicine activities; the medical director works with primary care physicians. For adults, there are the Women's Behavioral Health Initiative; contract with the Maine Association of Psychiatric Physicians to provide psychiatric consultation to primary care practices; and Medicaid contract with Schaller Anderson to provide care management and coordination services.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. Adult Behavioral Health is working with primary care medical doctors after identifying increased morbidity in the serious emotional disturbances (SED) population; the medical director is currently working with the Maine DHHS Division of Health on focused studies of health status and needs of persons with mental illness. Also, there is a legislative study by the Maine Health Access Foundation (MeHAF) to examine primary care integration with behavioral health. This foundation supports solutions to Maine's healthcare needs by providing grants, including one in support of projects to identify policy and programmatic issues related to integration.

The SMHA has the following initiatives promoting the understanding that mental health is essential to overall health: The SMHA works with the Office of Quality Improvement Services and publicizes the health risks experienced by people with mental illness. In addition, the MeHAF integration grant involves two counties with a focus on integrating physical health screening assessments in mental healthcare agencies.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	16
Supported Employment	Statewide	30
Family Psychoeducation	Parts of the state	1
Integrated Mental Health/Substance Abuse Services	Parts of the state	36
Illness Self-Management	Parts of the state	NR
Supported Housing	Parts of the state and a pilot program	NR
Consumer-Operated Services	Parts of the state	NR
Multisystemic Therapy (Conduct Disorder)	Parts of the state	8
Therapeutic Foster Care	Statewide	10
Functional Family Therapy	Parts of the state	3

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Trauma-Informed Services	Parts of the state	1
Children's ACT Approach	Parts of the state	5
Collaborative Problem Solving (Ross Green)	Parts of the state	2

Staffing and Workforce Development Initiatives:

Maine reimburses adult consumer peer specialists through Medicaid for providing mental health services. Peers facilitate Wellness Recovery Action Plan (WRAP) groups and recovery workbook groups; the Certified Intentional Peer Specialist Program trains and certifies peers for positions in state hospitals, in the statewide Maine Warm Line, in the Peer Support in Education Program, and on some ACT teams—not all of these are Maine Care reimbursable.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care.

Custody Relinquishment:

Maine 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. Mental health services are available to all Maine children who meet medical necessity regardless of custody status.

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 SMHA departmental offices, to enable mental health services to be more readily available to areas that lack those services.

Electronic Health Records (EHRs):

The SMHA is installing and operating an EHR in state hospitals and community mental health programs. Maine does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. For further information, visit: http://ccbh.ehealthinitiative.org/communities/states.aspx?Location=Maine&Record=283

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for only some providers: Some data requirements specify that providers meeting criteria submit data; however, these requirements do not cover all clients.

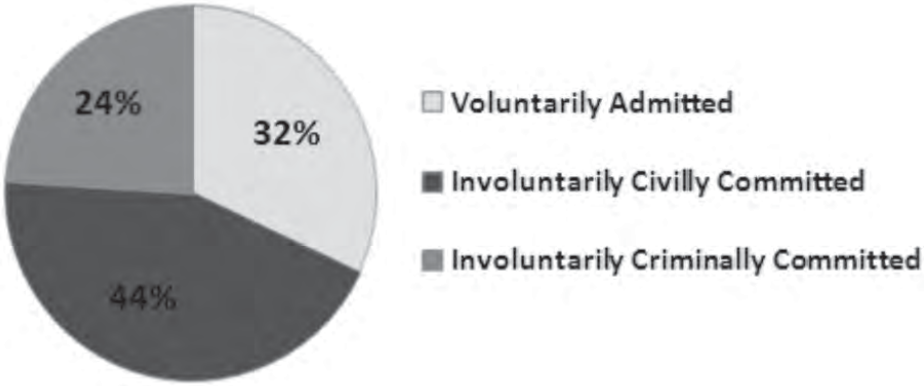
State Psychiatric Hospitals:

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 hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There have been declines in Maine psychiatric hospital beds in the last 5 years; however, the state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families.

Maine has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is no arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Maryland 2009

Department of Health & Mental Hygiene Mental Hygiene Administration 55 Wade Avenue Catonsville, MD 21228 www.dhmh.state.md.us/mha/	The Mental Hygiene Administration (MHA), the division of the State of Maryland Department of Health and Mental Hygiene (DHMH), 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 Research Demonstration (1115) waiver. Specialty mental healthcare 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 which, in collaboration with MHA, develop and manage a coordinated network of Maryland public mental health services. An Administrative Service Organization (ASO) assists MHA and the CSAs in the management of the system.

Statistics:

State Population (2007): 5,618,344

Number of Persons Served (2008): 97,761

Utilization Rate for Adults: 12.9 per 1,000

Utilization Rate for Children: 31.5 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$858.3 million
Revenue From Medicaid	$263.9 million
Expenditures for Community Mental Health Services (68% of Total Mental Health Agency Revenues)	$580.2 million
Per Capita State Mental Health Expenditures	$153.55

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 Services	Part of the SMHA
Brain Impaired Services	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	Shared with another agency
Sex Offender Services	No responsibility

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
Housing Agency	Different state department
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	9	0	9
Community Mental Health Providers	0	375	375
Private Psychiatric Hospitals	NA	3	3

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services: The SMHA directly funds, but does not operate, local community-based agencies. CSAs are the entities at the local level that have the authority and responsibility to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. The SMHA funds CSAs.

The SMHA is not undertaking initiatives to restructure Maryland's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other Maryland government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The state has initiatives to transform the way it delivers mental health services. In the Residential Treatment Center (RTC) waiver demonstration, the SMHA will reimburse family-to-family and youth-to-youth peer support.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	Yes	NR	Yes	Yes
Education	Yes	No	Yes	Yes
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	NR	Yes
National Guard	Yes	NR	NR	Yes

NR = not reported.

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. Collaborative efforts include coordination of the Core Committee (under the Medicaid 1115 waiver) monthly meeting of the managed care organization (MCO), medical directors of Maryland's ASO, and the SMHA.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The SMHA conducts regular meetings with county health officers, medical directors, and special needs coordinators of MCOs; funds psychogeriatric specialists in some local mental health authorities to work with nursing homes and community programs; and participates in Mental Health Coalition on Aging advocacy efforts.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: Mental Health First Aid is being implemented in Maryland. Coordination with ASO/MCO/ mental health providers receives downloads of MHA Pharmacy data to promote integration of care. Other initiatives are Maryland's Commitment to Veteran's Initiative and its statewide Anti-Stigma Project. The SMHA has activities to promote coordination of care with somatic and mental health.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	8
Supported Employment	Statewide	44
Medication Algorithms (Schizophrenia)	Parts of the state	NR
Medication Algorithms (Bipolar Disorders)	Parts of the state	NR
Family Psychoeducation	Parts of the state	4
Integrated Mental Health/Substance Abuse Services	Pilot program	3
Illness Self-Management	Parts of the state	NR
Supported Housing	Statewide	83
Consumer-Operated Services	Statewide	NR
Multisystemic Therapy (Conduct Disorder)	Pilot program	3
Therapeutic Foster Care	Parts of the state	6
Functional Family Therapy	Parts of the state	5

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Child Psychiatric Rehabilitation	Available statewide	NR
Seclusion and Restraint	Available in parts of the state	5
Respite	Available in parts of the state	6
Adult Partial Capitation	Available in parts of the state	2
PATCH Project in Senior Housing	Available in parts of the state	1

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, advanced practice nurses, nurse practitioners and clinical specialists (master's level and above), registered nurses, physical therapists, and occupational therapists in state psychiatric hospitals. The SMHA offers recruitment bonuses or other financial incentives to address staffing shortages.

The SMHA has initiatives to improve the quality of the mental health workforce, including providing retention incentives as well as hiring bonuses for nursing staff.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Its relationship with these professional schools includes providing staff training.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1115 waiver. Approximately 99,812 persons received behavioral health services under the managed care plan in 2008.

Custody Relinquishment:

Maryland 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: an Executive order from the prior administration's Voluntary Placement Policies.

Telemedicine:

The SMHA promotes the use of telemedicine. The SMHA worked in partnership with the CSA to apply for Health Resources and Services Administration (HRSA) funds to develop telemental health in rural areas, and the grant was awarded.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is installing an EHR in state hospitals. The SMHA has selected a vendor to implement an EHR in state hospitals; however, budget constraints have delayed the implementation process. The SMHA is currently operating an EHR in one of nine Maryland hospitals. Maryland does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

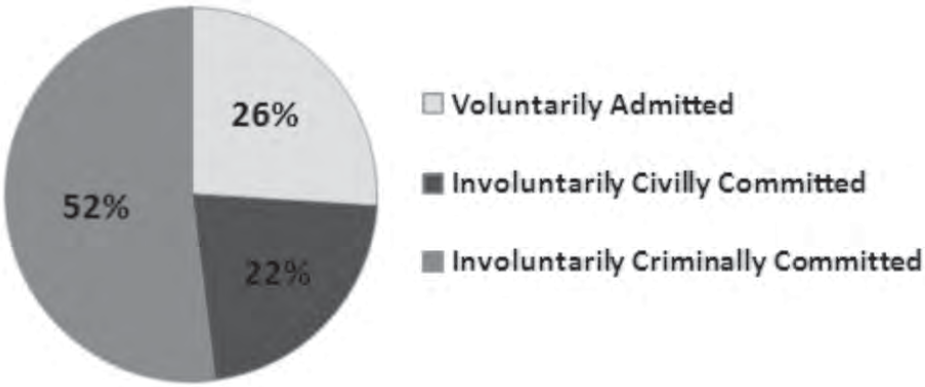
State Psychiatric Hospitals:

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 nine SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Maryland is experiencing a shortage of psychiatric beds. There have been declines in state psychiatric hospital beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, the Reserve, and family members of military personnel: Maryland's Commitment to Veterans provides gap behavioral health services to Operation Iraqi Freedom and Operation Enduring Freedom veterans. In addition to behavioral health services, crisis services are provided, and regional resource coordinators link veterans to service through the Maryland Veterans Administration. The Maryland National Guard Family Readiness Program provided training to families in recognizing signs of Post-Traumatic Stress Disorder (PTSD) in returning veterans. The state also has focused on timely access to services for behavioral health needs through the U.S. Department of Veterans Affairs (USVA) or the state public mental health system and has assisted with housing, employment, benefits, and Memorandums of Understanding (MOUs) between DHMH and USVA.

Maryland has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Massachusetts 2009

Department of Mental Health Office of Health & Human Services 25 Staniford Street Boston, MA 02114 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 (2007): 6,449,755
Number of Persons Served (2008): 27,617
Utilization Rate for Adults: 4.9 per 1,000
Utilization Rate for Children: 2.1 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$896.4 million
Revenue From Medicaid	$128.7 million
Expenditures for Community Mental Health Services (80% of Total Mental Health Agency Revenues)	$604.8 million
Per Capita State Mental Health Expenditures	$116.68

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 Services	Part of the SMHA
Brain Impaired Services	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	Shared with another agency

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
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	5	0	5
Community Mental Health Providers	6	157	163
General Hospitals With Separate Psychiatric Units	0	1	1

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives to restructure Massachusetts's community-based system of mental health service delivery. Community Based Flexible Supports (CBFS) is a new service contracted for and operated by the Massachusetts SMHA. The CBFS provider will be responsible for providing treatment, rehabilitation, support, and supervision to a defined set of DMH clients in a particular area. CBFS services are designed to increase a client's capacity for independent living and recovery from mental illness. CBFS providers will individualize the delivery of services in partnership with each client. A provider will be required to adjust the mix and intensity of CBFS services provided to individual clients to meet their changing needs and goals as they move toward recovery and, when applicable, coordinates the services a client receives from multiple community providers. The focus of CBFS service delivery is on rehabilitative interventions that facilitate recovery and achieve the following outcomes for the clients being served: (1) Safe, stable housing; (2) full participation in the community; (3) self-management; (4) self-determination and empowerment; (5) wellness and improved physical health; and (6) independent employment.

Interagency Collaboration:

The SMHA is working with other Massachusetts government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. A focus of the current state administration is interagency collaboration and coordination. DMH participates in numerous interagency initiatives. Additionally, Massachusetts has created a Children's Behavioral Health Initiative specifically charged with reducing fragmentation and coordinating funding and service delivery.

Massachusetts has initiatives to transform the way it delivers mental health services. For example, effective July 2009, DMH will contract with providers to deliver CFBS services that are consumer and family driven.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	Yes
Employment	Yes	No	Yes	Yes
Juvenile Justice	Yes	Yes	No	Yes
Criminal Justice	Yes	Yes	No	Yes
Education	Yes	No	Yes	Yes
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	No	Yes	Yes
Substance Abuse	Yes	No	No	NR
National Guard	Yes	No	No	Yes

NR = not reported.

The SMHA collaborates with the Massachusetts's health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The SMHA, along with the Medicaid agency, is developing specifications in the Managed Care Entities contracts to ensure integration of primary care and mental healthcare. The SMHA also is participating in the Community First Initiative along with other Executive Office of Health and Human Services (EOHHS) agencies.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The Healthy Changes Initiative for staff and consumers is being implemented across DMH to address the modifiable risk factors (smoking, obesity, and a sedentary lifestyle) for premature death and chronic illness. Efforts to inform health providers include information on the DMH Web site, work with the state legislature, and other state health agencies in the EOHHS. Local DMH geographic areas are working with the providers in their area to implement the initiative.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health:

- DMH, the EOHHS, and the trade organizations representing community health centers (CHCs) and community mental health centers (CMHCs) collaborated in developing six regionally based pilot projects to develop and test strategies and systems to strengthen mental health, substance abuse, and primary care coordination.
- DMH is engaging in a project, the Healthy Changes Initiative, designed to address the modifiable risk factors for premature death and disability through screening, assessing, and providing evidence-based treatment for nicotine addiction, obesity, and inactivity throughout the system of care.
- The Massachusetts Child Psychiatry Access Project (MCPAP), administered by the Massachusetts Behavioral Health Partnership (MBHP), with DMH funding, makes psychiatric consultation available to pediatric practices to improve primary care as it relates to mental health, to address concerns about psychiatric medication, and to assess the need for, and assist with referrals to, specialized mental health treatment.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	15
Supported Employment	Parts of the state	24
Family Psychoeducation	Parts of the state	NR
Integrated Mental Health/Substance Abuse Services	Parts of the state	NR
Illness Self-Management	Parts of the state	NR
Supported Housing	Statewide	63
Consumer-Operated Services	Parts of the state	26
Therapeutic Foster Care	Statewide	6

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Motivational Interviewing	Available in parts of the state	NR
Restraint Reduction (Children)	Available in parts of the state	9
Trauma-Informed Care	NR	9
Motivational Interviewing	Available in parts of the state	NR
Psychosocial Rehabilitation	Available in parts of the state	NR
Restraint Reduction (Adults)	Available in parts of the state	10

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists and registered nurses in state psychiatric hospitals and community mental health programs.

The SMHA has the following initiatives to address staffing shortages: special university-based training initiatives; training at mental health programs/providers; increased salaries; and recruitment bonuses or other financial incentives.

The SMHA has initiatives to improve the quality of the mental health workforce. DMH has two specific initiatives aimed at enhancing the quality of the mental health workforce. First, in responding to projected workforce shortages nationally, DMH initiated a Nurse Recruitment and Retention plan. DMH identified current needs and projected needs 5 and 10 years into the future. A plan was developed and implemented to enhance the quality of job performance among nurses, to assure the quantity needed, to ensure diversity among nursing ranks, and to develop nurse professional support resources. The second initiative is the development of a Career Ladder and succession planning. The goal of this effort is to create a dynamic and diverse organization within DMH that fosters knowledge transfer through communication and integration, professional growth, and career development across disciplines.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online and DVD trainings.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, nursing, and schools of pharmacy. Its relationships with professional schools include: the Massachusetts DMH has placed students from over 27 private and public colleges and universities in internships and training programs throughout the agency. DMH has an arrangement with Boston University to use some of its curriculum in general orientation and training programs (e.g., restraint reduction).

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. Services are carved in and are provided by the primary healthcare provider networks and HMO. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 173,935 persons received behavioral health services under the managed care plan in 2008, and 901,311 persons were covered under the plan.

Custody Relinquishment:

Massachusetts 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. The SMHA is not a custodial agency, nor is juvenile justice. Child welfare regulations were amended in 2001 to create a provision so that parents seeking mental health services for their child would not have to relinquish custody if there had been no substantiated abuse or neglect.

Telemedicine:

The SMHA does not promote the use of telemedicine.

Electronic Health Records (EHRs):

The SMHA is operating an EHR in state hospitals and in state-operated CMHCs and case management sites. Massachusetts uses a single EHR system for all state-operated community mental health providers and state-operated case management sites. Local state-funded providers use a variety of EHR systems.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA does not receive information directly from state funded community providers. Client information on services received from state-funded community providers is directly entered into the client-level database at the state-operated case management sites.

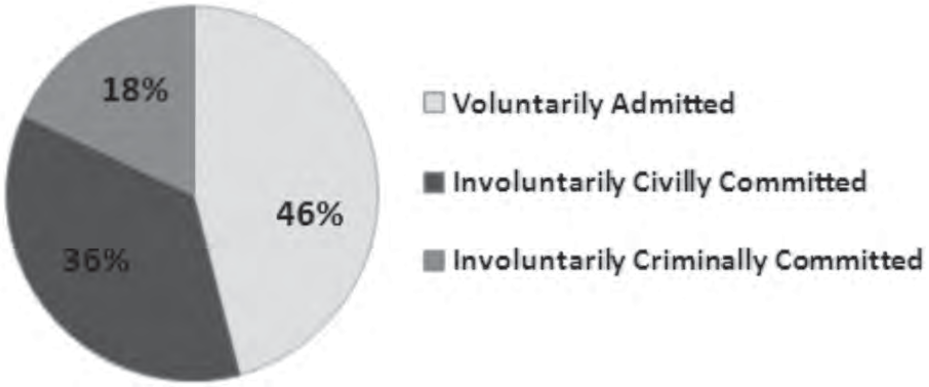
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	Yes	No	No
Adolescents	Yes	Yes	No
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Massachusetts is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, the Statewide Head Injury Program (SHIP)/Massachusetts Rehabilitation Commission (MRC) program received a federal grant to strengthen services for veterans with head injuries.

Massachusetts has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services because Massachusetts has mandatory requirements for insurance coverage. The Massachusetts DMH also provides training to the state VA regarding accessing and maximizing benefits.

Michigan 2009

Mental Health & Substance Abuse Administration Department of Community Health 320 South Walnut Street Lansing, MI 48913 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 (2007): 10,071,822
Number of Persons Served (2008): 213,257
Utilization Rate for Adults: 22 per 1,000
Utilization Rate for Children: 18.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$1 billion
Revenue From Medicaid	$633.8 million
Expenditures for Community Mental Health Services (80% of Total Mental Health Agency Revenues)	$849.5 million
Per Capita State Mental Health Expenditures	$106.03

New Financing Initiatives:

Michigan did not implement any changes in how the delivery of mental health services is financed, and there were no new financing initiatives.

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
Housing Agency	Different state department
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	5	0	5
Community Mental Health Providers	0	46	46

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly funds local community-based agencies.

Interagency Collaboration:

The SMHA is working with other Michigan government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The SMHA administers the mental health/substance abuse Medicaid benefit and establishes Medicaid policies. Michigan initiated a Michigan Prisoner Recovery Initiative (MPRI) in coordination with multiple state agencies. Michigan State Housing Development Authority has a 10-year plan and activities to end homelessness.

Michigan has initiatives to transform the way it delivers mental health services. These initiatives include: recovery; self-determination; psychiatric advanced directives; a trauma initiative; implementation of evidenced-based practices (EBPs); wraparound; and peer support specialists. The SMHA also is providing substance abuse services within mental health services through the Comprehensive, Continuous, Integrated System of Care (CCISC) model and is providing a family-driven system of care for children.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	No	Yes	Yes
Criminal Justice	Yes	No	Yes	Yes
Education	Yes	No	Yes	Yes
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	No	No	No	No

The SMHA is coordinating care between specialty mental health and primary care.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The SMHA is currently working with 11 CMHSPs to develop collocated, integrated, and coordinated care for individuals with physical health problems. The SMHA is also working closely with federally qualified health centers (FQHCs), Medicaid health plans, primary care physicians (PCPs), and CMHSPs.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health. Michigan has over 500 Certified Peer Support Specialists (CPSS). CPSS are providing classes for Personal Action Toward Health (PATH), an EBP chronic disease management program, with two additional sessions based in recovery for persons with mental illness. The additional sessions were developed by MDCH in partnership with the Appalachian Group of Georgia. This self-management approach was developed to address the NRI report for morbidity and mortality that persons with mental illness are dying 25 years earlier than the general population. By the fall of 2009, 50 CPSS will be trained by master trainers for PATH to become leaders with the ability to train other consumers/peers to conduct health and wellness classes.

Additionally, Michigan received a Transformation Transfer Initiative (TTI) grant concentrating on integrated healthcare for persons with serious mental illness. Funding was provided to four community mental health agencies to employ CPSS in conducting and leading classes in health and wellness. CPSS leading the initiatives will provide additional training and support for the large peer-trained workforce to implement PATH classes in their regions across Michigan.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	88
Supported Employment	Parts of the state	NR
Medication Algorithms (Schizophrenia)	Pilot program	NR
Medication Algorithms (Bipolar Disorders)	Pilot program	NR
Family Psychoeducation	Statewide	70
Integrated Mental Health/Substance Abuse Services	Statewide	78
Supported Housing	Parts of the state	NR
Consumer-Operated Services	Statewide	50
Multisystemic Therapy (Conduct Disorder)	Parts of the state	7
Therapeutic Foster Care	Pilot program	NR
Functional Family Therapy	NR	1

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Wraparound (Children)	Statewide	NR
Baby Court	Parts of the state	3
Parent to Parent Support Model	Parts of the state	NR
Dialectical Behavioral Therapy	Statewide	30
Motivational Interviewing	Statewide	NR
Wraparound (Older Adults)	Parts of the state	NR
Cognitive Behavioral Therapy for Older Adults	Parts of the state	NR

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), and registered nurses in Michigan psychiatric hospitals and community mental health programs. The SMHA has the following initiatives to address staffing shortages: recruitment bonuses or other financial incentives, job fairs, and recruitment efforts.

The SMHA has initiatives to improve the quality of the mental health workforce. Several trainings are provided to improve the practices of the workforce, including training on EBPs, recovery, and the Mental Health and Aging Conference. Effective October 1, 2008, Michigan campuses became nonsmoking.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Its relationships with professional schools include students doing rotations.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 130,000 persons received behavioral health services under the managed care plan in 2008.

Custody Relinquishment:

Michigan 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. It is a covered Medicaid benefit.

Electronic Health Records (EHRs):

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.

MDCH has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. Michigan has over 10 RHIOs that each encompass specific regions of the state.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community 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 five SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:

Note 1: Voluntary admissions are all children, and "criminally committed".
Note 2: Percentage may not total 100 because of rounding.

Psychiatric Inpatient Bed Shortages:

Michigan is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have not been specific initiatives to address the need for mental health services for returning veterans and their families.

Michigan has not appropriated funds specifically to address the mental health service needs of returning veterans and their families; however, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Minnesota 2009

Adult Mental Health Division Department of Human Services P.O. Box 64981 St. Paul, MN 55164 0981 www.dhs.state.mn.us/	Minnesota is a state supervised, county administered public mental health system. Within this system, three agencies/organizations are responsible for funding and assuring quality mental health services: (1) the state mental health authority, 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 (C&MHSA). The C&MHSA 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 (2007): 5,197,621
Number of Persons Served (2008): 163,059
Utilization Rate for Adults: 30 per 1,000
Utilization Rate for Children: 35.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$773.2 million
Revenue From Medicaid	$339.2 million
Expenditures for Community Mental Health Services (72% of Total Mental Health Agency Revenues)	$557.7 million
Per Capita State Mental Health Expenditures	$149.30

New Financing Initiatives:

Minnesota is planning or implementing a change in how the delivery of mental health services is financed—its county health plan for collaborative managed care including physical and behavioral care integration.

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 Services	Part of the SMHA
Brain Impaired Services	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	Part of the SMHA

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
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
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	600	600
General Hospitals With Separate Psychiatric Units	0	16	16
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county or city mental health authorities statewide.

Interagency Collaboration:

The SMHA is working with other Minnesota government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services:

- **Housing** – Pooled SMHA housing funds with Minnesota Housing for capital development;
- **Employment** – A demonstration project to maintain independence that provides employment for adults with serious mental illnesses (SMI); and
- **Substance Abuse** – Grant efforts with federal systems improvement initiatives regarding co-occurring mental illness/substance abuse disorders and treatment.

Minnesota has initiatives including integration of physical mental healthcare with social services under a capitated model to transform the way it delivers mental health services.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	Yes
Employment	Yes	No	Yes	Yes
Juvenile Justice	Yes	No	No	No
Criminal Justice	Yes	No	No	Yes
Education	Yes	No	No	Yes
Child Welfare	Yes	No	No	Yes
Medicaid	Yes	Yes	No	Yes
Substance Abuse	Yes	No	Yes	Yes
National Guard	Yes	No	No	No

The SMHA collaborates with the state health department to increase the recognition and treatment of persons with mental illness by primary care providers. Collaborative efforts include: the federal Health Care Home Initiative; the DIAMOND Initiative for early identification of depression; and a consultative model for intervention, the “Shared Care” model.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. For fee-for-service (FFS) and managed care enrollees, care managers will be expected to assume annual physical and dental exams and recommend two batteries of lab tests.

The SMHA has the following initiative to promote the understanding that mental health is essential to overall health: implementation of the Preferred Integrated Network, a capitated delivery model that integrates physical and mental healthcare and services with county-delivered social services.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	27
Supported Employment	Parts of the state	31
Integrated Mental Health/Substance Abuse Services	Parts of the state	23
Illness Self-Management	Statewide	60
Supported Housing	Statewide	24
Consumer-Operated Services	Parts of the state	NR
Multisystemic Therapy (Conduct Disorder)	Parts of the state	21
Therapeutic Foster Care	Parts of the state	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
Minnesota Model	Parts of the state
Dialectical Behavior Therapy	Parts of the state

Staffing and Workforce Development Initiatives:

Minnesota reimburses adult consumer peer specialists through Medicaid for providing mental health services. Modeled after Arizona's program, peer specialists are to be trained and certified by the state, and services are to be provided in Medicaid Rehabilitation Option settings.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. Services are carved in and are provided by the primary healthcare provider networks or HMO. Approximately 79,000 persons received behavioral health services under the managed care plan in 2008, and 500,000 persons were covered under the plan.

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. The Minnesota law passed in 2003 prohibits counties from transferring legal custody or terminating parental rights.

Telemedicine:

The SMHA promotes the use of telemedicine.

Electronic Health Records (EHRs):

Minnesota does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

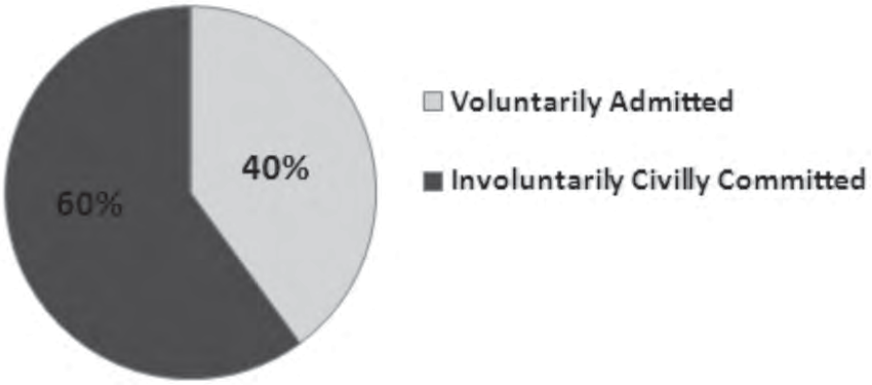
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Adolescents	No	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	No	Yes	Yes
Forensic	No	No	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There have been declines in general hospital specialty unit psychiatric and state psychiatric hospital beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed National Guard members, the Reserve, and family members of military personnel.

Minnesota has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is no arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Mississippi 2009

Department of Mental Health Robert E. Lee Building, Suite 1101 239 North Lamar Street Jackson, MS 39201 www.dmh.state.ms.us/	The Mississippi Department of Mental Health (DMH) 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 (2007):	2,918,785
Number of Persons Served (2008):	96,334
Utilization Rate for Adults:	30.2 per 1,000
Utilization Rate for Children:	40.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$351.9 million
Revenue From Medicaid	$169.7 million
Expenditures for Community Mental Health Services (45% of Total Mental Health Agency Revenues)	$157.1 million
Per Capita State Mental Health Expenditures	$121.12

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
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	4	0	4
Community Mental Health Providers	0	43	43
Nursing Homes and Other ICF-MI and SNF Providers	2	0	2

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county or city mental health authorities statewide.

Interagency Collaboration:

The SMHA is working with other Mississippi government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The state-level Interagency Coordinating Council for Children and Youth (ICCCY) includes representatives from education, health, human services (welfare and juvenile justice), mental health, rehabilitation services, Medicaid, and the state family organization. The ICCCY has focused efforts on reducing fragmentation and coordinating resources and service delivery, primarily through local Making A Plan (MAP) teams. An interagency agreement reinforces the structure and work of the ICCCY. The adult Division of Community Services has begun development of pilot programs in three community mental health center (CMHC) regions for adults based on the youth MAP team model. The state-level Interagency Case Review/MAP team includes similar interagency representation and reviews cases of youth at risk for out-of-home services or with complex, intensive needs for which funding or resources do not appear accessible at the local level. The state-level team facilitates a wraparound process to coordinate services and supports across agencies whenever possible. The Division of Youth Services (DYS) works collaboratively with the juvenile justice agency to support implementation of A Teams, which are specialized teams for youth in the justice system (modeled after MAP teams) and of Adolescent Offender Programs, which are in place statewide. The Co-Occurring Disorders Coordinating Committee, including mental health and substance abuse representatives from the state and local levels, was formed to move forward the implementation of a Strategic Plan for addressing the needs of individuals with co-occurring disorders, the development of which was facilitated by the Co-Occurring Disorders Center for Excellence (SAMHSA funded). Since 2008, statewide training has been underway to support implementation of a statewide Global Appraisal of Individual Needs (GAIN)–Short Screener and implementation of an evidence-based integrated treatment approach.

Though less well-developed at this time, initiatives to increase collaboration with law enforcement and criminal justice and to establish partnerships to facilitate the development of housing are underway. The DMH Division of Community Services participated in the Bureau of Community Services, Division of Community Services, workgroup established by one county and involving local law enforcement, chancery court, community hospital, community mental health, and governmental officials to plan development of Crisis Intervention Training (CIT); related legislation was introduced in the 2009 session but was not approved. DMH developed a proposal for federal Transformation Transfer Initiative funding to support CIT program development in 2008; however, the proposal was not funded. The Bureau of Community Services is continuing efforts to increase collaboration with law enforcement and criminal justice to more effectively intervene in crisis situations involving individuals with mental illness; this area is addressed in the new SMHA strategic plan. The Bureau of Community Services has been participating in the National Association of State Mental Health Program Directors (NASMHPD) housing task force, and as part of the SMHA's new Strategic Plan implementation, the Division of Planning in the Bureau was recently appointed to establish a working committee to focus on addressing the need for housing. Efforts will continue to network with potential partners at the state and local levels and to seek specialized technical assistance to develop a more detailed Strategic Plan for housing. The Division of Community Services continues to have a staff person assigned to work with the Project for Assistance in Transition from Homelessness (PATH) projects, who participates in established interagency community groups concerned with addressing the needs of persons who are homeless.

Mississippi has initiatives to transform the way it delivers mental health services. The SMHA received legislative approval in 2009 to pilot the shifting of operation of one state crisis center previously operated by a state psychiatric hospital to operation by a regional community mental health center; part of implementation of the program will be the piloting of a Program of Assertive Community Treatment (PACT). Related efforts to improve crisis intervention are Mississippi's efforts to work with law enforcement, court officials, and community mental health and health providers to develop jail diversion programs; the Division of Community Services participated in a group organized in one county in 2009 to address this issue, and the Bureau of Community Services plans to continue to work to develop jail diversion programs, such as CIT. The initiative to disseminate evidence-based treatment for individuals with co-occurring disorders of mental illness and substance abuse involves implementation of a standard screening instrument (in 2009) and training in the evidence-based practice (EBP); this initiative is guided by the Co-Occurring Disorders Coordinating Committee, which includes state and local representatives from both mental health and substance abuse service areas.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	No	Yes
Employment	Yes	NR	NR	NR
Juvenile Justice	Yes	NR	NR	Yes
Criminal Justice	Yes	NR	NR	Yes
Education	Yes	NR	NR	Yes
Child Welfare	Yes	NR	NR	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	NR	Yes	Yes
National Guard	No	No	No	No

NR = not reported.

The SMHA collaborates with the Mississippi chapter of the American Academy of Pediatrics to increase the recognition and treatment of persons with mental illness by primary care providers. The Pediatric Mental Health Task Force has developed a Web site link, listing mental health resources in the Greater Jackson metropolitan area, and is continuing work to include statewide resources available via the Web site.

The SMHA works with public providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The DMH Division of Children and Youth Services (CYS) continues to provide funding to two community mental health regions for the provision of therapeutic nursing services; these nurses are available to provide assistance with health objectives on treatment plans. In partnership with the Mississippi Department of Education, Office of Safe and Healthy Schools, CYS also continues to provide training for school nurses on topics such as mental health screening and assessment.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: statewide Anti-Stigma Campaign and Youth Suicide Prevention Programs. The Mississippi Youth Suicide Prevention Advisory Council was established initially as part of the structure and governance of a SAMHSA-funded grant received in 2006 to strengthen Mississippi's response to the mental health needs of youth, ages 10 to 24, in six Gulf Coast Counties most adversely affected by Hurricane Katrina. Subsequently, the advisory council supported and approved a statewide plan for addressing suicide prevention for the targeted population of 10 to 24 year olds. In addition to addressing stigma, the plan addresses the training of community gatekeepers, promotes effective clinical and professional practice and suicide prevention programs in Mississippi, and sets forth evaluation strategies for prevention methodologies.

DMH developed the public awareness campaign, "Shatter in Silence." The campaign's goal is to educate the public on suicide prevention. The campaign targets young adults in Mississippi and encourages youth to speak out if they or someone they know is thinking, writing, or talking about suicide. The campaign has consisted of radio advertisements; billboards; brochures; posters; presentations; advertisements in college newspapers; and television, radio, and newspaper coverage. DMH's Hurricane Katrina Youth Suicide Prevention Project was funded in 2006 for 3 years to target those youth along the Gulf Coast who may experience symptoms of depression as a result of their displacement and/or loss of loved ones during the storm. As a result of the grant, the Mississippi Youth Suicide Prevention Advisory Council was formed, and trainings in EBPs have been conducted across the state. The prevention kits and training include the following evidence-based programs: Yellow Ribbon, Signs of Suicide (SOS), and the Applied Suicide Intervention Skills Training (ASSIST); these programs were implemented in schools, community colleges, and universities.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Family Psychoeducation	Parts of the state	1
Integrated Mental Health/ Substance Abuse Services	Statewide and parts of the state (Screening only available at this time)	NA
Self-Management (Peer to Peer; Mississippi Leadership Academy)	Statewide	2
Therapeutic Foster Care	Parts of the state	1

NA = not available.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), registered nurses, physical therapists, and occupational therapists in state psychiatric hospitals and community mental health programs. The SMHA offers recruitment bonuses or other financial incentives to address staffing shortages. Other initiatives to reduce staff shortages include: Educational Leave Program for Critical Shortage Classes: psychology, nursing, occupational therapy and physical therapy, and dietetics.

The SMHA has initiatives to improve the quality of the mental health workforce including its Educational Leave Program; Credentialing Program, Basic Supervisory Program, Certified Public Manager Program, Accelerated Leadership Development Program, and Knowledge Transfer Program; and Mandt Training and Inservice Training.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Mississippi 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 state-level Interagency Case Review/MAP team and the local MAP teams, as well as the ICCCY, promote strategies and policies for prevention of out-of-home placement for difficult-to-serve youth whenever possible. The A teams and Adolescent Offender Programs, implemented by the Department of Human Services in collaboration with the DMH CYS, also facilitate the provision of community-based mental health support services.

Telemedicine:

The SMHA promotes the use of telemedicine. The SMHA is supportive of the current initiative of the University of Mississippi Medical Center, providing telepsychiatry services in two community mental health regions (Regions 1 and 6), with grant support from the Delta Health Alliance.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in state hospitals. The SMHA is installing an EHR 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA does not receive information for all community providers but for only some providers: Once the SMHA completes work on the CDR, all providers will be able to submit client-level data.

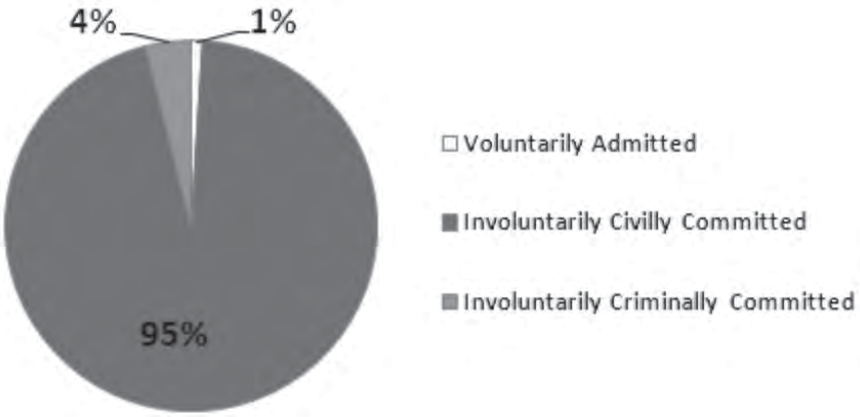
State Psychiatric Hospitals:

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 hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	Yes	Yes	No
Adolescents	Yes	Yes	No
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There have been declines in state psychiatric hospitals beds since 2008; however, Mississippi is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. The DMH Office of Constituency Services (OCS) has contracted with the National Suicide Prevention Lifeline (NSPL) as a network provider to cover all 82 counties in Mississippi. The federally funded NSPL routes callers from Mississippi to OCS for crisis intervention, suicide prevention, and resource referrals. This affiliation allows OCS access to real-time call traces on all crisis calls and tele-interpreter services for all non-English-speaking callers. OCS has also contracted with NSPL to give population-specific referrals to individuals who identify themselves as veterans. In addition, the DMH Division of Community Services has submitted a federal grant proposal for jail diversion with a focus on returning veterans; however, no grant award has been received to date.

Mississippi has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is no arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Missouri 2009

Department of Mental Health 1706 East Elm Street Jefferson City, MO 65102 www.dmh.missouri.gov/	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 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 composed of 11 CPS inpatient facilities. For the provision of community-based services, Missouri s 114 counties and the City of St. Louis are subdivided into 25 mental health service areas, each with an administrative agent (AA). AAs are community mental health centers (CMHCs) 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 (2007):	5,878,415
Number of Persons Served (2008):	75,458
Utilization Rate for Adults:	13.2 per 1,000
Utilization Rate for Children:	11.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$611.9 million
Revenue From Medicaid	$260.7 million
Expenditures for Community Mental Health Services (48% of Total Mental Health Agency Revenues)	$214.7 million
Per Capita State Mental Health Expenditures	$77.13

New Financing Initiatives:

Missouri is planning or implementing a change in how the delivery of mental health services is financed. The state is moving toward the provision of acute psychiatric hospitalization by community hospitals and not state-funded hospitals.

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Same umbrella department as the SMHA
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
State Psychiatric Hospitals	9	0	9
Community Mental Health Providers	0	30	30

Primary Mechanism Used To Deliver Community Mental Health Services:

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

Interagency Collaboration:

The SMHA is working with other Missouri government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services.

Missouri has initiatives to transform the way it delivers mental health services. One such initiative is the Mental Health Transformation plan; more information on this plan is available at: www.dmh.mo.gov/transformation/TransformationReports.htm.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	Yes	Yes	Yes
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	Yes	No	Yes

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers through the DMH Net, a disease management initiative.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses through the DMH Net Initiative and the federally qualified health center (FQHC)/CMHC initiative.

The SMHA has the following initiative to promote the understanding that mental health is essential to overall health: Mental Health First Aid.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	6
Supported Employment	Parts of the state	NR
Medication Algorithms (Schizophrenia)	Statewide	30
Medication Algorithms (Bipolar Disorders)	Statewide	30
Integrated Mental Health/Substance Abuse Services	Statewide	17
Supported Housing	Statewide	NR
Consumer-Operated Services	Parts of the state	10
Therapeutic Foster Care	Parts of the state	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
FQHC/CMHC Partnerships	Available in parts of the state	6

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), registered nurses, and substance abuse counselors in Missouri psychiatric hospitals and community mental health programs. The SMHA has special university-based training initiatives and offers training at mental health programs/providers to address staffing shortages. Other initiatives to reduce staff shortages include: hosting college classes on hospital grounds and hosting hospital open houses with CEU offerings.

The SMHA has initiatives to improve the quality of the mental health workforce. Limited tuition reimbursement and stipends for advanced education in hard-to-recruit disciplines and special training initiatives such as DBT and the Sanctuary Model.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings and video conferencing.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Its relationships with professional schools include providing clinical experiences, rotations, and a limited number of internship positions; providing administrative/clinical preceptors for graduate students; and serving as faculty for one medical school of psychiatry.

Missouri reimburses adult consumer peer specialists through Medicaid for providing mental health services. CPS has adopted the Appalachian Consulting Group "Georgia Model" for peer specialist training and certification.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Missouri 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.

Electronic Health Records (EHRs):

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.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. The startup RHIO in St. Louis is not yet fully operational.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

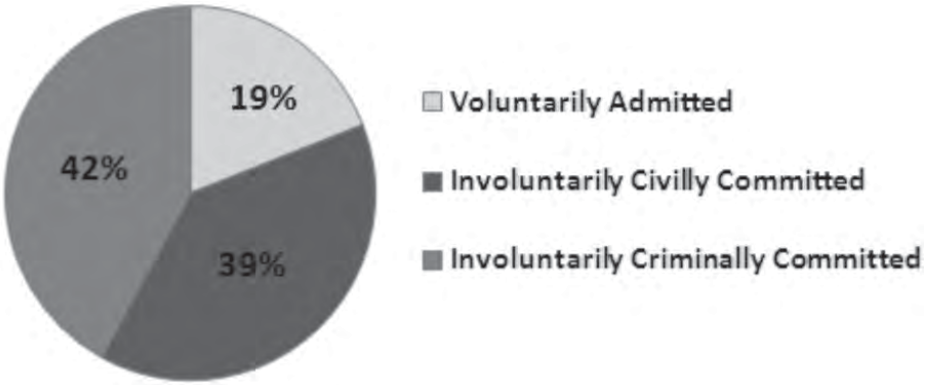
State Psychiatric Hospitals:

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 nine SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Missouri is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric and state psychiatric hospital beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, the Reserve, and family members of military personnel. An example is the Help for the Homefront Initiative, a cooperative effort of the DMH, CMHCs, and Mental Health America of Greater St. Louis, which has provided families of National Guard members, the Reserve, and discharged Active Duty veterans with support.

Missouri has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Montana 2009

Addictive & Mental Disorders Division Department of Public Health & Human Services 555 Fuller Avenue P.O. Box 202905 Helena, MT 59620 www.dphhs.mt.gov/amdd/	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 (AMDD). 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 (HRD) administers children's services through the Children's Mental Health 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. Montana 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 (2007):	957,861
Number of Persons Served (2008):	24,650
Utilization Rate for Adults:	22.4 per 1,000
Utilization Rate for Children:	37 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$138.9 million
Revenue From Medicaid	$92.3 million
Expenditures for Community Mental Health Services (79% of Total Mental Health Agency Revenues)	$109.5 million
Per Capita State Mental Health Expenditures	$145.79

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Different state department
Housing Agency	Same umbrella department as the SMHA
Health Department	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	1	0	1
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives such as crisis stabilization for uninsured adults without regard for financial eligibility to restructure Montana's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other Montana government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Montana's service systems include: the Co-Occurring Disorders (COD) initiative, Projects in Assistance for Transition from Homelessness (PATH), employment resources, the Department of Corrections (DOC)/ DPHHS coordinator, WRAP training support, and the Mental Health Oversight Advisory Council (MHOAC).

Montana has initiatives, for example, the 72-Hour Presumptive Eligibility Program, MHSP expansion, and COD initiatives, to transform the way it delivers mental health services.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	NR	NR	NR
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	No	No	No	No

NR = not reported.

The SMHA is not collaborating with Montana's health department, Medicaid agency, or any other agencies to increase the recognition and treatment of persons with mental illness by primary care providers.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The SMHA is working on expansion of provider types outside of mental health centers, rural health clinics (RHCs), and hospitals.

The SMHA has the following initiative to promote the understanding that mental health is essential to overall health: Stakeholder groups funded through the SMHA collaborate to help develop comprehensive health systems.

Evidence-Based Services:

Evidence-Based Practices	Implementation
Supported Employment	Parts of the state
Integrated Mental Health/Substance Abuse Services	Parts of the state
Illness Self-Management	Parts of the state
Supported Housing	Parts of the state
Consumer-Operated Services	Pilot Program

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
Dialectical Behavior Therapy	Parts of the state
Consumer-Run Drop Center	Parts of the state
WRAP/Strengths Based	Parts of the state
Illness Management and Recovery (IMR)	Parts of the state
Program for Assertive Community Treatment	Parts of the state
Service Outcome Action Research (SOAR) (SSI/SSDI Outreach, Access, and Recovery)	Parts of the state

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists and registered nurses in state psychiatric hospitals and community mental health programs.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, nursing, and physicians' assistant and pharmacy.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Montana 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 (EHRs):

The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is operating an EHR in state hospitals. Montana does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives detailed information for only regional mental health center recipients and receives claims data for all recipients.

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 hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:

Psychiatric Inpatient Bed Shortages:

Montana is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel.

Montana has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. However, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Nebraska 2009

Division of Behavioral Health Department of Health & Human Services 301 Centennial Mall South P.O. Box 95026 Lincoln, NE 68509 www.hhs.state.ne.us/Behavioral Health/	The Division of Behavioral Health is within the Nebraska Department of Health and Human Services (DHHS). 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 six Regional Behavioral Health Authorities (RBHAs) to purchase community mental health and substance abuse services using 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 them to live in the community of their choice.

Statistics:

State Population (2007):	1,774,571
Number of Persons Served (2008):	36,911
Utilization Rate for Adults:	24.7 per 1,000
Utilization Rate for Children:	9.1 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$116.2 million
Revenue From Medicaid	$16.9 million
Expenditures for Community Mental Health Services (61% of Total Mental Health Agency Revenues)	$70.7 million
Per Capita State Mental Health Expenditures	$65.93

New Financing Initiatives:

Early exploration and further development of managed care systems ensuring accuracy and accountability of service delivery.

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 Services	Part of the SMHA
Brain Impaired Services	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	Part of the SMHA

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
Housing Agency	Same umbrella department as the SMHA
Developmental Disabilities	Same umbrella department as the SMHA
Children and Family Services	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
General Hospitals With Separate Psychiatric Units	0	8	8

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds aggregations of counties through RBHA formed under interlocal agreements.

The SMHA is undertaking initiatives to restructure Nebraska's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other Nebraska government agencies to coordinate, reduce, and eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The Northeast SMHA has agreements with other agencies to collaborate on services related to housing, employment, juvenile justice, criminal justice, education, substance abuse, and National Guard services. The Northeast SMHA coordinates with other divisions within the same state agency (DHHS) on child welfare, Medicaid, and co-occurring disorders diagnosis (mental illness and developmental disabilities) services.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	NR
Juvenile Justice	Yes	Yes	Yes	NR
Criminal Justice	Yes	Yes	Yes	NR
Education	Yes	Yes	Yes	NR
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	Yes	Yes	Yes
Dual Diagnosis (Mental Illness and Developmental Disability)	Yes	No	Yes	Yes

NR = not reported.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Yes	3
Supported Employment	Yes	7
Family Psychoeducation	Yes	2
Integrated Mental Health/Substance Abuse Services	Yes	3
Supported Housing	Yes	6
Multisystemic Therapy (Conduct Disorder)	Yes	1
Functional Family Therapy	Yes	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Family Navigator Services (Family Peer Mentoring)	Yes	7

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), registered nurses, and direct care staff in state psychiatric hospitals and community mental health programs.

The SMHA has initiatives to improve the quality of the mental health workforce. Through Legislative Bill (LB) 603 (see below) and the Rural Health Advisory Commission initiatives, the SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through video conferencing, Webinars, and telehealth.

The SMHA does not reimburse peer specialists through Medicaid for providing mental health services. The SMHA reimburses with state general funds for administrative services only.

Managed Behavioral Healthcare:

The SMHA contracts for managing mental health, substance abuse, and gambling addiction services.

Custody Relinquishment:

Nebraska 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. LB 603 passed in 2009 authorizing the increase of services to children and youth experiencing behavioral health issues. The services include a Children's Behavioral Helpline; Family Navigator Services (family peer mentoring); and an additional $1.5 million for children's behavioral healthcare needs, such as Wraparound services. The SMHA is unable to report the number of children whose parents had their custody relinquished in 2008; however, a current state ward study is in progress.

Telemedicine:

The SMHA promotes the use of telemedicine with the Office of Rural Health.

Electronic Health Records (EHRs):

Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information exists in Nebraska, but is not part of the SMHA.

Client-Level Data:

Through Nebraska's managed care vendor, the SMHA maintains an individual client-level database for consumers served in community mental health settings.

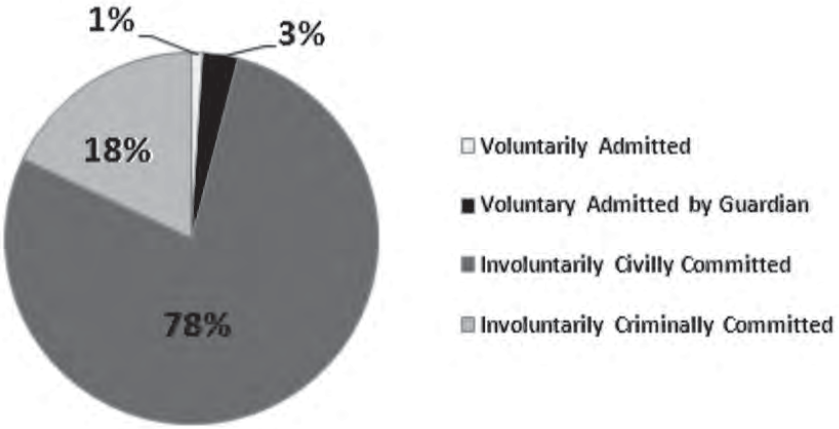
State Psychiatric Hospitals:

The responsibility for the operation of state psychiatric hospitals is under the direction of the SMHA 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 hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	No	No	No
Adolescents (Chemical Dependency)	No	Yes	No
Adults	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There have been declines in state psychiatric hospital beds since 2008; however, Nebraska is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, the Reserve, and family members of military personnel.

Nebraska has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Nevada 2009

Division of Mental Health & Developmental Services Department of Health & Human Services 4126 Technology Way, 2nd Floor Carson City, NV 89706 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 (2007):	2,565,382
Number of Persons Served (2008):	32,253
Utilization Rate for Adults:	14.5 per 1,000
Utilization Rate for Children:	6.9 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$200.8 million
Revenue From Medicaid	$27.9 million
Expenditures for Community Mental Health Services (65% of Total Mental Health Agency Revenues)	$130.8 million
Per Capita State Mental Health Expenditures	$78.92

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 Services	Part of the SMHA
Brain Impaired Services	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	No responsibility

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Different state department
Housing Agency	Same umbrella department as the SMHA
Health Department	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	0	3
Community Mental Health Providers	24	0	24

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly operates community-based programs.

The SMHA is not undertaking initiatives to restructure Nevada's community-based system of mental health service delivery.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	2
Supported Employment	Parts of the state	3
Medication Algorithms (Schizophrenia)	Statewide	NA
Family Psychoeducation	Statewide	NA
Integrated Mental Health/Substance Abuse Services	Parts of the state and a pilot program	2
Supported Housing	Parts of the state	3
Consumer-Operated Services	Statewide	3
Multisystemic Therapy (Conduct Disorder)	NR	1

NR = not reported; NA = not available.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Wraparound Case Management	Available statewide	3
Aggression Replacement Therapy	Available in parts of the state	2
Family to Family Support	Available statewide	1

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), and registered nurses in state psychiatric hospitals and community mental health programs. The SMHA has special university-based training initiatives and offers increased salaries to address staffing shortages. Other initiatives to reduce staff shortages include: the central State Personnel Department does biennial salary surveys, with results presented to the legislature for potential market increases to classifications identified as having significant lags to the market. In recent years, there have been market increases for psychiatric nurses and nurse practitioners, mental health counselors, CSWs, and psychologists.

The SMHA has initiatives to improve the quality of the mental health workforce. There are a variety of training requirements and opportunities for staff, which can be met through classes offered at the agency or by the State Department of Personnel's training group. Employees can apply or be nominated for a statewide Certified Public Manager program. There is an annual divisionwide service coordination conference. The division's agencies provide as much in-house training as possible for clinicians. The division requires its mental health technicians to complete certification.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, nursing, pharmacy, and technical schools. Its relationships with professional schools include various agencies providing internships, externships, and residencies for their students, as well as job fairs at the locations.

Nevada reimburses adult and adolescent consumer peer specialists through Medicaid for providing mental health services. No peer program for youth exists, although it is Medicaid reimbursable.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care.

Custody Relinquishment:

Policy allows voluntary access of mental health services without relinquishing custody of children. Many of the children served are in the custody of their family.

Electronic Health Records (EHRs):

The SMHA is operating an EHR in state hospitals and community mental health programs. The state uses a single EHR system for all community mental health providers.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The database includes information for all SMHA-operated community 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 three SMHA-operated psychiatric hospitals providing adult services, including one that is limited to forensic services. A fourth state facility provides child and adolescent hospital services.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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	No	No
Elderly	Yes	No	No
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:

Psychiatric Inpatient Bed Shortages:

Nevada is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

The Nevada Legislature recently passed legislation authorizing the creation of specialty Veterans Courts. These specialty courts would allow veterans and Active Duty service members to be diverted from the standard criminal justice system under certain circumstances. The specialty court is designed to assist the individual with completing an appropriate treatment program and avoiding incarceration. The SMHA is collaborating with the criminal justice system and local veterans services on implementing this initiative.

New Hampshire 2009

Bureau of Behavioral Health Department of Health & Human Services 105 Pleasant Street Concord, NH 03301 www.dhhs.state.nh.us	The New Hampshire Bureau of Behavioral Health (BBH), within the Department of Health and Human Services (DHHS), 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 (2007):	1,315,828
Number of Persons Served (2008):	47,726
Utilization Rate for Adults:	35 per 1,000
Utilization Rate for Children:	40.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$170.8 million
Revenue From Medicaid	$137.3 million
Expenditures for Community Mental Health Services (67% of Total Mental Health Agency Revenues)	$114 million
Per Capita State Mental Health Expenditures	$130.30

New Financing Initiatives:

New Hampshire is looking at various models to determine how the delivery of mental health services is financed.

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
Housing Agency	Same umbrella department as the SMHA
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	0	0	0
Community Mental Health Providers	0	11	11

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives to restructure New Hampshire's community-based system of mental health service delivery. Implementation of evidence-based practices (EBPs) is a priority.

Interagency Collaboration:

The SMHA is working with other New Hampshire government agencies to coordinate, reduce, or eliminate barriers among delivery systems and funding streams for the provision of appropriate mental health services. Integrated children's services, mental health courts, the Housing Subsidy Bridge Program, and services to the National Guard are examples.

New Hampshire has initiatives to transform the way it delivers mental health services. These include EBPs, single point of access, and the Ten Year Plan.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	No	No	Yes
Juvenile Justice	Yes	No	Yes	Yes
Criminal Justice	Yes	No	No	Yes
Education	Yes	No	Yes	Yes
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	No	No	Yes
National Guard	Yes	No	No	Yes

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses by contract with CMHS.

The SMHA has added State Performance Measures for Health Promotion, to promote the understanding that mental health is essential to overall health.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	3
Supported Employment	Statewide	10
Integrated Mental Health/Substance Abuse Services	Parts of the state	NR
Illness Self-Management	Statewide	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Statewide	10
Peer Support	Statewide	9

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), and registered nurses in community mental health programs.

The SMHA has initiatives to improve the quality of the mental health workforce, for example, the Ten Year Plan.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through DVD training.

Managed Behavioral Healthcare:

Mental health services are being delivered through managed care.

Custody Relinquishment:

New Hampshire 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 RSA 169-C3 Child Protection Act.

Telemedicine:

The SMHA promotes the use of telemedicine. Telemedicine is used for emergency services in rural areas and psychiatric evaluations.

Electronic Health Records (EHRs):

The SMHA is installing an EHR in state hospitals and community mental health programs. New Hampshire does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

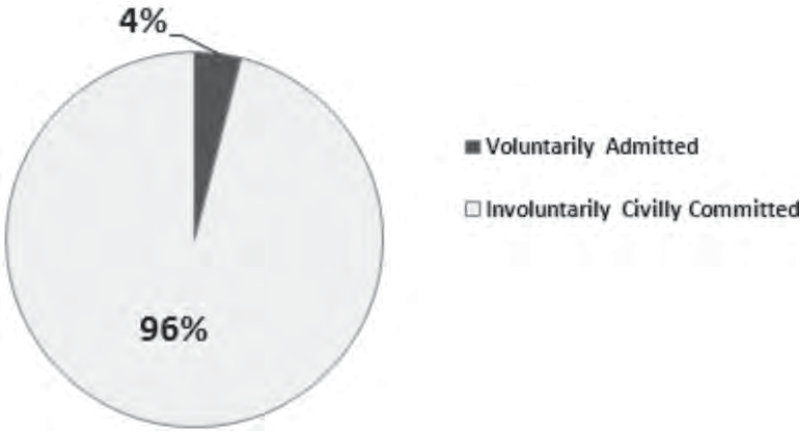
State Psychiatric Hospitals:

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. The New Hampshire Hospital is under DHHS, Office of the Commissioner. Care is coordinated between the hospital and the community systems through regular and as-needed interactions among staff of both systems, including, but not limited to, protocols for admissions and discharge planning and meetings among medical directors.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	Yes	No	No
Adolescents	Yes	No	No
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	No	No	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

New Hampshire is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel.

Specific initiatives include:

- The Deployment Cycle Program Pilot is a care coordination program that provides services such as financial management, transportation, counseling, childcare, and other needs to service members prior to deployment, during deployment (to the families), and postdeployment.
- The State Committee on Aging is partnering with the New Hampshire DHHS on providing education, outreach, and trainings to the long-term care provider community.
- The State Mental Health Council is partnering with the National Guard and the State Suicide Prevention Council on education, outreach, and training.

- The State Suicide Prevention Council has added a Military Subcommittee that focuses on education to veterans, service members, and their families, as well as the community.
- The Commission on Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) was legislatively mandated and has just started working on these issues.

New Hampshire has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

New Jersey 2009

Division of Mental Health Services Department of Human Services 222 South Warren Street P.O. Box 700 Trenton, NJ 08625 0727 www.state.nj.us/humanservices/dmhs/	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. Although the division 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 (2007):	8,685,920
Number of Persons Served (2008):	324,190
Utilization Rate for Adults:	43.3 per 1,000
Utilization Rate for Children:	17.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$1.6 billion
Revenue From Medicaid	$454.2 million
Expenditures for Community Mental Health Services (70% of Total Mental Health Agency Revenues)	$1.1 billion
Per Capita State Mental Health Expenditures	$188.91

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Different state department
Housing Agency	Different state department
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	5	0	5
Community Mental Health Providers	0	126	126

Primary Mechanism Used To Deliver Community Mental Health Services:

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

Interagency Collaboration:

The SMHA is working with other New Jersey government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The New Jersey Division of Mental Health Services (NJ DMHS) partners with the New Jersey Housing and Mortgage Finance Agency (NJHMFA) and the Department of Community Affairs (DCA) in the development of affordable supportive housing. NJ DMHS provides funds for support services and rental assistance; NJHMFA administers major sources of capital funding including the Special Needs Housing Trust Fund, the Low-Income Housing Tax Credit (LIHTC) program, and other financial products; and DCA provides project-based rental assistance to eligible supportive housing units. The LIHTC program awards points for projects that include units for persons with special needs, and the State Rental Assistance Program sets aside 15 percent of funds for people with disabilities. Approximately 800 new units of supportive housing have been developed through this partnership since 2006.

The NJ DMHS partners with the Division of Vocational Rehabilitation (DVR) to provide Supported Employment services to eligible mental health consumers in all 21 counties, including matching funds.

The NJ DMHS recently began funding supported education services. Six agencies have been selected to provide these services, each covering two counties. These services focus on postsecondary education.

The NJ DMHS provides funding to selected providers and works in partnership with the local criminal justice systems for jail diversion services in 10 counties, with the intent to implement jail diversion programs in all 21 counties as funding allows. The primary target populations are those at the prebooking and postbooking stages. The NJ DMHS provides Mental Health/Criminal Justice Intercept Systems Mapping to interested counties and has completed mapping in five counties. The NJ DMHS also partners with the Department of Corrections on funding and services for a prison reentry supportive housing program in Camden County.

The NJ DMHS and the Division of Addiction Services have an executed Memorandum of Understanding and share funding for 14 statewide inpatient detoxification beds and specialized case management or outpatient services in 4 counties. Senior staff from each division cochair a recently convened Co-Occurring Task Force. This task force is time limited and comprises various stakeholders including consumers, families, providers, and other state department representatives. The charge of this task force is to examine the existing systems in three subcommittees: Systems Integration, Services Integration, and Workforce Development. Each subcommittee will submit short, intermediate, and long-term actionable objectives that will create a co-occurring competent system of care. It is anticipated that the final report will be issued in the late summer of 2009 and will include a 3- to 5-year strategic plan.

Staff of the NJ DMHS sit on the Post-Traumatic Stress Disorder (PTSD) task force convened by the New Jersey Department of Military and Veterans Affairs (NJ DMAVA) that includes representatives from the VA system. DMHS is working in partnership with NJ DMAVA to ensure that returning guardsmen/women receive screening for combat and service-related mental health issues and receive the necessary treatment. DMHS and NJ DMAVA funded training for mental health outpatient clinicians to identify and refer to appropriate service veterans who may be experiencing combat/service-related PTSD or traumatic brain injury (TBI). DMHS staff assisted the State Administrative Office of the Courts in piloting a modified mental health court for veterans in Atlantic County. From the results of these efforts, other counties may choose to establish similar systems.

New Jersey has initiatives to transform the way it delivers mental health services. DMHS has developed a 3-year Wellness and Recovery Transformation Action Plan. This plan is the culmination of an extensive stakeholder input process and involves multiple objectives in three areas: (1) systems enhancement to promote wellness and recovery; (2) data-driven decisionmaking; and (3) workforce development.

First, under systems enhancement, key actions include creating Consumer and Family Advisory Committees to provide ongoing input and involvement in the multiyear process; expanding and emphasizing evidence-based, best, and promising practices through funding and contracting decisions; and establishing two task forces: one to improve integration between primary care and mental health treatment and the other to create a co-occurring competent system. Second, data-driven decisionmaking involves establishing systems, service, and consumer-based recovery-oriented outcomes and contract reform toward performance-based contracting. Third, the workforce development objective involves designing, implementing, and evaluating systemwide workforce development focusing on identified core competencies.

Executive Order #77 established guidelines for the DMHS pilot program of Operational Incentives that applies to all DMHS nonprofit, nonhospital, and nongovernmental agencies with cost-reimbursement contracts (fixed price and fixed rate contracts are not eligible) that provide DMHS services. Often DMHS nonprofit contracted providers do not have sufficient reserves of fund balances to pay for infrastructure upgrades and replacements or to cover short-term liabilities with operating funds reserves. Therefore, they rely on the availability of one-time awards or their own ability to raise or borrow funds. This policy, made available with certain limitations, is designed to enable this category of providers to build a fund balance from which emergency expenditures can be made; equipment replaced; property repaired; saving accrued, and the provider's financial viability improved, thereby promoting improved services to DMHS clients. In addition, Executive Order #78 directed the following systems changes: Financing of New Jersey's mental health system should be changed to promote state-of-the-art treatment alternatives that would include, but not be limited to, permanent supportive housing, supportive employment, in-home services, and consumer self-help. As a result of this commitment, over $26 million in additional funding was allocated to DMHS to develop a series of service initiatives designed to promote the provision of comprehensive, accessible, wellness and recovery-based, consumer-driven services for consumers with mental illness. To date, the following state-funded initiatives are within various forms of implementation: Governor's Council of Mental Stigma, Mental Health Screening Center expansion, Self-Help Center expansion, Psychiatric Services expansion of service hours, Housing Trust Fund, Support Services for Permanent Supportive Housing, Bilingual and Cultural Competent Services, Short-Term Care Facility expansion, and Jail Diversion expansion. Concurrently, the Executive order also called for the immediate review of currently licensed partial care and partial hospitalization programs to determine the appropriateness of utilizing and funding recovery-based programming and services for adults and children. The State Medicaid Plan was examined to determine whether it should adopt the Medicaid Rehabilitation Option, which would allow greater flexibility than currently exists to bill for non-facility-based services such as outreach, peer services, family education, supportive housing services, case management, and social and recreational activities.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	Yes	No	Yes

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	No	No	Yes
Division of Developmental Disabilities	Yes	No	No	No

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. Members of the Primary Care/Mental Health task force have met with the office in the New Jersey Department of Health and Senior Services (DHSS), the entity which oversees the federally qualified health centers (FQHCs), and DMHS has also been out to tour many FQHCs in various parts of the state. DMHS also has a pilot program with Medicaid and the DHSS to meet consumers' needs for primary healthcare in an FQHC. This pilot is being evaluated to determine to what extent an affiliation between mental health and FQHCs would improve access to healthcare for consumers.

DMHS has several initiatives to address wellness and physical health needs of consumers and employees. DMHS funds the "Bridging the Gap" program, which provides training for agency staff on wellness issues (including tobacco cessation), as well as Consumers Helping Others Improve their Condition by Ending Smoking (CHOICES), a tobacco cessation program.

DMHS funded eight agencies to provide Supportive Housing specifically for individuals with preexisting medical conditions. The Supportive Housing Model funded with these awards allowed those agencies the opportunity to partner with FQHCs and to develop meaningful affiliations with primary care practitioners (PCPs) to render direct healthcare to mental health consumers.

Plans have been made for all of New Jersey's five state inpatient psychiatric hospitals to go smoke free (for both consumers and staff) in 2009. At the time of writing, two hospitals are smoke free; the remaining three will be smoke free in the winter of 2009.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: Improving the integration between primary care and mental health treatment is a system enhancement recommendation detailed in the DMHS Wellness and Recovery Transformation Action Plan. In addition, the efforts of the New Jersey Mental Health Anti-Stigma council will continue to underscore the importance of mental health in overall personal wellness. Furthermore, the DMHS Home to Recovery–Conditional Extension Pending Placement (CEPP) plan (Olmstead related) aids in the timely discharge of CEPP patients in the state's psychiatric hospitals. This plan further reinforces and highlights (at the state level) the understanding that mental health is a critical component to overall health and personal wellness.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	31
Supported Employment	Statewide	22
Medication Algorithms (Schizophrenia)	Parts of the state	5
Family Psychoeducation	Statewide	23
Integrated Mental Health/Substance Abuse Services	Parts of the state	13
Illness Self-Management	Statewide	75
Supported Housing	Statewide	45
Consumer-Operated Services	Statewide	32

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Supported Education	Parts of the state	3
Cognitive Behavioral Interventions	Statewide as part of illness management and recovery (IMR) training	75
Motivational Enhancement/Interviewing	Statewide as part of IMR training	75

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners and clinical specialists (master's level and above), and registered nurses in state psychiatric hospitals and community mental health programs. The SMHA has special university-based training initiatives and offers increased salaries and recruitment bonuses or other financial incentives to address staffing shortages. Other initiatives to reduce staff shortages include the following: DMHS has affiliations with colleges to hire nursing students during their summer vacation so that they can gain experience in psychiatric care. DMHS also conducts job fairs and recruitment fairs. In addition, DMHS has a scholarship program for current employees that pays for their tuition and full salary while attending nursing school.

The SMHA has initiatives to improve the quality of the mental health workforce. DMHS established an Office of Workforce Development in September 2008. Each state psychiatric hospital has a training department that introduces individualized training initiatives addressing training gaps specific to each hospital.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings and video conferencing (video conferences occur on a limited basis among state psychiatric hospitals to improve and enhance staff skill sets). Online trainings (such as ethics and disaster preparedness) are provided to DMHS staff through the New Jersey Department of Human Services.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, and psychiatry.

DMHS has a relationship with the University of Medicine and Dentistry of New Jersey (UMDNJ) School of Health-Related Professions and also with UMDNJ-University Behavioral Health Care (UBHC). DMHS also has initiated an academic collaboration with the University of Pennsylvania Collaborative Forensic Fellowship Program.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Telemedicine:

The SMHA promotes the use of telemedicine. Telemedicine is utilized in selected screening centers in the southern region, one in the central (Somerset) and one in the north (Warren). DMHS does not actively encourage the use of telepsychiatry, but if a provider wishes to offer this as a treatment option, the provider must apply to DMHS for a waiver. Such waivers are only granted under special circumstances (typically related to staffing challenges). Such waivers are unfortunately necessary because DMHS regulations require face-to-face contact for evaluations in screening centers. If DMHS issues such a waiver, it is to a facility offering 24-hour services that possesses the necessary equipment to carry out the telepsychiatry.

Electronic Health Records (EHRs):

The SMHA has no EHR activities or plans for 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings.

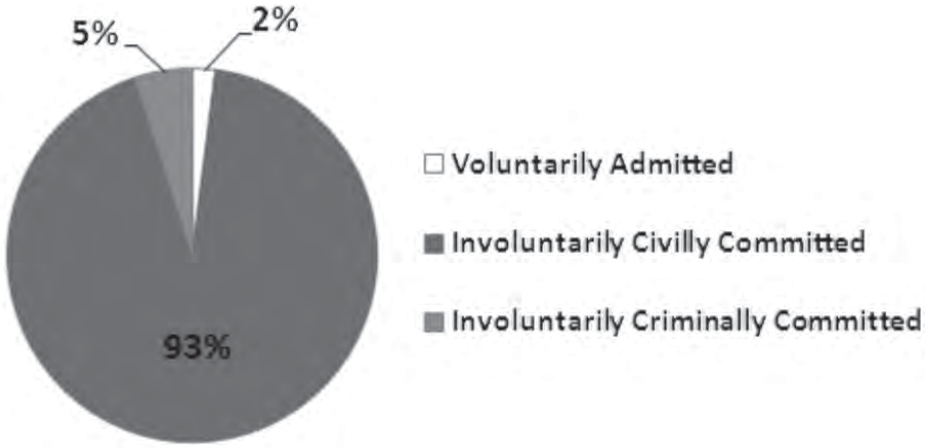
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

New Jersey is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds since 2008. The DMHS recently partnered with DHHS on a Certificate of Need process for short-term care facility beds, adding 91 new beds to the system.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives, described below, have addressed veterans, National Guard members, the Reserve, and family members of military personnel.

DMHS has partnered with NJ 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 NJ DMAVA will continue to explore partnership opportunities that will increase access to mental health services for veterans. DMHS provided a range of services to over 7,300 veterans in FY 2008. Discussions are tentatively scheduled to take place in the fall of 2009. DMHS has also initiated discussion with the VA New Jersey Healthcare system to enhance services to New Jersey veterans. Additionally, DMHS has partnered with the New Jersey Judiciary, that is, the Administrative Office of the Courts, and NJ DMAVA to initiate a court-based referral program for veterans. Veterans identified by police, the county jail, and the municipal and superior courts are referred to NJ DMAVA for appropriate services and then referred for further necessary mental health services to DMHS. DMHS Justice Involved Services in 14 counties have been alerted to identify veteran participants so that appropriate services can be accessed. Also, DMHS Supported Employment providers in all counties and newly funded Supported Education programs have also been alerted to screen for veterans status and provide appropriate services. The Governor's Council on Mental Health Stigma, in collaboration with the NJ DMAVA PTSD Task Force, created and launched an ongoing public relations campaign entitled "Life Doesn't Have to be a Battlefield. Don't Let Stigma Stand in Your Way." This campaign is being used to enhance statewide awareness efforts.

New Jersey has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

New Mexico 2009

Behavioral Health Purchasing Collaborative Human Services Department P.O. Box 2348 Santa Fe, NM 87504 www.bhc.state.nm.us/	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. The Behavioral Health Purchasing Collaborative (the Collaborative) is the only one of its kind in the country. The Collaborative was created during the 2004 legislature to allow state agencies and resources involved in behavioral health treatment and recovery to work as one in an effort to improve mental health and substance abuse services in New Mexico. The Collaborative comprises 17 state agencies and commissions. It also oversees a behavioral health budget that includes mental health and substance abuse funds exceeding $400 million. The overall structure of the Collaborative also includes a Governor appointed advisory group called the Behavioral Health Planning Council, which represents a statewide voice as well as 15 Local Collaboratives throughout New Mexico that bring local voices to the table.

Statistics:

State Population (2007):	1,969,915
Number of Persons Served (2008):	73,670
Utilization Rate for Adults:	28.9 per 1,000
Utilization Rate for Children:	62.4 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)*	Dollars
Total Mental Health Agency-Controlled Revenue	$190.7 million
Revenue From Medicaid	$117.7 million
Expenditures for Community Mental Health Services (89% of Total Mental Health Agency Revenues)	$169.8 million
Per Capita State Mental Health Expenditures	$97.61

*NASMHPD Research Institute (NRI) report of funding sources and expenditures of SMHAs for FY 2007 had been completed by the Behavioral Health Services Division (BHSD), which was part of the Department of Health (DOH) prior to FY 2007. BHSD interpreted that DOH was the SMHA, so BHSD personnel included in the NRI reports only funds for mental health services controlled by DOH. This limited inclusion of data to state hospital funding and adult services funded through BHSD-controlled state general funds.

For the FY 2007 Revenues and Expenditures Report, it was decided to designate the New Mexico Behavioral Health Purchasing Collaborative (the Collaborative) as the SMHA. This Collaborative was created by Governor Bill Richardson and the New Mexico State Legislature during the 2004 Legislative Session. The legislation allows several state agencies and resources involved in behavioral health prevention, treatment, and recovery to work as one in an effort to improve mental health and substance abuse services in New Mexico. The Collaborative is charged with creating a single behavioral healthcare and services delivery system that promotes mental health; emphasizes prevention, early intervention, resiliency, recovery, and rehabilitation; manages funds efficiently; and ensures availability of services throughout the state. Funding for public mental health services for adults and children is primarily accomplished through contracting with a single, statewide entity (SE) managed care organization.

The change in interpretation of the SMHA resulted in a significant increase in funds being used in the calculation for the NRI report. Funding items included within the FY 2007 NRI report that were not included in prior reports are the following: Children – Residential treatment funded through Medicaid and less than 24-hour mental health services funded through Medicaid and state general funds; Adults – Less than 24-hour mental health services funded though Medicaid and inpatient and residential mental health treatment services funded through Medicaid and state revenues. The change in data inclusion has resulted in a $141,291,833 (286%) increase in reported mental health funding between FY 2006 and FY 2007. This result is an artifact of data collection and not any significant increase in funding.

New Financing Initiatives:

New Mexico is planning or implementing a change in how the delivery of mental health services is financed through utilizing its Collaborative.

Responsibilities of the SMHA in Administering Specific Mental Health Services:

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA/HSD/CYFD
Elderly Mental Health Services	Part of the SMHA/ALTSD
Adult Forensic Services	Part of the SMHA/DOH
Brain Impaired Services	Part of the SMHA/ALTSD
Alzheimer's Disease and Organic Brain Syndrome Services	Part of the SMHA/ALTSD
Court Evaluation of Mental Health Status	Part of the SMHA/HSD
Services to Persons With Mental Illness in Prison/Jail	Part of the SMHA/NMCD
Sex Offender Services	Part of the SMHA/DOH/HSD/CYFD

HSD = Human Services Department; CYFD = Children, Youth and Families Department; ALTSD = Aging and Long-Term Services Department; and NMCD = New Mexico Corrections Department.

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA and HSD
Substance Abuse Agency	Same umbrella department as the SMHA and HSD
Housing Agency	Same umbrella department as the SMHA, HSD, and MFA
Health Department	Same umbrella department as the SMHA and DOH

MFA = Mortgage Finance Authority.

The Number of Mental Health Providers the SMHA Operates or Funds:

Mental Health Providers	SMHA Operated	SMHA Funded	Total
Community Mental Health Providers	0	60	60
General Hospitals With Separate Psychiatric Units	0	3	3

Primary Mechanism Used To Deliver Community Mental Health Services:

The Collaborative directly funds, but does not operate, local community-based agencies.

The Collaborative is not undertaking initiatives to restructure New Mexico's community-based system of mental health service delivery.

Interagency Collaboration:

The Collaborative works with other New Mexico government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. New Mexico is a transformation grant state. It is the only state that has formed a Behavioral Health Purchasing Collaborative comprising all agencies coordinating funding sources for behavioral health services for both children and adults.

The Behavioral Health Purchasing Collaborative comprises 17 state agencies and partners: Aging and Long-Term Services Department (ALTSD); Administrative Office of the Courts (AOC); Children, Youth and Families Department (CYFD); New Mexico Corrections Department (NMCD); Department of Finance and Administration (DFA); Department of Health (DOH); Department of Workforce Solutions (NMDWS); Department of Transportation (DOT); Developmental Disabilities Planning Council (NMDDPC); Division of Vocational Rehabilitation (DVR); Health Policy Commission (HPC); Human Services Department (HSD); Indian Affairs Department (IAD); Mortgage Finance Authority (MFA); Public Education Department (PED), the Governor's Commission on Disability; and the Governor's Health Policy Advisor. The Transformation grant is designed to help eliminate fragmentation and increase consumer choice.

New Mexico has initiatives including the SOAR initiative to transform the way it delivers mental health services. This initiative works to obtain quick approval of SSI/SSDI benefits for individuals who are homeless.

Agency	Working To Reduce Fragmentation	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	NR	NR
Employment	Yes	NR	NR
Juvenile Justice	Yes	NR	NR
Criminal Justice	Yes	NR	NR
Education	Yes	NR	NR
Child Welfare	Yes	NR	NR
Medicaid	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes

NR = not reported.

The Collaborative includes the Medicaid agency working to increase the recognition and treatment of persons with mental illness by primary care providers. Seventeen state agencies are part of the New Mexico Behavioral Health Purchasing Collaborative through a contract with the SE overseeing care coordination between physical and behavioral health. They work together to coordinate behavioral health services across populations and funding sources throughout the state.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	3
Family Psychoeducation	Pilot program	NR
Integrated Mental Health/Substance Abuse Services	Statewide	NR
Illness Self-Management	Pilot program	NR
Supported Housing	Parts of the state and a pilot program	4
Consumer-Operated Services	Parts of the state and a pilot program	NR
Multisystemic Therapy (Conduct Disorder)	Parts of the state	11
Therapeutic Foster Care	Statewide	NR
Functional Family Therapy	Parts of the state	2

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is not currently experiencing shortages of mental health staff.

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

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Its relationships with professional schools include the University of New Mexico–Rural Psychiatric Initiative.

New Mexico reimburses adult consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization.

Custody Relinquishment:

New Mexico 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. The 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 its contractors to ensure this service. There is a state Medicaid plan to use telehealth. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant has 32 sites that have telemed capabilities to do motivational interviewing and counseling.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA does not receive information for all community providers.

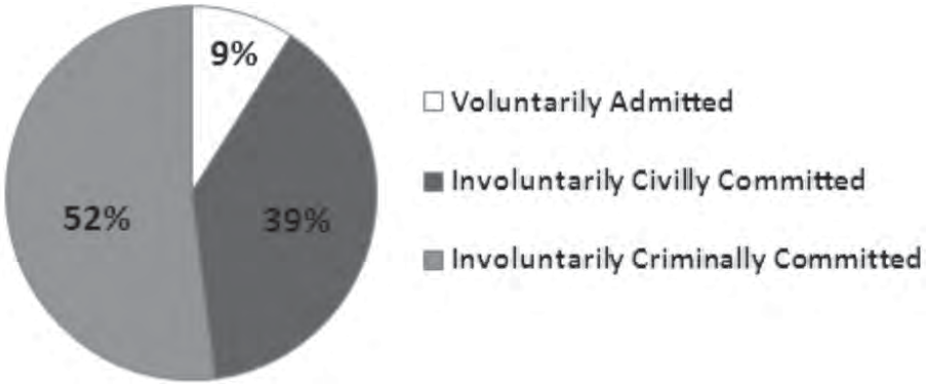
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

New Mexico is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for New Mexico's returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, and the Reserve. In addition, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

New York 2009

Office of Mental Health 44 Holland Avenue Albany, NY 12229 www.omh.state.ny.us	The Office of Mental Health (OMH) 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 New York other than private practice and federal facilities.

Statistics:

State Population (2007):	19,297,729
Number of Persons Served (2008):	687,867
Utilization Rate for Adults:	36.5 per 1,000
Utilization Rate for Children:	32.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$4.1 billion
Revenue From Medicaid	$2.5 billion
Expenditures for Community Mental Health Services (67% of Total Mental Health Agency Revenues)	$3 billion
Per Capita State Mental Health Expenditures	$222.58

New Financing Initiatives:

New York is planning and implementing a change in how the delivery of mental health services is financed. New York State (NYS) is proposing to restructure Medicaid reimbursement and to implement a new payment methodology (Ambulatory Patient Groupings) for outpatient mental health clinics as part of broader ambulatory reform agenda.

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 Services	Shared with another agency
Brain Impaired Services	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	Responsibility of the SMHA
Sex Offender Services	Part of the SMHA coordinated with Corrections, parole, and courts

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
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
State Psychiatric Hospitals	27	0	27
Community Mental Health Providers	160	3,041	3,201
Private Psychiatric Hospitals	NA	11	11
General Hospitals With Separate Psychiatric Units	0	127	127

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county or city mental health authorities statewide.

The SMHA is undertaking initiatives to restructure New York's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other New York government agencies to coordinate, reduce, or eliminate barriers to the provision of appropriate mental health services between delivery systems and funding streams. Examples include: integrated mental health and substance abuse treatment, employment services, work with housing agencies to develop housing, and work with veterans agencies (state and federal) to address needed services for returning veterans.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	No
Employment	Yes	No	Yes	Yes
Juvenile Justice	Yes	No	No	No
Criminal Justice	Yes	No	No	Yes
Education	Yes	No	Yes	No
Child Welfare	Yes	No	No	No
Medicaid	Yes	No	No	No
Substance Abuse	Yes	No	Yes	Yes
National Guard	Yes	No	No	No

The SMHA collaborates with New York's health department to increase the recognition and treatment of persons with mental illness by primary care providers. The clinical division works closely with the Department of Health around these issues. There are plans to provide cross-training in this area, for example, co-occurring (mental health and substance abuse) training.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. An example is the "LifeSPAN Campaign." The SMHA is encouraging people with mental illness to live healthy lives by exercising regularly, not smoking, and watching their weight. OMH also measures cardiometabolic functions (e.g., BMI and lipids) within the state-operated facilities and programs.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: suicide prevention training, education and community coalition building, services to veterans, and services to individuals with co-occurring disorders.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	NR	78
Supported Employment	Statewide	394
Medication Algorithms (Schizophrenia)	Parts of the state	NR
Medication Algorithms (Bipolar Disorders)	Parts of the state	NR
Family Psychoeducation	Parts of the state	40
Integrated Mental Health/Substance Abuse Services	Parts of the state	NR
Illness Self-Management	Parts of the state	NR
Supported Housing	Statewide	410
Consumer Operated Services	Statewide	NR
Multisystemic Therapy (Conduct Disorder)	Pilot program	10
Therapeutic Foster Care	Parts of the state	NR
Functional Family Therapy	Parts of the state	10

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Home and Community-Based Waiver	Statewide	40
Single Point of Access	Statewide	65
Clinic Plus	Statewide	300
PTSD	Statewide	NR
Peer Support/Self-Help	Statewide	NR
Dialectical Behavioral Therapy (DBT)	Parts of the state	NR
"Gatekeeper" at Risk Identification	Parts of the state	3
Mental Health–Physical Health Integration	Parts of the state	7

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists and registered nurses in state psychiatric hospitals. The SMHA has special university-based training initiatives and nurse development programs (e.g., allowing qualified OMH staff to earn nursing credentials and offering salary differentials for work in underserved areas). Other initiatives to reduce staff shortages include: postings on over 100 collegiate Web sites to recruit nurses, attendance at job fairs geared toward nurses, a reallocation package to minimize the wage gap for nurses, targeted advertising for nurses and psychiatrists, and increased hiring rates and salary enhancement packages.

The SMHA has initiatives to improve the quality of the mental health workforce. OMH plans, develops, and implements educational strategies and training initiatives in support of the OMH mission and strategic goals. Education and workforce development efforts are directly aimed at providing OMH guidance, direction, and support needed to ensure that staff training and development keep pace with the demands of existing programs and new initiatives.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online training, video conferencing, and DVD training. Additionally, OMH is currently developing a Web-based Learning Management System (LMS) to deliver, track, and manage all employee training programs. Pilot testing began in April 2009, and rollout to all OMH facilities is expected to be completed by the end of 2009.

The SMHA has relationships with professional schools to provide training in disciplines including psychology, psychiatry, and nursing. Its relationships with professional schools include support of a paid psychiatrist training program (resident physicians) and psychologist program (psychology interns).

New York reimburses neither adult nor adolescent consumer peer specialists through Medicaid for providing mental health services.

Custody Relinquishment:

New York has laws or policies that prevent parents from having to relinquish custody of children (to the SMHA, child welfare, or juvenile justice systems) in order for them to obtain mental health services. Timothy's Law (NYS mental health parity) no longer allows insurance companies to require higher copays or to allow mental health treatment to be treated differently from physical health services.

Telemedicine:

The SMHA promotes the use of telemedicine through Grand Rounds Satellite training, New York Psychiatric Institute's Science to Service consulting, rural counties consulting, and training for primary doctors.

Electronic Health Records (EHRs):

The SMHA did not indicate whether it has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA has not indicated whether it maintains an individual client-level database for consumers served in community mental health settings.

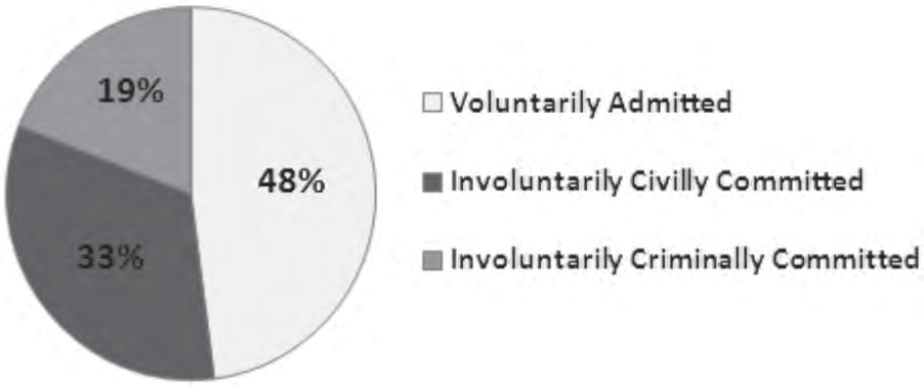
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There have been declines in general hospital with specialty psychiatric units and state-operated psychiatric hospital beds since 2008; however, the state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, through the NYS National Guard, OMH participates in reintegration events for returning soldiers and families at 30 to 60 days postdeployment.

New York has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. However, there is an arrangement in place for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

North Carolina 2009

Division of Mental Health, Developmental Disabilities & Substance Abuse Services Albermarle Building, Room 1149 Raleigh, NC 27606 www.ncdhhs.gov/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, three developmental disabilities centers, three substance abuse treatment centers, three neuromedical treatment facilities, and two residential facilities for children with serious emotional disturbances.

Statistics:

State Population (2007):	9,061,032
Number of Persons Served (2008):	237,966
Utilization Rate for Adults:	25.4 per 1,000
Utilization Rate for Children:	28.8 per 1,000

Revenues and Expenditures

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$1.7 billion
Revenue From Medicaid	$1.3 billion
Expenditures for Community Mental Health Services (82% of Total Mental Health Agency Revenues)	$1.4 billion
Per Capita State Mental Health Expenditures	$192.49

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
Housing Agency	Separate state agency
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	4	0	4
Community Mental Health Providers*	0	24	24
Private Psychiatric Hospitals	NA	2	2
General Hospitals With Separate Psychiatric Units	0	10	10
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

*The SMHA funds 24 Local Management Entities (LMEs) who then contract with private providers to deliver services.
NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds single county and multicounty mental health authorities statewide. The area authorities then contract with private providers for direct service delivery.

Interagency Collaboration:

The SMHA is working with other North Carolina government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The SMHA has an Interagency Memorandum of Agreement with the Division of Vocational Rehabilitation Services detailing supported employment services and the ensuing follow-along supports. The SMHA also has a Memorandum of Agreement with Public Instruction, Juvenile Justice, the Administrative Office of Courts, and Social Services for children and youth with or at risk for serious emotional disorder and with the Department of Corrections and the court system for adults with mental illness and substance use disorders. The SMHA falls under the same umbrella (MHDDSAS) as Substance Abuse. The state collaborates with Medicaid through the development of the enhanced service benefits continuum, among others. Collaboration with other agencies on initiatives related to veterans and National Guard issues is reported elsewhere in the surveys.

North Carolina has initiatives to transform the way it delivers mental health services. A major restructuring was legislatively mandated in the North Carolina Mental Health Reform Act of 2001.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	Yes
Employment	Yes	No	Yes	Yes
Juvenile Justice	Yes	No	Yes	Yes
Criminal Justice	Yes	No	No	Yes
Education	Yes	No	No	Yes
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	No	Yes	Yes
Substance Abuse	Yes	No	Yes	Yes
National Guard	Yes	No	Yes	Yes

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. North Carolina has a Mental Health Integration Program called Community Care of North Carolina, a state-level collaboration between the SMHA, the Division of Medical Assistance (DMA), the Office of Rural Health and Community Care (ORHCC), and the North Carolina Foundation for Advanced Health Programs, Inc. The program integrates the identification and care of depression as well as other psychiatric diagnoses and behavioral health problems in the primary care provider's office. With the joint cooperation of the Medicaid Division and ORHCC, the SMHA, and LMEs, the Community Care Program of North Carolina (a network of primary care provider practices) is implementing a collocation model of primary and behavioral health services in 41 primary care practices and 3 behavioral healthcare centers. Through the ICARE (Integrated, Collaborative, Accessible, Respectful and Evidence-based) Partnership, the SMHA also collaborates with Medicaid and ORHCC to bring together professionals from disciplines such as family practice, pediatrics, psychiatry, and psychology to promote research, education, pilot studies, and practice tool development in integrated care.

The SMHA works with both public and private health providers to increase the recognition and treatment of physical health needs of persons with mental illness through North Carolina's Mental Health Integration Program.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health:

- North Carolina has a Mental Health Integration Program called Community Care of North Carolina, a state-level collaboration between the SMHA, DMA, ORHCC, and the North Carolina Foundation for Advanced Health Programs, Inc. The program integrates the identification and care of depression as well as other psychiatric diagnoses and behavioral health problems in the primary care provider's office.
- With the joint cooperation of the Medicaid Division and ORHCC, the SMHA, and LMEs, the Community Care Program of North Carolina (a network of primary care provider practices) is implementing a collocation model of primary and behavioral health services in 41 primary care practices and 3 behavioral healthcare centers. Through the ICARE Partnership, the SMHA also collaborates with Medicaid and ORHCC to bring together professionals from disciplines such as family practice, pediatrics, psychiatry, and psychology to promote research, education, pilot studies, and practice tool development in integrated care.
- North Carolina now mandates full mental health benefits that include full parity with coverage of bipolar depressive disorder, major depressive disorder, obsessive compulsive disorder, paranoid or other psychotic disorder, schizoaffective disorder, schizophrenia, PTSD, anorexia nervosa, and bulimia. All other mental health disorders are covered at financial parity. Deductibles, copayments, and lifetime limits must be the same as those for physical health service, with minimum required benefits of 30 combined inpatient and outpatient visits per year and 30 office visits per year. The SMHA further supports a statewide organization of youth diagnosed with mental illness—Powerful Youth—that is funded with Mental Health Block Grant money. Powerful Youth organizes leadership training and does presentations on mental illness at various venues such as schools and conferences.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	45
Supported Employment	Parts of the state	40
Family Psychoeducation	Parts of the state	5
Integrated Mental Health/Substance Abuse Services	Parts of the state	10
Illness Self-Management	Parts of the state	9
Supported Housing	Statewide	26
Consumer-Operated Services	Parts of the state	13
Multisystemic Therapy (Conduct Disorder)	Parts of the state	6
Therapeutic Foster Care	Statewide	1
Functional Family Therapy	Parts of the state	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Peer Family Support/Family Partners	Available in parts of the state	10
Child and Family Support Team	Available statewide	13
Family to Family NAMI Basics	Available in parts of the state	20
Consumer-Run Services Peer Bridges	Available in parts of the state	5
Consumer-Run Recovery Center	Available in parts of the state	10
Geriatric Specialty Teams	Available in parts of the state	20

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners and clinical specialists (master's level and above), healthcare technicians, and pharmacy staff in state psychiatric hospitals and community mental health programs. The SMHA has special university-based training initiatives, offers training at mental health programs/providers, and offers increased salaries as well as recruitment bonuses or other financial incentives to address staffing shortages. All of the strategies above have been addressed by the joint SMHA and North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse Workforce Development Initiative.

The SMHA has initiatives to improve the quality of the mental health workforce. The SMHA provides training on EBPs and other topics with continuing education credits through Area Health Education Centers, universities, and colleges.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, nursing, and community colleges. Its relationships with professional schools include the following: The SMHA contracts with universities to provide training on EBPs and innovative practices to service providers. The SMHA also has collaborated with and funded universities to enhance existing curriculums in professional schools to include EBPs and promising practices.

North Carolina reimburses adult consumer peer specialists through Medicaid for providing mental health services. Peer specialists can be part of the staff on ACT and community support teams.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care in five North Carolina counties. These behavioral health services are administered through a Medicaid 1915(b) waiver. Approximately 37,539 persons received behavioral health services under the managed care plan in 2008.

Custody Relinquishment:

North Carolina 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. Mental Health and Social Service policies around the Child and Family Team process were developed collaboratively, and guidance around the issue is part of continuous training and technical assistance. The SMHA has further worked with child welfare at the state and community levels to align practice and policy specific to therapeutic foster care and to implement respective state and federal plans and reviews for improved outcomes for children and families.

Telemedicine:

The SMHA promotes the use of telemedicine. The SMHA has an existing North Carolina Division of Mental Health Tele-Psyche Network initiative to improve access to and coordination of services in rural and underserved areas of the state. Ten telepsychiatry pilot projects were funded through grants from ORHCC. Startup funds were distributed to LMEs and some providers for the purchase of video-conferencing equipment and installation of transmission lines. The pilot sites were expanded, so there are now 78 hub and remote sites that provide an array of outpatient services as well as implement discharge planning and helping consumers transition into community-based intervention after hospitalization.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is installing an EHR in state hospitals.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA does not receive information for all community providers.

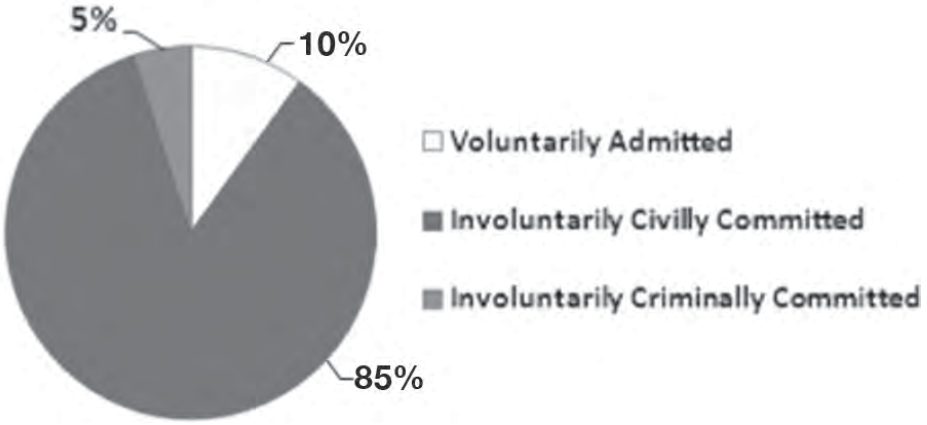
State Psychiatric Hospitals:

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 four SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There have been declines in general hospital specialty unit psychiatric and state psychiatric hospital beds in the last 5 years. North Carolina currently has an initiative designed to increase the number of psychiatric inpatient beds in community hospitals.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, the SMHA has a number of initiatives to provide mental health services to meet the needs of National Guard members or veterans of Armed Forces that take place through the Governor's Post-Deployment Support Initiative for Veterans and Their Families. These initiatives are the Veterans Administration Infrastructure Initiative, the Veterans Educational Initiative, the Veterans State-Wide Training Initiative, the Veterans Military Family Resiliency Assessment Initiative, the Veterans Telemental Health Services Initiative for rural areas, and the Veterans Outreach and Faith-based Initiatives. The link to the Web page for the Governor's Focus on Returning Combat Veterans and Their Families is www.veteransfocus.org/.

North Carolina has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

North Dakota 2009

Division of Mental Health & Substance Abuse Services Department of Human Services 1237 West Divide Avenue, Suite 1C Bismarck, ND 58501 1208 www.nd.gov/dhs/services/mentalhealth/	The Division of Mental Health and Substance Abuse Services is 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 (DOCR)), 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 North Dakota.

Statistics:

State Population (2007):	639,715
Number of Persons Served (2008):	16,260
Utilization Rate for Adults:	24.5 per 1,000
Utilization Rate for Children:	22.1 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$50.2 million
Revenue From Medicaid	$9.7 million
Expenditures for Community Mental Health Services (66% of Total Mental Health Agency Revenues)	$33.2 million
Per Capita State Mental Health Expenditures	$79.66

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

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

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is not undertaking initiatives to restructure North Dakota's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other North Dakota government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Examples include the Housing Initiative Project with Money Follows the Person, for SEP; transition planning with the DOCR Division of Adults Services; and training efforts with the National Guard.

North Dakota has initiatives, for example, Mental Health Transformation and Recovery, to transform the way it delivers mental health services.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	No
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	No	No	No	No
Criminal Justice	Yes	No	No	Yes
Education	No	No	No	No
Child Welfare	Yes	No	No	Yes
Medicaid	No	No	No	No
Substance Abuse	Yes	Yes	No	Yes
National Guard	Yes	Yes	No	Yes

The SMHA collaborates with the Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. Collaborative efforts include working with the Medical Association on Disease Management for Depression Workgroup.

The SMHA has the following initiative to promote the understanding that mental health is essential to overall health: The Children and Family Services Division and the Division of Mental Health and Substance Abuse Services have completed work on the development of mental/behavioral health screening toolkit training with system partners. The screening tools chosen were the Pediatric Symptom Checklist and the Ages and Stages Questionnaire: Social/Emotional. The Mental Health Screening Toolkit is available to human service center staff through the University of North Dakota's Children and Family Services Training Center.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Supported Employment	Parts of the state and a pilot program	NR
Integrated Mental Health/Substance Abuse Services	Parts of the state	1
Therapeutic Foster Care	Statewide	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Wraparound	Available statewide	NR
Mental Health Recovery	Available statewide	8

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists and psychologists (doctoral level) in community mental health programs. To address the shortage problem, the SMHA offers recruitment bonuses or other financial incentives.

The SMHA has initiatives to improve the quality of the mental health workforce such as the Mental Health and Aging Education initiative and the Annual Clinical Forum on Mental Health Conference.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

North Dakota reimburses neither adult nor adolescent consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

The SMHA has no mental health or substance abuse services delivered through managed care.

Custody Relinquishment:

North Dakota 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. A telehealth connection between the Badlands Human Service Center in Dickinson and a private provider in Fargo has been established.

Electronic Health Records (EHRs):

The SMHA is operating an EHR in state hospitals and community mental health programs. The state uses a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

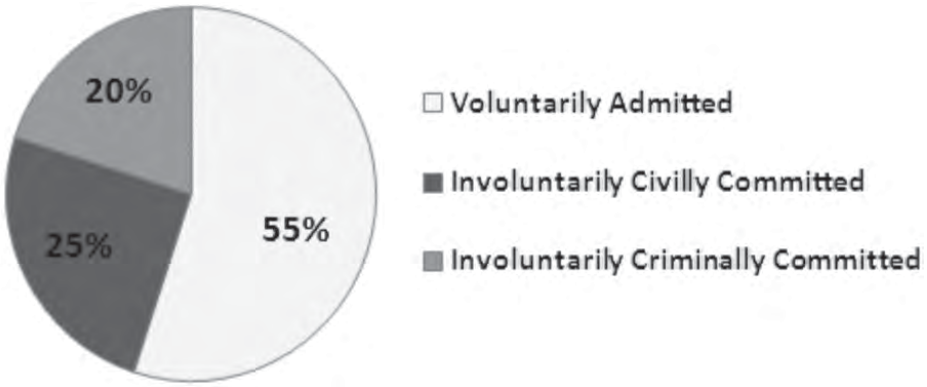
State Psychiatric Hospitals:

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. The SMHA does not operate state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	Yes	Yes	Yes
Adolescents	Yes	Yes	Yes
Adults	No	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

North Dakota is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, and family members of military personnel. North Dakota is committed to supporting service members and their families through the Suicide Prevention Program, Sexual Assault Prevention and Response Program, and outreach services.

North Dakota has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. However, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Ohio 2009

Department of Mental Health 30 East Broad Street, Suite 800 Columbus, OH 43215 www.mh.state.oh.us/	The Ohio Department of Mental Health (ODMH) contracts with 50 county and multicounty mental health boards that plan, develop, fund, and evaluate mental health services. Of these boards, 47 also administer substance abuse services. Three counties have separate boards for substance abuse services that contract separately with the Ohio Department of Alcohol and Drug Addiction Services. The boards receive federal, state, and local funds and are responsible for ensuring that mental health and substance abuse services are available to those who need them.

Statistics:

State Population (2007):	11,466,917
Number of Persons Served (2008):	321,145
Utilization Rate for Adults:	24.3 per 1,000
Utilization Rate for Children:	39.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$1,051 million
Revenue From Medicaid	$304 million
Expenditures for Community Mental Health Services (67.3% of Total Mental Health Agency Revenues)	$626 million
Per Capita State Mental Health Expenditures	$77.49

New Financing Initiatives:

Financial reform initiatives include plans to develop service benefit packages for priority populations (SPMI and SED—serious and persistent mental illness and seriously emotionally disturbed). Additional work includes implementing expedited Supplemental Security Income/Social Security Disability Income (SSI/SSDI) eligibility for unemployed adults with severe mental illness and Medicaid buy-in. Ohio will also develop mechanisms to better serve and assure continuity of care for youth in transition. Also, the SMHA will continue to pursue state hospital efficiencies, standardize the financing of forensic psychiatric centers, and explore alternative hospital relationships with private or academic providers.

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
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
State Psychiatric Hospitals	7	0	7
Community Mental Health Providers	33	384	417
Private Psychiatric Hospitals	NA	6	6
General Hospitals With Separate Psychiatric Units	0	77	77

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county behavioral health authorities statewide that plan, evaluate, and allocate resources to a wide range of providers. Providers include comprehensive community mental health centers (CMHCs), small specialized agencies (i.e., consumer-operated services and children's counseling), and large hospitals that provide behavioral healthcare services in multiple board areas.

The SMHA is undertaking initiatives to restructure Ohio's community-based system of mental health service delivery as described in the Mental Health & Alcohol and Other Drug System Sustainability Plan, March 2009.

Interagency Collaboration:

The SMHA works with other Ohio government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The Transformation State Incentive Grant (TSIG) has nine Content Workgroups, each of which collaborates with several other state agencies and community constituents. All together, TSIG partners manage over 30 projects, in conjunction with 13 Ohio entities. These entities include the Departments of Public Safety, Alcohol and Drug Addictions, Youth Services (youth corrections), Rehabilitation and Correction, Job and Family Services (Medicaid and child welfare), Aging, Development (housing), Health, and Education; the Rehabilitation Services Commission; the Ohio Child and Family First Cabinet Council; and the Ohio Housing Finance Agency. Some specific initiatives are the children and youth System of Care Initiative, training for a network of early childhood mental health consultants, supporting the transition of each system to trauma-informed practice, and reshaping the system of Behavioral Health/Juvenile Justice policy and practice framework. Additional initiatives address older adults, housing, and the criminal justice system.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	NR	Yes	Yes
Employment	Yes	NR	NR	NR
Juvenile Justice	Yes	NR	Yes	Yes
Criminal Justice	Yes	NR	NR	NR
Education	Yes	NR	NR	Yes
Child Welfare	Yes	NR	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	NR	Yes	Yes
National Guard	Yes	NR	No	Yes

NR = not reported.

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The Ohio Children's Health Insurance Program (OCHIP) promotes developmental and social emotional screening with pediatric offices.

The SMHA works with private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses through OCHIP and the Integrating Clinical Care Initiative. The Integrating Clinical Care Initiative is designed to promote the understanding that mental health is essential to overall health. The SMHA created the Ohio Coordinating Center for Integrating Care (OCCIC) in FY 2009 to share information and resources about integrating and coordinating physical and mental healthcare in Ohio. OCCIC helps providers and communities identify needs, plan integrated care solutions, and share successes and obstacles. The Health Foundation of Greater Cincinnati hosts OCCIC. OCCIC is a resource for Ohio's mental health providers and communities that are interested in learning more about how to create and run programs integrating mental health into physical health. OCCIC has five areas of responsibility: Share information; determine need and solutions; connect providers and other stakeholders; advocate for integrated care; and evaluate efficacy.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	30
Supported Employment	Parts of the state	14
Integrated Mental Health/Substance Abuse Services	Statewide	45
Supported Housing	Statewide	21
Consumer-Operated Services	Statewide	68
Multisystemic Therapy (Conduct Disorder)	Parts of the state	13
Therapeutic Foster Care	NR	11
Functional Family Therapy	NR	6

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Tobacco Cessation Re-Treatment	Available in parts of the state	5
Family-to-Family (NAMI-Ohio)	Statewide	55
Wellness Management and Recovery (WMR)	Available in parts of the state	12
Wellness Recovery Action Plan (WRAP)	Statewide	30

Ohio offers Family-to-Family to meet the needs addressed by the evidence-based practice (EBP) of Family Psychoeducation. Ohio offers two emerging best practices for consumers. WMR builds on illness self-management and is led by a peer specialist and a professional. WRAP, which is usually peer led, is being evaluated for its potential as an EBP by a federally funded study directed by Judith Cook, Ph.D., University of Illinois at Chicago, in collaboration with two Ohio consumer leaders and others. Additionally, the SMHA funds the Ohio Empowerment Center (a consumer advocacy organization) to offer WRAP.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of mental health staff in state psychiatric hospitals. Shortages are in the discipline of psychiatry, as well as shortages of other physicians, advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above).

The SMHA has initiatives to improve the quality of the mental health workforce by improving the recruitment and selection processes, training, orientation, and inservice training for SMHA staff. The SMHA cosponsors a conference with a medical school for psychiatrists and a Coordinating Centers of Excellence that provide training for CMHC staff on EBPs.

The SMHA has relationships with professional schools of social work, psychology, psychiatry, and nursing. Activities with professional schools include training interns and residents and having employees teach at these schools.

The state mental health certification standards include peer specialist mental health services; however, this service is not reimbursable by Medicaid. Peers (consumers) can be paid if under the direction of a licensed mental health professional to do community support activities reimbursed as part of Community Psychiatric Supportive Treatment provided by "trained others."

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Telemedicine:

The SMHA promotes the use of telemedicine. In December 2007, the SMHA updated rules that allow the use of interactive video conferencing in behavioral health counseling and pharmacologic management service to remove some of the prescriptive elements in order to reduce the regulation surrounding its use. In addition, in July 2008, the SMHA promulgated changes to the Mental Health Assessment rule to allow provision of the service via interactive video conferencing and community psychiatric supportive treatment (CPST). However, a federal lawsuit over an unrelated issue prevents the SMHA from enforcing the new CPST rule and providers from being able to bill Medicaid for mental health assessment services provided through interactive video conferencing.

Electronic Health Records (EHR):

The SMHA is engaged in several initiatives related to the adoption of EHR:

- The SMHA participates in Ohio's Health Information Technology Strategic Action Plan. This is a collaborative initiative involving consumer advocates, providers, and business leaders in the use of technology to support Governor Strickland's administration's Vision for a Healthy Ohio. One of the cornerstones of the plan is to use stimulus funds to develop a statewide Health Information Exchange (HIE) necessary to provide seamless and secure movement of health information between authorized users to integrate and improve the quality of healthcare services.
- The SMHA supports educational and awareness efforts to encourage adoption of certified electronic medical records within the behavioral health community. These efforts include raising awareness of the benefits of adoption, communicating health information technology standards and certification requirements, and engaging in initiatives to remove state policy barriers to adoption.
- The state psychiatric hospitals managed to implement successfully three of five phases of a certified electronic medical record system project. All hospitals use the software for treatment planning, group scheduling, progress notes, and assessments. The hospitals are implementing individual progress notes and clinical assessments. The goal is to have all EHR clinical assessments implemented in state fiscal year (SFY) 2010, with completion of all phases in SFY 2011.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings that is used to reimburse Medicaid claims.

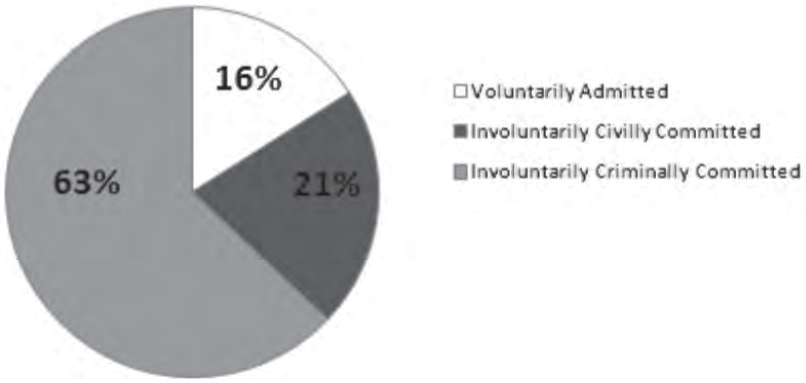
State Psychiatric Hospitals:

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 hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Ohio is experiencing a shortage of psychiatric beds. Since 1997, Ohio has lost a significant percentage of its private and public inpatient psychiatric beds (see the table below for details). The SMHA is currently updating its 2004 acute care report on Ohio's inpatient psychiatric beds. The updated report with recommendations is anticipated by early 2010.

Percent Change in Ohio Psychiatric Hospital Beds by Time Period and Provider Type:

Percent Change in Bed Capacity	1997 to 2002	2002 to 2008	1997 to 2008
Adult Private Psychiatric Hospital Providers	-19%	-11%	-28%
Child and Adolescent Hospital Providers	-25%	-4%	-28%
Adult State Hospitals	-18%	-2%	-19%

Services for Armed Forces Veterans and National Guard Members:

Ohio has specific initiatives to address the mental health service needs of returning veterans and their families; however, the state has not appropriated funds specifically for this purpose. These initiatives address the needs of Active Duty military, Armed Forces veterans, National Guard members, the Reserve, and family members of military personnel. Referral procedures are in place, and funds are available to pay for the mental health needs of returning veterans or their families who do not have access to military-funded services.

Ohio has veteran-specific initiatives for service members to reduce stigma related to mental health and substance abuse needs including community-based surveys to assess local service member needs and community events. Additionally, Ohio has a state agency that works directly with communities and agencies to identify service member needs, provides hotlines, and coordinates referrals through OHIOCARES.

Oklahoma 2009

Department of Mental Health & Substance Abuse Services 1200 NE. 13th Street Oklahoma City, OK 73117 www.odmhsas.org/	The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), a publicly supported community mental health center (CMHC), 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 younger than 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, ODMHSAS 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 (2007):	3,617,316
Number of Persons Served (2008):	46,719
Utilization Rate for Adults:	14.9 per 1,000
Utilization Rate for Children:	7 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$190 million
Revenue From Medicaid	$24 million
Expenditures for Community Mental Health Services (67% of Total Mental Health Agency Revenues)	$127.9 million
Per Capita State Mental Health Expenditures	$53.02

New Financing Initiatives:

Oklahoma is implementing a change in how the delivery of mental health services is financed. The Enhanced Tier Payment System (ETPS) is an innovative payment structure developed to enhance the outcomes of consumers in the mental health and substance abuse system. CMHCs have an opportunity to earn money directly related to individual levels of performance on six outcome measures.

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 Services	Part of the SMHA
Brain Impaired Services	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	No responsibility

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
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
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	5	10	15

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly funds and operates local community-based agencies.

Interagency Collaboration:

The SMHA is working with other Oklahoma government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The state has initiatives to transform the way it delivers mental health services.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	NR	Yes	Yes
Juvenile Justice	Yes	NR	NR	Yes
Criminal Justice	Yes	NR	NR	Yes
Education	Yes	NR	NR	Yes
Child Welfare	Yes	NR	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	NR	NR	Yes

NR = not reported.

The SMHA collaborates with the state health department, Medicaid agency, and the University of Oklahoma's Child Study Center to increase the recognition and treatment of persons with mental illness by primary care providers.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses.

The SMHA is publicly promoting the understanding that mental health is essential to overall health through presentations and publications, including a joint report with the Oklahoma Department of Health.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	NR
Integrated Mental Health/Substance Abuse Services	Statewide	NR
Illness Self-Management	Parts of the state	4
Supported Housing	Parts of the state	8
Consumer-Operated Services	Statewide	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
Wraparound	Available in parts of the state
Correctional Officer Crisis Diversion Training	Available in parts of the state

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists and registered nurses in state psychiatric hospitals. The SMHA has the following initiative to address staffing shortages: recruitment emphasis.

The SMHA uses education and training to improve the quality of the mental health workforce.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings and video conferencing.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing.

Oklahoma reimburses adult consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Oklahoma 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 and has installed telemedicine equipment in over 80 locations.

Electronic Health Records (EHRs):

The SMHA is installing an EHR in state-operated CMHCs and hospitals. The state does not use a single EHR system for all contracted community mental health providers. Local providers use a variety of EHR systems.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. A CMHC located in a RHIO can receive data from another provider but cannot share its data.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings and state psychiatric hospitals. The SMHA receives information for all SMHA-funded community providers.

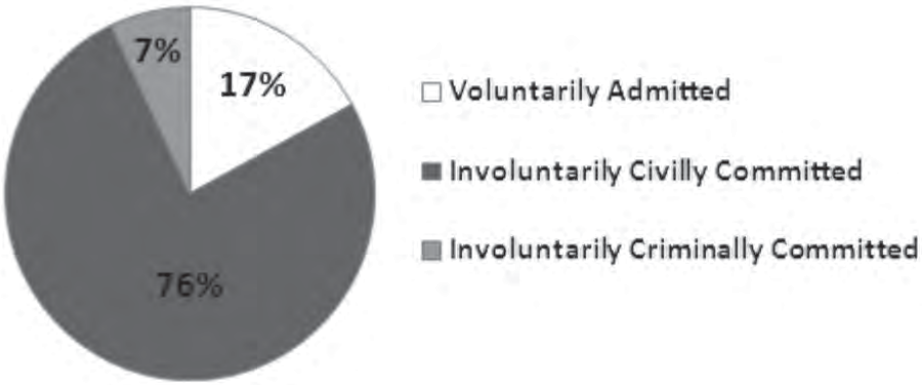
State Psychiatric Hospitals:

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 six SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	Yes	No	No
Adolescents	Yes	No	No
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Oklahoma is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel.

Oklahoma has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. However, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Oregon 2009

Addictions & Mental Health Division Department of Human Services 500 Summer Street, NE. Salem, OR 97301 www.oregon.gov	The Oregon Addictions and Mental Health Division (AMH) is currently located within the Department of Human Services (DHS) and will become part of the newly created Oregon Health Authority (2009 Legislation). 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 a 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 noncapitated 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 (2007):	3,747,455
Number of Persons Served (2008):	106,089
Utilization Rate for Adults:	24.7 per 1,000
Utilization Rate for Children:	40.3 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$430.6 million
Revenue From Medicaid	$276 million
Expenditures for Community Mental Health Services (71% of Total Mental Health Agency Revenues)	$303.7 million
Per Capita State Mental Health Expenditures	$115.39

New Financing Initiatives:

The 2009 Oregon Legislature requested that AMH develop an integrated management and service delivery model concept paper for the Joint Committee on Ways and Means Subcommittee and DHS. The concept paper recommends the establishment of two to three collaborative demonstration projects that meet specified criteria. At the end of the demonstration, AMH expects to integrate the addictions, health, and mental health service payment system; develop an outcomes-based contracting and payment system; develop a consolidated funding and management system; and identify a model to braid funding, including the use of federal waivers if necessary while identifying cost savings and efficiencies in service delivery.

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA*:

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

*The current DHS structure will change when the Oregon Health Authority becomes fully functional.

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
General Hospitals With Separate Psychiatric Units	0	13	13

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives to restructure Oregon's community-based system of mental health service delivery. An independent Assessment and Evaluation of the Mental Health Care Delivery System in Oregon by Public Consulting Group, Inc., was completed in November 2008 as a result of legislative mandate. This work is likely to yield legislative action to test new models for delivery of mental health, addictions, and health services.

Interagency Collaboration:

The SMHA is working with other Oregon government agencies to coordinate, reduce, or eliminate barriers to and fragmentation in the provision of appropriate mental health services. This work includes collaboration with other agencies through the Children's Mental Health System Change Initiative and Statewide Children's Wraparound Initiative.

Oregon has initiatives to transform the way it delivers mental health services: Children's Mental Health System Change Initiative and AMH demonstration pilot projects focusing on services, management, and financial integration.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	No	No
Employment	Yes	No	No	No
Juvenile Justice	Yes	No	No	No
Criminal Justice	Yes	No	No	No
Education	Yes	No	No	No
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	No*	No*
Substance Abuse	Yes	No	No	Yes
National Guard	NA	NA	NA	NA

*AMH demonstration pilot project will be working toward this end.

The SMHA collaborates with the state health department to increase the recognition and treatment of persons with mental illness by primary care providers.

DHS is working with health providers to increase the recognition and treatment of physical health needs of persons with mental illnesses.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: In June 2008, AMH updated a statewide study documenting years per life lost for people with mental health and or substance abuse disorders. The report concludes that premature mortality among this population is a healthcare crisis. It also directs AMH (through a Wellness Task Force) to work with community agencies to implement changes in care coordination, wellness screening, and the use of peer-to-peer support services to empower people with SMI to achieve lifestyle changes that will enhance their overall health.

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	28
Family Psychoeducation	Parts of the state	14
Integrated Mental Health/Substance Abuse Services	Parts of the state	42
Supported Housing	Parts of the state	25
Consumer-Operated Services	Parts of the state	48
Multisystemic Therapy (Conduct Disorder)	Parts of the state	8
Therapeutic Foster Care	Parts of the state	NR
Functional Family Therapy	Parts of the state	7

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Supported Education	Parts of the state and OSH	4
Peer-Delivered Services	Parts of the state and OSH	4

OSH = Oregon State Hospital.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners and clinical specialists (master's level and above), registered nurses, certified occupational therapy assistants (OTAs), and pharmacists in state psychiatric hospitals and community mental health programs. All categories need more culturally diverse providers, in particular Latino providers. Initiatives to reduce staff shortages include: the Psychiatric Nurse Workforce Development initiative and the AMH/OSH/Community College Collaborative.

The SMHA has initiatives to improve the quality of the mental health workforce. The AMH workforce development plan includes basics to evidence-based practice and organizational change initiatives.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through video conferencing, Webinars, learning circles, conference calls, and consultations.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychiatry, nursing, Oregon Health Sciences University (OHSU), several community college projects, addiction studies programs, master's in counseling through private universities, and Northwest Frontier Addiction Technology Transfer Center. Its relationships with professional schools include: contracts with OHSU for consultation in several areas, contract with Portland State University and several community

colleges, University of Oregon working with social learning center on research, and University of Washington Strengthening Families program evaluation.

The state reimburses adult consumer peer specialists through Medicaid for providing mental health services. SAIF Corporation, in Lane County, is currently the only program that bills Medicaid for mental health services delivered by peers.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. Approximately 180,000 persons received behavioral health services under the managed care plan in 2008, and 380,000 persons were covered under the plan.

Custody Relinquishment:

Oregon 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 law allows voluntary placement by parent in agreement with child welfare.

Telemedicine:

The SMHA promotes the use of telemedicine. Youth and adults in rural areas are served.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is installing an EHR in state hospitals.

Legislation passed during the 2009 legislative session directs the state to coordinate and maximize EHR adoption and interconnectivity.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

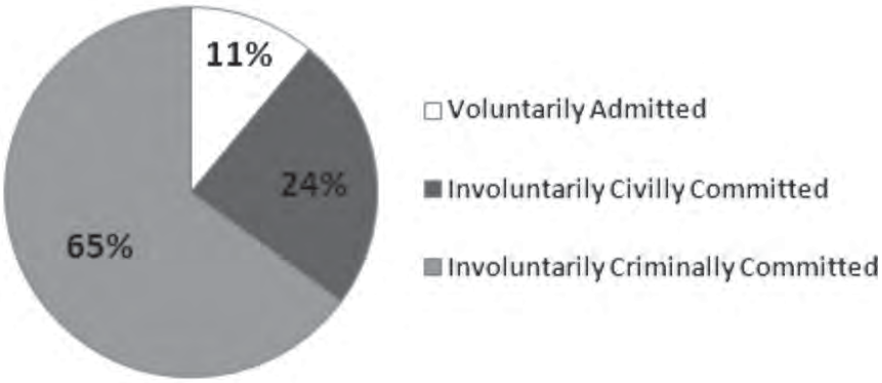
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Adults	No	Yes	Yes
Elderly	No	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status:



Psychiatric Inpatient Bed Shortages:

Oregon is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric and state psychiatric hospital beds in the last 5 years.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, and family members of military personnel.

The November 2008 final report of the Assessment and Evaluation of the Mental Health Care Delivery System by Public Consulting Group, Inc., includes a recommendation that DHS interface with the reintegration efforts of the Oregon National Guard and the U.S. Department of Veterans Affairs in meeting the needs of returning veterans.

Oregon has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is no arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Pennsylvania 2009

Office of Mental Health & Substance Abuse Services Department of Public Welfare P.O. Box 2675 Administration Building, DGS Complex Annex Harrisburg, PA 17105 2675 www.dpw.state.pa.us/About/OMHSAS/	The 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, whereas the Department of Health manages the non Medicaid substance abuse services.

Statistics:

State Population (2007):	12,432,792
Number of Persons Served (2008):	391,167
Utilization Rate for Adults:	29.3 per 1,000
Utilization Rate for Children:	38.9 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$3.2 billion
Revenue From Medicaid	$2 billion
Expenditures for Community Mental Health Services (84% of Total Mental Health Agency Revenues)	$2.7 billion
Per Capita State Mental Health Expenditures	$259.65

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Part of the SMHA
Substance Abuse Agency	Shared with another agency
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
State Psychiatric Hospitals	7	0	7
Community Mental Health Providers	0	9,523	9,523
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 Used To Deliver Community Mental Health Services:

The SMHA funds county or city mental health authorities statewide.

Interagency Collaboration:

The SMHA is working with other Pennsylvania government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. These agencies include housing; criminal justice, the National Guard PA CARES initiative, juvenile justice and child welfare; education; employment; and substance abuse. Initiatives include the Medical Assistance Expedited Enrollment Pilot Project.

Pennsylvania has initiatives to transform the way it delivers mental health services. Peer support services were added to the State Plan; the SMHA has established a training program for peer support specialists and was successful in obtaining civil service status for peer support specialists in the state system.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	No	Yes	Yes
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	No	Yes	Yes
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	No	No	No
Supported Education (Adults in Higher Education)	Yes	No	Yes	Yes

The SMHA collaborates with the Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. A physical health/behavioral health managed care coordination project is underway in urban/suburban areas of southeast and southwest Pennsylvania; a fee for service/managed care coordination project has been developed for the suburban/rural central part of the state.

The SMHA is working with providers to increase the recognition and treatment of physical health needs of persons with mental illnesses.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: State mental hospital screening initiative for metabolic syndrome; participation in the Serious Mental Illness Innovation Project, whose goal is improving quality of care by fostering collaboration and coordination of physical and behavioral healthcare needs; initiation of an antismoking policy in state hospitals; and an increased focus on obesity.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	22
Supported Employment	Parts of the state	56
Integrated Mental Health/Substance Abuse Services	Parts of the state	21
Illness Self-Management	Parts of the state	45
Supported Housing	Parts of the state	66
Consumer-Operated Services	Parts of the state	NR
Multisystemic Therapy (Conduct Disorder)	Parts of the state	12
Therapeutic Foster Care	Parts of the state	1
Functional Family Therapy	Parts of the state	20

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Family-Based MH Services	Available statewide	131
Crisis Intervention Training	Available in parts of the state	NR
Mental Health Courts	Available in parts of the state	9

NR = not reported.

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, social workers (master's level and above), advanced practice nurses, nurse practitioners and clinical specialists (master's level and above) in state psychiatric hospitals and community mental health programs. The SMHA has special university-based training initiatives to address staffing shortages. Other initiatives to reduce staff shortages include the fellowship program initiated in Pennsylvania that involves three medical schools: University of Pittsburgh, University of Pennsylvania, and Mill Creek Hospital in Erie, PA. The aforementioned is a Community Psychiatry Fellowship program that will produce psychiatrists who may eventually work in the community-based MH system or in the state mental hospital system. There is no formal relationship guaranteeing these doctors will become employees in either setting.

The SMHA has initiatives to improve the quality of the mental health workforce. Pennsylvania state mental hospitals provide ongoing training to staff and promote participation in trainings and education that maintain credentialing and certifications.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. Its relationships with professional schools include the following: The state mental hospitals have relationships with professional Schools of Nursing (29), Social Work (18), Occupational Therapy (35), Psychology (29), Psychiatry (9), Medicine (5), Physician's Assistant (3), Therapeutic Recreational (9), Continuing Ed (1), Pharmacy (1), Dietary (1); Pastoral Care (1); Art Therapy (1); Medical Records (1), and Staff Development (1).

Pennsylvania reimburses adult consumer peer specialists through Medicaid for providing mental health services. Specialized therapeutic interaction is conducted by self-identified current or former consumers who are trained and certified to help others in their recovery (certification process/training curriculum).

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 281,140 persons received behavioral health services under the managed care plan in 2008. Services in the second 1915(b) waiver are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization.

Custody Relinquishment:

Pennsylvania 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. The SMHA-funded county-based services are available based on income and ability to pay. Pennsylvania also has a policy that allows children younger than 21 to become eligible for medical assistance based on disability rather than on their parents' income.

Telemedicine:

The SMHA promotes the use of telemedicine. Telemedicine projects are in place in several areas of Pennsylvania.

Electronic Health Records (EHRs):

The SMHA has some EHR activities or plans for state hospitals and community mental health programs. The SMHA is considering the adoption of an EHR in community mental health programs and has explored possible software products for the 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

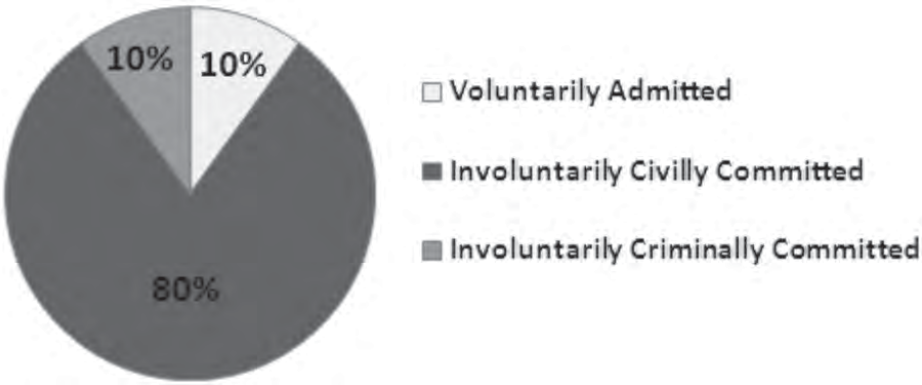
State Psychiatric Hospitals:

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 seven SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Adults	Yes	Yes	Yes
Elderly	No	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There have been declines in general hospital specialty unit psychiatric beds, state psychiatric hospital beds, and private psychiatric hospital beds since 2008; however, the state is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, the SMHA has helped organize and cochair the PA CARES task force, a collaborative effort of over 20 organizations including DPW, the Department of Health, the Department of Military and Veterans Affairs, county mental health authorities, colleges and universities, vocational rehabilitation, the Association for the Blind, clergy, and other organizations as well as veterans. PA CARES has sponsored or delivered more than 30 events aimed at program development, training, education, and public awareness.

Pennsylvania has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. However, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Rhode Island 2009

Department of Mental Health, Retardation & Hospitals 14 Harrington Road Cranston, RI 02920 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 to reach their full potential.

Statistics:

State Population (2007):	1,057,832
Number of Persons Served (2008):	29,045
Utilization Rate for Adults:	25.5 per 1,000
Utilization Rate for Children:	34.2 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$111.7 million
Revenue From Medicaid	$95.6 million
Expenditures for Community Mental Health Services (71% of Total Mental Health Agency Revenues)	$78.7 million
Per Capita State Mental Health Expenditures	$106.47

New Financing Initiatives:

Rhode Island is undertaking two new financing initiatives: (1) expansion of Medicaid funding to over Cost Not Otherwise Matchable under the Global Waiver demonstration; and (2) establishment of Acute Care/ Stabilization services funded through Medicaid.

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 Services	Part of the SMHA
Brain Impaired Services	Part of the SMHA
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	No responsibility

Location of Other State Agencies in Relation to the SMHA:

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

The Number of Mental Health Providers the SMHA Operates or Funds:

Mental Health Providers	SMHA Operated	SMHA Funded	Total
Community Mental Health Providers	0	9	9
General Hospitals With Separate Psychiatric Units	1	0	1

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives to restructure Rhode Island's community-based system of mental health service delivery. One such initiative is a consumer-oriented system of care pilot for Community Support Program (CSP) clients at selected community mental health centers (CMHCs). Another initiative is the program under the existing Medicaid Rehabilitative Services option to extend current residential coverage to allow for the development of a high-intensity, hospital diversion/stepdown program to be offered by any willing CMHC.

Interagency Collaboration:

The SMHA is collaborating with the Department of Health on H1N1 planning specific to patients in the behavioral health system. The SMHA also consults with the Department of Health on critical incidents and complaints. The SMHA has contributed to reviews related to hospital mergers.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	9
Supported Employment	Statewide	9
Family Psychoeducation	Parts of the state	1
Integrated Mental Health/Substance Abuse Services	Statewide	9
Supported Housing	Parts of the state	2
Consumer-Operated Services	Parts of the state	4

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Rhode Island Consumer System of Care	Statewide	5

Staffing and Workforce Development Initiatives:

The SMHA has established training for local police departments on dealing with behavioral health crises using a train-the-trainer approach.

The SMHA funds the Rhode Island Council of Community Mental Health Organizations to provide training and workforce development (in a number of areas including best practices, e.g., Individual Placement and Support (IPS) and case management).

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Custody relinquishment is not a prerequisite for obtaining mental health services.

Telemedicine:

The SMHA supports the use of telemedicine.

Electronic Health Records (EHRs):

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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

The SMHA is working on providing a statewide, online critical incidents reporting system.

Client-Level Data:

The SMHA receives and maintains client-level data from CMHCs.

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. The SMHA does not operate a state psychiatric hospital.

The SMHA uses psychiatric hospital beds at the public general hospital for:

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

NA = not applicable.

Psychiatric Inpatient Bed Shortages:

Rhode Island does not experience a chronic shortage of inpatient beds; the diversion and stepdown units will help the SMHA manage the ebb and flow admissions.

Services for Armed Forces Veterans and National Guard Members:

The SMHA has not appropriated funds specifically to address the mental health needs of returning veterans and their families. The SMHA does not currently have any initiatives specifically to address mental health needs of returning veterans and their families.

South Carolina 2009

Department of Mental Health 2414 Bull Street Columbia, SC 29202 www.state.sc.us/dmh/	The South Carolina Department of Mental Health (SCDMH) provides assessment, diagnosis, and treatment to its priority populations through a network of 17 community mental health centers (CMHCs) and three 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 (2007):	4,407,709
Number of Persons Served (2008):	88,412
Utilization Rate for Adults:	17.3 per 1,000
Utilization Rate for Children:	28.7 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$287.3 million
Revenue From Medicaid	$126.8 million
Expenditures for Community Mental Health Services (64% of Total Mental Health Agency Revenues)	$182.2 million
Per Capita State Mental Health Expenditures	$65.07

New Financing Initiatives:

South Carolina is planning or implementing a change in how the delivery of mental health services is financed: 1915(i) option.

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
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
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	17	0	17
Private Psychiatric Hospitals	NA	1	1
Nursing Homes and Other ICF-MI and SNF Providers	1	2	3

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly operates community-based programs.

The SMHA is undertaking initiatives to restructure South Carolina's community-based system of mental health service delivery, for example, evaluating the concept of centralization and regionalization of CMHCs.

Interagency Collaboration:

The SMHA is working with other South Carolina government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services:

- The school-based team provides a continuum of services at school sites to address the needs of youth and their families. All clinical services are voluntary and require parental permission. Services include: primary prevention, for example, helping to increase parental involvement in school and helping to coordinate activities related to a violence prevention initiative; early intervention and services to youth dealing with transitions and milestones, for example, social skills training and school transition programs; and individual and family services such as individual, family, and group counseling, crisis intervention, mentoring, and tutoring.
- The South Carolina Vocational Rehabilitation Department (SCVRD) and SCDMH have collaborated to implement supported employment programs that follow evidenced-based best practices in South Carolina. This partnership between the two state agencies has helped individuals with severe psychiatric disabilities achieve competitive employment in the community.
- SCDMH also partners with the South Carolina Department of Juvenile Justice (DJJ) to serve clients diagnosed with mental illness.

South Carolina has initiatives such as the Veterans Policy Academy, Duke Endowment for Telepsychiatry in ER/ED, Blue Cross/Blue Shield Rural Initiative, and Psychiatric Residential Treatment Facility (PRTF) children's waiver to transform the way it delivers mental health services.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	Yes	Yes	Yes	Yes
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	Yes	Yes	Yes

The SMHA collaborates with the state health department, Medicaid agency, Primary Healthcare Association, and the Department of Alcohol and Other Drug Abuse Services (DAODAS) to increase the recognition and treatment of persons with mental illness by primary care providers, the Medicaid State Plan, Rural Health Initiatives, ACCESS Health, and the South Carolina Hospital Association.

The SMHA works with public providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. Case managers identify clients without primary care providers and refer them to community health clinics to monitor basic health needs.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: South Carolinians understand that mental health is essential to overall health. Health screenings, assessments, and service referrals are common practices in SCDMH. Mental healthcare is consumer and family driven in South Carolina. A few of the SCDMH initiatives are the following:

- The Office of Public Affairs produces Palmetto MediaWatch, Get the Conversation Started initiative, and the Lighting the Way event, a collaborative with the Mental Illness Recovery Center, Inc. (MIRCI); coordinates the OASIS project; and produces an Anti-Stigma Campaign, "Good Mental Health Makes Good Sense."
- SCDMH empowers clients by hiring them to be planners, policymakers, program evaluators, and service providers.
- Shared Decision-Making (SDM) is an interactive process occurring within a therapeutic alliance between a physician and client.
- Making Recovery Real in Mental Health Care Project is a SAMHSA/CMHS SDM project in which South Carolina participates. The project is being developed under a contract with Advocates for Human Potential, Inc. (AHP), and Westat to design, develop, and pilot test SDM products. The work plan for the SDM project calls for regular input and feedback from a Planning Team, an advisory group of researchers, policymakers, consumers, family members, and practitioners.
- The CAPSS Newsletter provides specialized information on client issues, at the center, state, and national levels for self-identified employees and to the public. SCDMH designed this quarterly newsletter to foster information sharing and to develop a greater sense of community.
- The Committee to Preserve and Restore Historic Cemeteries is a consortium of concerned citizens, as well as public and private agencies, dedicated to the dignified and respectful treatment of people buried in public cemeteries.
- The South Carolina Emergency Planning Sub-Committee for Special Populations is a course intended to provide those with responsibilities for providing emergency planning or care of seniors, people with disabilities, and/or special needs groups with the skills and knowledge they will need to prepare for, respond to, and recover from emergency situations. The target audience for this course includes emergency managers, senior first-response personnel, special needs coordinators, human services organizational personnel, facility planners, community-based organizational personnel, advocacy group personnel, elected officials, public health personnel, and Voluntary Organizations Active in Disaster (VOAD) personnel.
- The South Carolina Disability Vote Coalition is a nonpartisan coalition dedicated to increasing the number of people with disabilities who vote through voter education and improved access to the voting process.

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
Family Psychoeducation	Parts of the state	NR
Integrated Mental Health/Substance Abuse Services	Parts of the state	2
Supported Housing	Statewide	1,619
Multisystemic Therapy (Conduct Disorder)	Parts of the state	5
Therapeutic Foster Care	Parts of the state	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
School-Based Services	Available in parts of the state	450
Multisystemic Therapy	Available in parts of the state	4
Peer Support Services	Available in parts of the state	28

Staffing and Workforce Development Initiatives:

The SMHA consistently has difficulty maintaining specialized staff, especially psychiatrists and registered nurses. Initiatives to reduce staff shortages include recruitment bonuses, which are permitted under the state guidelines. However, these bonuses have been limited to the budgeted funds available at each hospital or mental health center. For psychiatrists, the Office of the Comptroller General has allowed a flat agency fee for recruitment, but current budget funds have prevented this activity. Requests for capital dedicated for retention of staff have gone unfunded.

The SMHA now has online curriculums for Public Safety, Certified Nursing Assistant, and Mental Health Specialist. These curriculums are designed to increase their knowledge and ability to perform their duties.

The SMHA also has initiatives to improve the quality of the mental health workforce: leadership and mentoring programs; a vast array of distance learning opportunities, classroom learning, face-to-face and grand rounds; tuition assistance programs, and mental health specialist training. During July 1, 2008, through June 30, 2009, the Division of Education, Training, and Research provided the following continuing education credits to SCDMH staff for use toward relicensure:

- **Continuing Medical Education –** 37 hours;
- **General Hours –** 14.34 CEUs or 143.4 contact hours;
- **Social Work –** 1.30 CEUs or 13 contact hours;
- **Licensed Professional Counselor/Licensed Marriage and Family Therapist –** 3.85 CEUs or 38.5 contact hours; and
- **Nursing –** 21 contact hours.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, DVD training, and Webinars. There are 50 online learning modules. Of those 50, 44 are mandatory for staff, based on their duties and credentials. These modules are required by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the South Carolina Department of Health and Environmental Control (DHEC), the South Carolina Occupational Safety and Health Administration (OSHA), and/or requirements of other

regulatory agencies. If the modules were not available, staff would have 44 hours of in-classroom training to take, not including travel time. For the clinical staff, such training and travel time would have a negative impact on their productivity and billable hours. The estimated man-hour cost savings to SCDMH for the online learning modules for FY 2008/FY 2009 is $4,283,796. This amount is based on 5,100 employees at an average hourly wage of $19.09.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, and nursing. For example, SCDMH has a contract with the University of South Carolina School of Medicine (USC SOM), Department of Neuropsychiatry and Behavioral Science (NPSY), for NPSY to provide clinical consultation and training to the SCDMH staff. In addition, there are four fully accredited psychiatric residency training programs (child, general, gero-psych, and forensics) that rotate through the SCDMH centers and facilities.

South Carolina reimburses adult consumer peer specialists through Medicaid for providing mental health services. Peer Support is a Medicaid-reimbursable service.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care.

Custody Relinquishment:

South Carolina 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. However, no children had their parents' custody relinquished in 2008 in order to receive mental health services.

Telemedicine:

The SMHA promotes the use of telemedicine. With the Duke Foundation Grant that SCDMH received, 14 hospitals will utilize this technology to provide telepsychiatry to local emergency room departments, and access to this technology will be offered to all hospitals in South Carolina.

Electronic Medical Records (EMR):

The SMHA is considering the adoption of an EMR in state hospitals. The SMHA is installing an EMR in community mental health programs. The SMHA is operating an EMR in 10 of the 17 community mental health programs. The state uses a single EMR system for all community mental health providers. Local providers do not use a variety of EMR systems.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. The South Carolina Health Exchange enables providers to view clinical data, including medications, diagnoses, procedures, and common problems, which positively impacts continuity and quality of patient care and helps control costs. The link to the South Carolina Health Exchange Web site is www.schiex.org.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA does not receive information for all community providers. The SMHA receives information for only some providers like the SCDMH CMHCs (by far, the largest providers), not for private community programs.

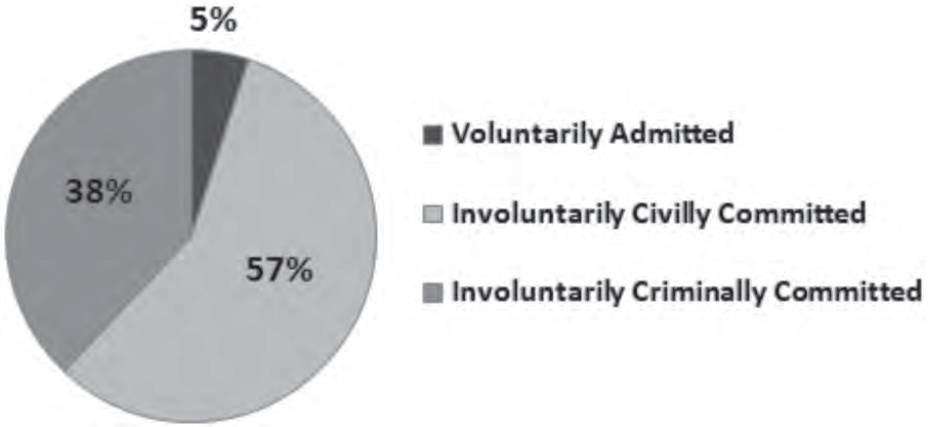
State Psychiatric Hospitals:

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 hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

South Carolina is experiencing a shortage of psychiatric beds. There have been declines in state psychiatric hospital beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, South Carolina was 1 of 10 states to attend a SAMHSA Policy Academy and has developed a statewide committee of state agencies, the VA, the National Guard, military installations, universities, veterans groups, and NAMI, working to develop a coordinated array of treatment, employment, and other services for veterans and their families.

South Carolina has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. However, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

South Dakota 2009

Division of Mental Health Department of Human Services 3800 East Highway 34 Hillsview Properties Plaza c/o 500 East Capitol Avenue Pierre, SD 57501 http://dhs.sd.gov/dmh/	The Division of Mental Health's mission is to ensure children and adults with mental health disorders in our 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 community mental health centers (CMHCs). The principal responsibilities of the Division of Mental Health are to establish policy, to develop and administer the implementation of the Community Mental Health Services Block Grant, to determine and establish reasonable standards and requirements for the locally operated CMHCs, and to enter into the purchase of service agreements to assist with 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 South Dakota s adult and juvenile correctional facilities.

Statistics:

State Population (2007):	796,214
Number of Persons Served (2008):	12,391
Utilization Rate for Adults:	12.4 per 1,000
Utilization Rate for Children:	25 per 1,000

New Financing Initiatives:

South Dakota is not planning or implementing a change in how the delivery of mental health services is financed at this time.

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 Services	Shared with another agency
Brain Impaired Services	No responsibility
Alzheimer's Disease and Organic Brain Syndrome Services	Shared with another agency
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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Same umbrella department as the SMHA
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
Community Mental Health Providers	0	11	11

Primary Mechanism Used To Deliver Community Mental Health Services:

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

Interagency Collaboration:

The SMHA is working with other South Dakota government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The Children's System of Care implementation and pilot program continue to reduce barriers between delivery systems. The Co-Occurring initiative also promotes seamless delivery between the systems.

South Dakota has initiatives to transform the way it delivers mental health services. System of Care, recovery, and co-occurring initiatives with cultural competency elements throughout have led to restructuring of services for adults and children.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	No	Yes
Employment	Yes	No	NR	Yes
Juvenile Justice	Yes	NR	NR	Yes
Criminal Justice	Yes	NR	NR	NR
Education	Yes	No	NR	Yes
Child Welfare	Yes	NR	NR	Yes
Medicaid	No	Yes	No	No
Substance Abuse	Yes	No	NR	Yes
National Guard	Yes	NR	NR	NR

NR = not reported.

The SMHA has the following initiative to promote the understanding that mental health is essential to overall health: The Primary Care Grant funded through the Wellmark Foundation increases communication/collaboration with primary care doctors and community mental health providers.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	4
Integrated Mental Health/Substance Abuse Services	Parts of the state	NR
Illness Self-Management	Parts of the state	NR
Supported Housing	Parts of the state	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
Wraparound	Available in parts of the state

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), and social workers (master's level and above) in state psychiatric hospitals and community mental health programs.

The SMHA has initiatives to improve the quality of the mental health workforce. The Transformation Transfer Initiative develops systems of care and provides training for workforce development; the Co-Occurring State Infrastructure Grant (COSIG) provides training for the workforce and is a catalyst for integrated care.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through video conferencing and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work and psychiatry. Its relationships with professional schools include providing classroom presentations and clinical faculty internships and residencies.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

South Dakota 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 by establishing telepsychiatry as a reimbursable service under State Medicaid. The SMHA also utilizes telemedicine for psychiatric services in correctional mental health.

Electronic Health Records (EHRs):

The SMHA has no EHR activities or plans for community mental health programs. 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for only providers that receive funding through the SMHA.

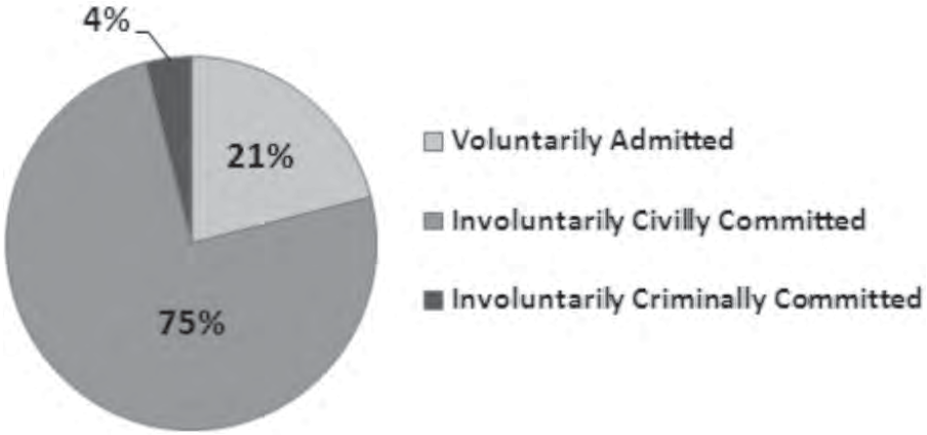
State Psychiatric Hospitals:

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. The SMHA does not operate state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

South Dakota is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Initiatives implemented by South Carolina have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. An example is the work of CMHCs with South Dakota's National Guard to ensure guardsmen and their families receive needed services.

Tennessee 2009

Tennessee Department of Mental Health & Developmental Disabilities Cordell Hull Building, 3rd Floor Nashville, TN 37243 www.state.tn.us/mental/	The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) contracts with community mental health agencies (CMHAs) for Behavioral Health Safety Net (BHSN) services, a clinical services program for adults who qualify as low income with SPMI who are not Medicaid eligible. The department 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 is responsible for provision and oversight of services to children in or at risk of state custody. The Bureau of TennCare is the state s Medicaid agency.

Statistics:

State Population (2007):	6,156,719
Number of Persons Served (2008):	182,541
Utilization Rate for Adults:	27.7 per 1,000
Utilization Rate for Children:	35.8 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$598.2 million
Revenue From Medicaid	$414.8 million
Expenditures for Community Mental Health Services (69% of Total Mental Health Agency Revenues)	$414.8 million
Per Capita State Mental Health Expenditures	$97.62

New Financing Initiatives:

Tennessee is planning or implementing a change in how the delivery of mental health services is financed. A category of individuals with SPMI who had behavioral health services (but not physical health services) covered by the TennCare program has been eliminated by TennCare and picked up by TDMHDD's BHSN, effective January 1, 2009. The BHSN is not an insurance program like TennCare but does provide a package of mental health services, including assessment, evaluation, therapy, case management, and medication management.

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Part of the SMHA
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
State Psychiatric Hospitals	5	0	5
Community Mental Health Providers	0	45	45
Private Psychiatric Hospitals	NA	4	4

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives to restructure Tennessee's community-based system of mental health service delivery.

Interagency Collaboration:

The SMHA is working with other Tennessee government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The state has initiatives to transform the way it delivers mental health services. The SMHA has two self-directed care pilots.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	No	No	Yes
Criminal Justice	No	No	No	No
Education	Yes	No	No	No
Child Welfare	No	No	No	No
Medicaid	Yes	No	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	Yes	No	Yes

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. There are integrated TennCare physical/mental health managed care contracts in all regions of the state; the SMHA collaborates with Department of Health primary care staff, federally qualified health centers (FQHCs), and TennCare managed care companies.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The SMHA promotes integrated treatment and provides educational awareness activities related to increased mortality rates for persons with serious mental illnesses.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: In 2006, the Commissioner of TDMHDD initiated a personal "Overcoming Stigma Campaign." This is a multiyear project to take the message that mental health consumers are our friends, family members, coworkers, and neighbors and that mental illness is treatable.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	2
Supported Employment	Statewide	5
Medication Algorithms (Schizophrenia)	Pilot program	1
Family Psychoeducation	Parts of the state	2
Integrated Mental Health/Substance Abuse Services	Statewide	8
Illness Self-Management	Parts of the state	132 WRAP classes
Supported Housing	Statewide	8
Consumer-Operated Services	Statewide	49
Multisystemic Therapy (Conduct Disorder)	Parts of the state	1
Therapeutic Foster Care	Statewide	NR

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Project BASIC (Better Attitudes and Skills in Children)	Statewide	47
Regional Intervention Program (RIP)	Parts of the state	8
Peer Support	Statewide	49
Peer Specialist	Parts of the state	12

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, advanced practice nurses, nurse practitioners, and clinical nurse specialists (master's level and above), registered nurses, and pharmacists in state psychiatric hospitals and community mental health programs.

The SMHA has initiatives to improve the quality of the mental health workforce. The SMHA has expanded the use of peer specialists, through training and certification, to crisis stabilization units as well as to crisis teams.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through video conferencing.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, nursing, and pharmacy. Its relationships with professional schools include the following: Two Tennessee hospitals are affiliated with medical schools and serve as training sites for medical students and psychiatric residents.

The state reimburses adult consumer peer specialists through Medicaid for providing mental health services. Under the supervision of Tennessee's licensed mental health professionals and Medicaid providers, a Certified Peer Support Specialist may perform a wide range of direct peer support services as a paid employee of a community mental health agency.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care.
These behavioral health services are administered through a Medicaid Research and Demonstration (1115) waiver. Services are carved in and are provided by the primary healthcare provider networks or HMO. Approximately 171,698 persons received behavioral health services under the managed care plan in 2008, and 1,200,000 persons were covered under the plan.

Custody Relinquishment:

Tennessee 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. TDMHDD promotes state-of-the-art diagnostic systems, such as telemedicine, to increase response time for diagnosing patients, reduce stressors on persons with a potential mental illness, and eliminate transportation costs.

Electronic Health Records (EHRs):

The SMHA is 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.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. Three RHIOs operate in Tennessee. They include hospitals, so stays with mental health diagnoses would be included in the shared data.

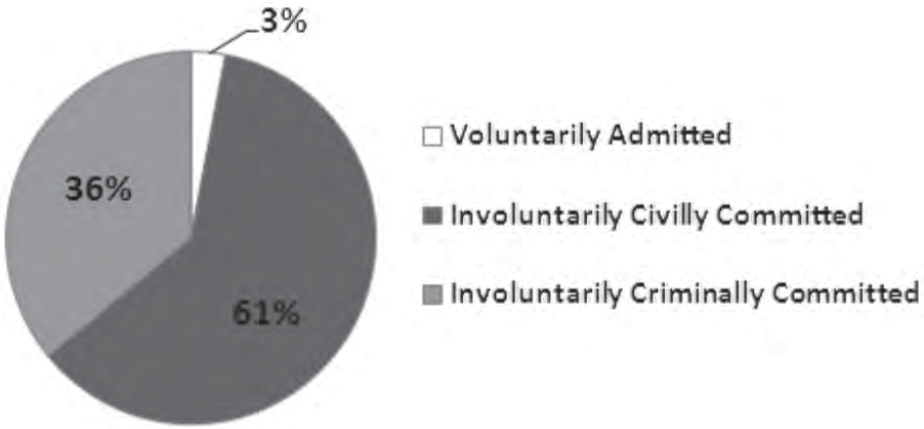
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	Yes	No	No
Adolescents	Yes	No	No
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

There have been declines in state psychiatric hospital and private psychiatric hospital beds since 2008; however, Tennessee is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. However, Tennessee has not appropriated funds specifically to address the mental health service needs of returning veterans and their families.

Texas 2009

Department of State Health Services 909 West 45th Street, Building 1 Mail Code 1536 Austin, TX 78751 www.dshs.state.tx.us/mentalhealth.shtm	The Department of State Health Services (DSHS) administers substance abuse services and public health services. Community mental health services for adults and children are administered through 37 local mental health authorities (LMHAs).

Statistics:

State Population (2007):	23,904,380
Number of Persons Served (2008):	258,470
Utilization Rate for Adults:	12 per 1,000
Utilization Rate for Children:	7.7 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$817.1 million
Revenue From Medicaid	$160.8 million
Expenditures for Community Mental Health Services (58% of Total Mental Health Agency Revenues)	$472.7 million
Per Capita State Mental Health Expenditures	$34.43

New Financing Initiatives:

Texas is planning or implementing a change in how the delivery of mental health services is financed. Texas is implementing a 1915(c) waiver for children with serious emotional disturbances (SED) in the fall of 2009. The Youth Empowerment Services (YES) waiver will enable Texas to use Medicaid funding to provide services that are not available or allowable under the Medicaid State Plan and to extend Medicaid eligibility to some children with SED who would not normally be eligible unless they were in an institutional setting. The waiver will be piloted in two counties. If successful and cost effective, the waiver will expand to serve more counties over time and could eventually be a statewide option.

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
Housing Agency	Different state department
Health Department	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	9	3	12
Community Mental Health Providers	0	37	37

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county or city community mental health authorities statewide.

Interagency Collaboration:

The SMHA is working with other Texas government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. LMHAs have benefit specialists trained to work closely with the Department of Aging and Disability Services (DADS), which will ensure that clients receive appropriate financial benefits to receive services. The Department of Family and Protective Services (DFPS) is collaborating with DSHS on psychotropic medication-prescribing protocols for children in protective foster care. The Texas Integrated Funding Initiative fosters interagency collaboration between community-based and state agencies including DSHS, DFPS, Texas Juvenile Probation Department, and Texas Education Agency to serve children and adolescents with multiple emotional and behavioral challenges. The SMHA, in collaboration with the Texas Correctional Office on Offenders with Medical or Mental Impairments, oversees the operation of local continuity of care programs designed to assist in linking individuals being released from incarceration to appropriate treatment programs.

Texas has initiatives to transform the way it delivers mental health services. The SMHA received a Mental Health Transformation Grant that is intended to promote transformation of the Texas mental health system. This grant will assist in building a solid foundation for delivering evidence-based mental health and related services. The grant also will foster recovery, improve the quality of life, and meet the needs of mental health consumers statewide. The Texas Mental Health and Substance Abuse Crisis Services Redesign Initiative is a statewide redesign of mental health crisis and substance abuse benefits provided within the mental health service delivery model called Resiliency and Disease Management.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	No	No	No	No
Juvenile Justice	Yes	Yes	Yes	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education	No	Yes	Yes	Yes
Child Welfare	Yes	No	No	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	No	Yes	Yes
National Guard	No	No	No	No

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The Early Childhood Mental Health Initiative and the Adolescent Behavioral Health Screening Project work to foster early detection and treatment in these populations.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The Adolescent Behavioral Health Screening Project coordinates services with LMHAs and federally qualified health centers to refer adolescents with healthcare needs to appropriate healthcare providers.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: DSHS contracts with Mental Health America of Texas to implement two public information programs targeting Hispanic and African American youth. These programs address the goals of reducing stigma associated with the treatment of mental illness; promote the message that mental health is essential to overall health; reduce barriers to minorities receiving mental health services; promote early screening, assessment, referral, and treatment; and promote the mental health of young people.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Statewide	38
Supported Employment	Statewide	38
Medication Algorithms (Schizophrenia)	Statewide	38
Medication Algorithms (Bipolar Disorders)	Statewide	38
Family Psychoeducation	Statewide	0
Integrated Mental Health/Substance Abuse Services	Statewide	38
Illness Self-Management	Statewide	38
Supported Housing	Statewide	38
Consumer-Operated Services	Parts of the state	7
Multisystemic Therapy (Conduct Disorder)	Parts of the state	3

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Infant Mental Health Training	Available statewide	1

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), registered nurses, licensed vocational nurses (LVNs), and pharmacists in state psychiatric hospitals and community mental health programs. The SMHA has special university-based training initiatives, offers training at mental health programs/providers, and offers increased salaries as well as recruitment bonuses or other financial incentives to address staffing shortages. Other initiatives to reduce staff shortages include Terrell State Hospital, which developed an innovative program that bridges high school students toward a career track as a registered nurse. This program benefits the Health and Human Services Commission, DSHS, along with Terrell State Hospital, as the nursing shortage increases. The program builds a connection between Terrell State Hospital and Terrell Independent School District by providing an opportunity to develop nurses for the community and DSHS. This program is being shared with the other state hospitals for possible implementation.

The SMHA has initiatives to improve the quality of the mental health workforce. Healing Today, Hope for Tomorrow is a 20-hour interactive training program designed to help shift the culture of the state hospitals toward a more patient-focused treatment with the ultimate goal of reducing the use of restraint and seclusion. This training program is required of all state hospital employees. Key elements of the training modules include: agency and facility value; how personal history of patients and staff impact their behaviors and interactions with others; trauma-informed care; application of the principles of the Antecedents, Behaviors, and Consequences (ABC) model; and therapeutic communication techniques.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, nursing, occupation therapy, music therapy, and recreational therapy. Its relationships with professional schools include the following: Students in the various schools are trained by staff in the hospital setting within their area of expertise. This training is also an effective tool for recruitment of students into professional positions. A Memorandum of Agreement is in place with all the professional schools.

Texas reimburses adult consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved in and are provided by the primary healthcare provider networks or HMO. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 73,326 persons received behavioral health services under the managed care plan in 2008. Services in the second 1915(b) waiver are carved in and are provided by the primary healthcare provider networks or HMO. Services in the second 1915(b) waiver are carved out to a specialty behavioral healthcare network or managed behavioral health organization. About 18,469 persons received behavioral health services under the second 1915(b) waiver last year, and 154,992 persons were covered under the plan. Services in the third 1915(b) waiver are carved in and are provided by the primary healthcare provider networks or an HMO. Services in the third 1915(b) waiver are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Services in the fourth 1915(b) waiver are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 53,484 persons received behavioral health services under the fourth 1915(b) waiver in 2008, and 983,000 persons were covered under the plan.

Custody Relinquishment:

Texas 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 number of children who had their parents' custody relinquished in 2008 in order to receive mental health services was not available.

Telemedicine:

The SMHA promotes the use of telemedicine. Texas has long allowed physician-to-physician consultations via telemedicine, and the SMHA has allowed LMHAs to utilize telemedicine as a means of delivering telemedicine services for several years.

Electronic Health Records (EHRs):

The SMHA is installing an EHR 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

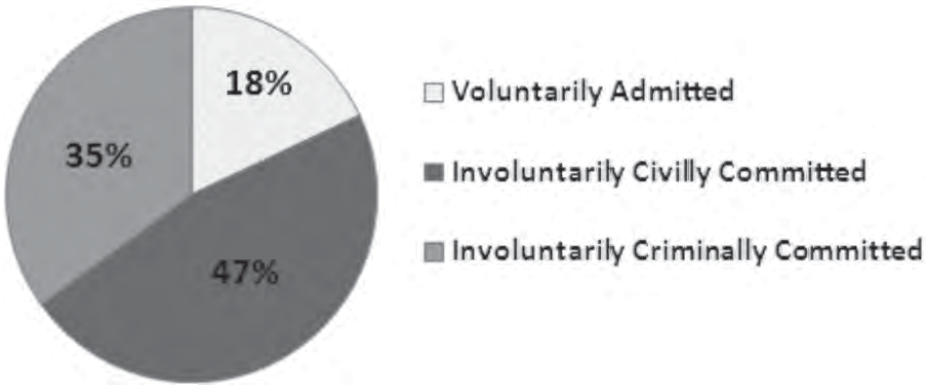
State Psychiatric Hospitals:

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 nine SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Texas is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have included Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. The Mental Health Transformation Working Group (TWG) is a partnership of the Governor's office, state and federal agencies, and consumers and is funded by SAMHSA's Mental Health Transformation State Incentive Grant program. Partners Across Texas, a collaborative effort of federal, state, and local organizations, provides resources to active and retired members of the military and their families. In FY 2009, the Texas Legislature appropriated $1.2 million for FY 2010 to FY 2011 to the SMHA to help address veterans' mental health needs. Additionally, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Utah 2009

Division of Substance Abuse & Mental Health Department of Human Services 195 North 1950 West Salt Lake City, UT 84116 www.dsamh.utah.gov/	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 that administer public mental healthcare through community mental health centers (CMHCs). The division is one of eight divisions and offices under the Department of Human Services. Under Utah law, local substance abuse and mental health authorities are responsible for providing services to their residents. A local authority is generally the governing body of a county. Some counties have joined together to provide services to their residents. There are 29 counties and 13 local authorities in Utah. By legislative intent, no substance abuse center or CMHC is operated by the state. Some local authorities contract with community substance abuse centers and mental health centers, which provide comprehensive services. Local authorities not only receive state and federal funds, they are required by law to match a minimum of 20 percent of the state general funds. However, counties statewide overmatch and contribute approximately 44 percent for substance abuse and mental health combined.

Statistics:

State Population (2007):	2,645,330
Number of Persons Served (2008):	38,784
Utilization Rate for Adults:	13.7 per 1,000
Utilization Rate for Children:	16.8 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$172.8 million
Revenue From Medicaid	$116.8 million
Expenditures for Community Mental Health Services (70% of Total Mental Health Agency Revenues)	$121 million
Per Capita State Mental Health Expenditures	$64.93

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Part of the SMHA
Housing Agency	Different state department
Health Department	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	1	0	1
Community Mental Health Providers	0	13	13

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county or city mental health authorities statewide.

Interagency Collaboration:

The SMHA is working with other Utah government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services.

Utah has initiatives to transform the way it delivers mental health services. Integrated physical and behavioral healthcare, person-centered treatment planning, recovery-based services, and a CMHS-funded transitional services grant are examples of some of the collaborative initiatives in Utah.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	No	Yes
Juvenile Justice	Yes	No	No	Yes
Criminal Justice	Yes	Yes	NR	Yes
Education	Yes	Yes	No	Yes
Child Welfare	Yes	NR	NR	NR
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	NR	NR	NR

NR = not reported.

The SMHA has a longstanding collaborative relationship with Utah's Department of Health (DOH) and Medicaid agency. SMHA agency staff collaborate with other state agencies, local provider agencies, private foundations, and consumer and advocacy organizations to increase the recognition and treatment of persons with mental illness by other agencies and primary care providers.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses.

The SMHA has the following initiative to promote the understanding that mental health is essential to overall health: The Utah SMHA mandated in 2008 that all public mental health providers will have a policy addressing the physical healthcare of consumers.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	3
Supported Employment	Statewide	7
Medication Algorithms (Schizophrenia)	Statewide	13
Medication Algorithms (Bipolar Disorders)	Statewide	13
Family Psychoeducation	Parts of the state	11
Integrated Mental Health/Substance Abuse Services	Parts of the state	9

Evidence-Based Services (Continued):

Evidence-Based Practices	Implementation	Number of Programs
Illness Self-Management	Parts of the state	NR
Supported Housing	Parts of the state	8
Consumer-Operated Services	Parts of the state	NR
Multisystemic Therapy (Conduct Disorder)	Parts of the state	1
Therapeutic Foster Care	NR	1
Functional Family Therapy	Parts of the state	2

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
School-Based Interventions	Available in parts of the state
Consumer-Run Services	Available in parts of the state
Trauma-Based Care	Available in parts of the state
Wellness Clinic	Available in parts of the state

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), and registered nurses in state psychiatric hospitals and community mental health programs. The SMHA has offered increased salaries to address staffing shortages.

The SMHA has initiatives to improve the quality of the mental health workforce. The SMHA is one of the primary sponsors of a statewide mental health conference focused on treatment across the lifespan, called the Generations Conference. The SMHA provides approximately 250 scholarships to mental health staff around Utah.

The SMHA also is using technology (e-learning) to improve the training of the workforce while limiting travel through video conferencing and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychiatry, and nursing.

Utah reimburses adult consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

In 11 of the 13 local mental health authorities, mental health services are being delivered through a prepaid mental health plan. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 40,426 persons received behavioral health services under the managed care plan in 2008. In two of the smaller, more rural counties, mental health services are provided in a Medicaid fee-for-service arrangement.

Custody Relinquishment:

Utah 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. Behavioral health services for children and youth in the custody of the Division of Child and Family and the Division of Juvenile Justice Services are currently provided through a behavioral health carve-out for those specific populations.

Telemedicine:

The SMHA promotes the use of telemedicine. Telemedicine primarily uses video-conferencing equipment, which is installed in all centers across the state, and all centers are linked through a central hub.

Electronic Health Records (EHRs):

The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

The SMHA has formal involvement with the Utah DOH and its Health Information Exchange (HIE) effort. The SMHA is a member of the DOH strategic planning committee for the HIE.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

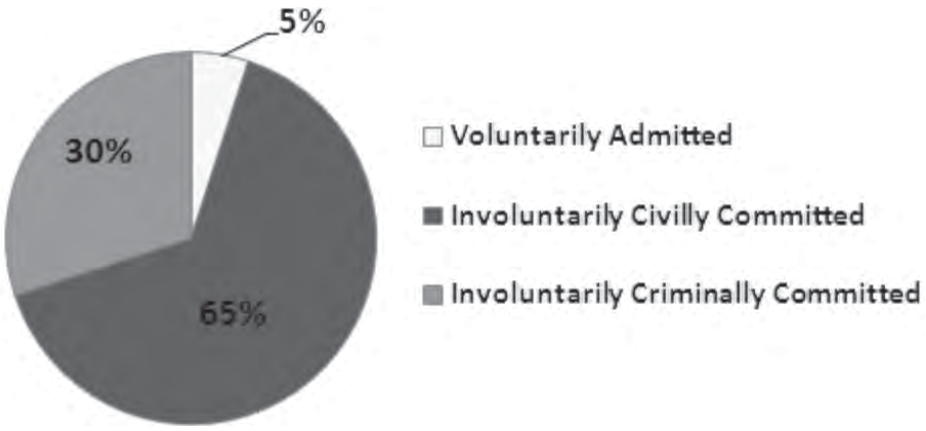
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less than 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (more than 90 days)
Children	No	Yes	Yes
Adolescents	No	Yes	Yes
Adults	Yes	Yes	Yes
Elderly	Yes	Yes	Yes
Forensic	Yes	Yes	Yes

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Utah 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:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel.

Utah created a Department of Veterans Affairs that has appropriated funds specifically to address the mental health service needs of returning veterans and their families.

Vermont 2009

Department of Mental Health Agency of Human Services 103 South Main Street Waterbury, VT 05671 http://healthvermont.gov/mh/mhindex.aspx	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 geographical 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 (2007):	621,254
Number of Persons Served (2008):	21,383
Utilization Rate for Adults:	25.2 per 1,000
Utilization Rate for Children:	68.6 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$132.6 million
Revenue From Medicaid	$109.2 million
Expenditures for Community Mental Health Services (82% of Total Mental Health Agency Revenues)	$109.3 million
Per Capita State Mental Health Expenditures	$213.82

New Financing Initiatives:

Vermont is planning or implementing a change in how the delivery of mental health services is financed. The state is currently under a Global Commitment waiver and seeking renewal of existing conditions.

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 Services	Shared with another agency
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
Housing Agency	Same umbrella department as the SMHA
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
General Hospitals With Separate Psychiatric Units	0	4	4

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA directly operates local community-based agencies.

Interagency Collaboration:

The SMHA is working with other Vermont government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. There are new or existing grant initiatives for co-occurring disorders, a returning veterans' initiative, a transition age youth initiative, and a trauma-informed system of care response. The SMHA also collaborates with vocational rehabilitation services and with the chief justice task force.

Vermont has initiatives to transform the way it delivers mental health services. An example is the Vermont Integrated Services Initiative (VISI) for co-occurring disorders of mental illness and substance abuse.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	No
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	No	Yes	No
Criminal Justice	Yes	No	No	Yes
Education	No	No	No	Yes
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	No	Yes	No
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	No	No	Yes

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. Utah continues to advance healthcare through innovative solutions such as its Blueprint for Health Initiative, Depression Screening, and Pediatric Collaborative for Children and Families.

The SMHA works with public providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. An example is the SMHA's collaboration with the Vermont Chronic Care Initiative to provide care coordination services.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	1
Supported Employment	Statewide	10
Integrated Mental Health/Substance Abuse Services	Statewide	10
Illness Self-Management	Parts of the state	1
Supported Housing	Statewide	10
Consumer-Operated Services	Parts of the state	NR
Therapeutic Foster Care	Statewide	1

NR = not reported.

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
Recovery Education	Available statewide
Dialectical Behavioral Therapy	Available in parts of the state

Managed Behavioral Healthcare:

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

Custody Relinquishment:

Vermont 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. The SMHA is working with Vermont's Medicaid Authority to increase the availability of telemedicine services.

Electronic Health Records (EHRs):

The SMHA is installing 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.

The SMHA has a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information. Vermont's HIE is in development (see www.VITL.net).

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community 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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:

Psychiatric Inpatient Bed Shortages:

There have been declines in general hospital specialty unit psychiatric beds and state psychiatric hospital beds in the last 5 years; however, Vermont is not experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, and family members of military personnel; for example, the SMHA jointly sponsored a conference on returning veteran and family support needs and resources.

Vermont has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is no arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Virginia 2009

Department of Behavioral Health & Developmental Services 1220 Bank Street Richmond, VA 23219 www.dbhds.virginia.gov	Virginia s Department of Behavioral Health and Developmental Services (DBHDS) is working with a broad network of stakeholders to transform the state health system to enhance community-based care for individuals, improve state facilities, and change service delivery. Its public mental health, mental retardation, and substance abuse services system comprises 40 community services boards (CSBs) and 16 state facilities. 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 (2007):	7,712,091
Number of Persons Served (2008):	121,523
Utilization Rate for Adults:	15.8 per 1,000
Utilization Rate for Children:	15.7 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$648.7 million
Revenue From Medicaid	$207.6 million
Expenditures for Community Mental Health Services (50% of Total Mental Health Agency Revenues)	$324.2 million
Per Capita State Mental Health Expenditures	$85.47

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Different state department
Substance Abuse Agency	Part of the SMHA
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
State Psychiatric Hospitals	11	0	11
Community Mental Health Providers	0	40	40

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county, city, or multijurisdictional mental health authorities statewide.

Interagency Collaboration:

The SMHA is working with other Virginia government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. These are targeted initiatives.

Virginia has initiatives to transform the way it delivers mental health services so that they are community based and recovery focused.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	No
Employment	Yes	No	Yes	Yes
Juvenile Justice	Yes	No	Yes	Yes
Criminal Justice	Yes	No	Yes	Yes
Education	No	No	Yes	No
Child Welfare	No	No	Yes	No
Medicaid	No	Yes	No	No
Substance Abuse	Yes	No	Yes	Yes
National Guard	Yes	No	Yes	No

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. DBHDS has formed relationships with state organizations representing free clinics and community health centers.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health:

- The SMHA has a partnership with the Virginia Department of Health to include mental health questions in their assessments (K-6 Psychological Distress Scale screens for serious mental illness in the general population, and the Stigma and Mental Health Behavioral Risk Factor Surveillance System (BRFSS) survey measures stress, depression, and problems with emotions).
- A SMHA representative serves on the Virginia Health Department's Epidemiology Workgroup.
- The SMHA is currently developing an antistigma short movie to be distributed throughout Virginia later in 2009.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	18
Supported Employment	Parts of the state	2
Integrated Mental Health/Substance Abuse Services	Parts of the state	1
Illness Self-Management	Parts of the state	1
Supported Housing	Parts of the state	2
Consumer-Operated Services	Parts of the state	17
Multisystemic Therapy (Conduct Disorder)	Parts of the state	2
Therapeutic Foster Care	Parts of the state	1
Functional Family Therapy	Parts of the state	1

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), social workers (master's level and above), registered nurses, and psychiatric technicians/direct services in state psychiatric hospitals and community mental health programs.

Initiatives to reduce staff shortages include: International Nurse Recruitment Program; Compensation Toolbox; Recruitment and Retention Site Plan Model; Nursing Clinical Ladder; Direct Service Assistant (DSA) to Licensed Practical Nurse (LPN) to Registered Nurse (RN) Program Community College Program; DSA Career Pathway Program; Psychiatry Loan Repayment Program; Sabbatical Leave Program; Educational Grants; Tuition Reimbursement; and Cultural and Linguistics Competency Initiatives (Education, Awareness, and Training).

The SMHA has initiatives to improve the quality of the mental health workforce. These initiatives are the DSA Career Pathway Program (College of Direct Support and Virginia Community College System); Nursing Clinical Ladder; Recovery Training; Person-Centered Planning Training; Leadership Training; and Case Management Training.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools, including Virginia Community College, to provide training in disciplines such as social work, psychology, psychiatry, and nursing. Its relationships with professional schools include: direct services support staff, career pathway program with the Virginia Community College System, and a Memorandum of Understanding.

Virginia reimburses adult consumer peer specialists through Medicaid for providing mental health services: Trained peers work in traditional mental health service settings. The Virginia Human Services Training Center (VHST) trains individuals called consumer providers who have been or are consumers of mental health services and who, with VHST training, serve as professionals in the mental health field (see http://vhst.avenue.org/index.htm).

Managed Behavioral Healthcare:

Some mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver.

Custody Relinquishment:

Virginia 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. Virginia law does not require parents to relinquish custody in order to receive mental health services.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is operating 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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all public community mental health providers.

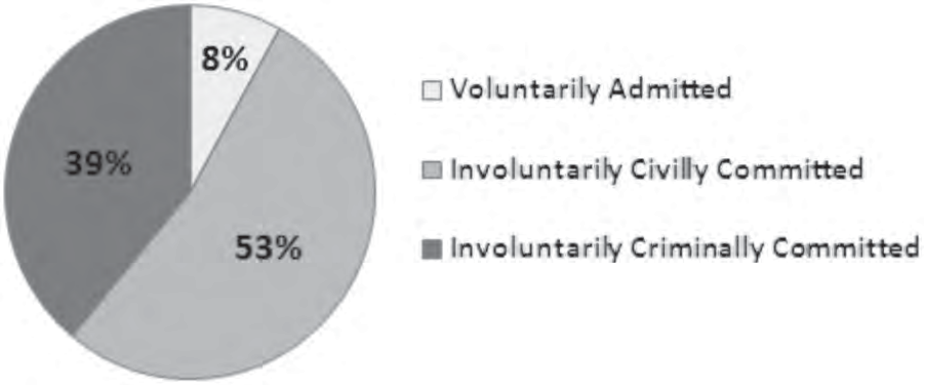
State Psychiatric Hospitals:

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 11 SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Virginia is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, the Virginia Wounded Warrior Program (VWWP) was authorized by the 2008 General Assembly and is charged with ensuring that veterans who have experienced stress-related injuries and traumatic brain injuries in combat and their families receive timely assessment, treatment, and support. The VWWP was implemented in 2008 to build capacity in the community service boards, traumatic brain injury service providers, and other community-based service providers. Additionally, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Washington 2009

Mental Health Division Department of Social & Health Services P.O. Box 45320 Olympia, WA 98501 www.dshs.wa.gov/mentalhealth/	The Mental Health Division (MHD) is a division within the Health and Recovery Services Administration (HRSA) of the Department of Social and Health Services (DSHS). This division 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 (2007):	6,468,424
Number of Persons Served (2008):	119,296
Utilization Rate for Adults:	17.8 per 1,000
Utilization Rate for Children:	20.3 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$681.6 million
Revenue From Medicaid	$457.3 million
Expenditures for Community Mental Health Services (66% of Total Mental Health Agency Revenues)	$450.3 million
Per Capita State Mental Health Expenditures	$106.29

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 Services	Part of the SMHA
Brain Impaired Services	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	Shared with another agency
Sex Offender Services	No responsibility

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Same umbrella department as the SMHA
Housing Agency	Different state department
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	3	0	3
Community Mental Health Providers	0	126	126
Private Psychiatric Hospitals	NA	4	4
General Hospitals With Separate Psychiatric Units	0	21	21
Nursing Homes and Other ICF-MI and SNF Providers	0	29	29

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county or city mental health authorities statewide.

The SMHA is undertaking initiatives to restructure Washington's community-based system of mental health service delivery. For example, the SMHA contracted with a forprofit managed care corporation to manage one of the regional support networks in 2009.

Interagency Collaboration:

The SMHA is working with other Washington government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams to enhance the provision of appropriate mental health services.

Washington has initiatives to transform the way it delivers mental health services. An example is its statewide PACT program, whose fidelity standards and the fidelity scale were revised to be more recovery oriented.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	Yes
Employment	Yes	Yes	Yes	Yes
Juvenile Justice	Yes	No	No	No
Criminal Justice	Yes	Yes	Yes	Yes
Education	No	No	No	No
Child Welfare	Yes	No	No	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	Yes	Yes	Yes
National Guard	Yes	No	No	Yes

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The SMHA has explored developing medical homes and has piloted a mental health benefit in the General Assistance Unemployable, a state-funded program.

The SMHA works with public providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. The SMHA is collaborating with efforts by the Mental Health Transformation Program.

The SMHA has the following initiative to promote the understanding that mental health is essential to overall health: In 2005 and expanded in 2007, the State of Washington passed one of the most comprehensive mental health insurance parity legislations in the country. This legislation includes protection for all covered lives in health insurance policies over which the state has authority.

Evidence-Based Services:

Evidence-Based Practices	Implementation
Assertive Community Treatment (ACT)	Parts of the state
Supported Employment	Parts of the state
Family Psychoeducation	Statewide
Integrated Mental Health/Substance Abuse Services	Parts of the state
Illness 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 and a pilot program
Therapeutic Foster Care	Parts of the state

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation
Parent Empowerment	Available in parts of the state
Wraparound	Available in parts of the state

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists and child psychiatrists in community mental health programs. To reduce staff shortages, the Eastern State Hospital provides opportunities to RNs, PLNs, and pharmacists to compete for student loan repayment.

The SMHA does not have initiatives to improve the quality of the mental health workforce.

The SMHA is not using technology (e-learning) to improve the training of the workforce while limiting travel.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, nursing, occupational therapy, physical therapy, and recreational therapy (all through Washington State hospitals). Its relationships with professional schools include Western State Hospital's contract with universities to provide student, intern, and residential rotations.

Washington reimburses adult consumer peer specialists through Medicaid for providing mental health services. Peer support counselors become certified by successfully completing the 40-hour program offered by the MHD or the Regional Support Network (RSN) and passing the certification exam and by completing the Department of Health Registered Counselor Program.

Managed Behavioral Healthcare:

Mental health services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 94,000 persons received behavioral health services under the managed care plan in 2008.

Custody Relinquishment:

The State of Washington 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 does not promote the use of telemedicine.

Electronic Health Records (EHRs):

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.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community 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 three SMHA-operated state psychiatric hospitals.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:

Psychiatric Inpatient Bed Shortages:

Washington is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel. For example, the SMHA is involved in an ongoing supportive workgroup.

The State of Washington has not appropriated funds specifically to address the mental health service needs of returning veterans and their families. However, there is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

West Virginia 2009

Bureau for Behavioral Health & Health Facilities Department of Health & Human Services 350 Capitol Street, Room 350 Charleston, WV 25301 www.wvdhhr.org/bhhf/	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 three offices: Operations, Community Programs, and Administration.

Statistics:

State Population (2007):	1,812,035
Number of Persons Served (2008):	62,413
Utilization Rate for Adults:	31.2 per 1,000
Utilization Rate for Children:	46.3 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$127.2 million
Revenue From Medicaid	$66.5 million
Expenditures for Community Mental Health Services (63% of Total Mental Health Agency Revenues)	$83.8 million
Per Capita State Mental Health Expenditures	$73.66

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 Services	Part of the SMHA
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
Housing Agency	Different state department
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	0	13	13
Private Psychiatric Hospitals	NA	3	3
General Hospitals With Separate Psychiatric Units	0	12	12
Nursing Homes and Other ICF-MI and SNF Providers	4	0	4

NA = not applicable.

Primary Mechanism Used To Deliver Community Mental Health Services:

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

The SMHA is undertaking initiatives to restructure West Virginia's community-based system of mental health service delivery. The legislative study committee has released a series of recommendations impacting the behavioral health system. Implementation teams have been formed to implement those recommendations.

Interagency Collaboration:

The SMHA is working with other West Virginia government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services.

The state has initiatives to transform the way it delivers mental health services. The bureau has begun an internal realignment. The West Virginia Comprehensive Behavioral Health Commission has issued its recommendations on transforming the state's behavioral health system.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	No
Employment	Yes	No	Yes	No
Juvenile Justice	Yes	No	No	No
Criminal Justice	NR	NR	Yes	No
Education	Yes	No	No	No
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	No	Yes	Yes
National Guard	Yes	No	No	No

NR = not reported.

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. Primary care representatives are on the Behavioral Health Commission.

Evidence-Based Services:

Evidence-Based Practices	Implementation
Assertive Community Treatment (ACT)	Parts of the state
Supported Employment	Parts of the state
Integrated Mental Health/Substance Abuse Services	Parts of the state
Illness Self-Management	Parts of the state
Supported Housing	Parts of the state
Consumer-Operated Services	Parts of the state
Therapeutic Foster Care	Parts of the state

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Suicide Prevention (Children)	Parts of the state	2
Leadership Academy	Parts of the state	1
Recovery Education	Parts of the state	1
Suicide Prevention (Adults)	Parts of the state	1

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners, and clinical specialists (master's level and above), registered nurses, licensed practical nurses (LPNs), pharmacists, medical technologists, and recreational specialists in state psychiatric hospitals. The SMHA offers educational assistance and paid educational leave to address staffing shortages. Other initiatives to reduce staff shortages include: tuition reimbursement and pay for up to 16 hours per week for educational leave related to the medical field.

The SMHA does not have initiatives to improve the quality of the mental health workforce.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings, video conferencing, and DVD training.

The SMHA has relationships with professional schools to provide training in disciplines including social work, psychology, psychiatry, nursing, pharmacy assistants, and recreational certification. Its relationships with professional schools include providing internship opportunities.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care.

Custody Relinquishment:

West Virginia 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, for example, West Virginia University Hospital's MDTV linkage with state hospitals and providers of health services.

Electronic Health Records (EHRs):

The SMHA is operating 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.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for SMHA-funded providers or Medicaid-reimbursed behavioral 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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:

Psychiatric Inpatient Bed Shortages:

West Virginia is experiencing a shortage of psychiatric beds.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed veterans, National Guard members, the Reserve, and family members of military personnel. Some examples follow: The SMHA works with the federal VA. The Council of Churches donates a professional to work with returning veterans. Under the Data Infrastructure Grant (DIG), the SMHA has begun collecting information on veterans and their families.

West Virginia has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Wisconsin 2009

Division of Mental Health & Substance Abuse Services Department of Health Services 1 West Wilson Street, Room 850 Madison, WI 53703 http://dhs.wisconsin.gov/mh bcmh/index.htm	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 (2007):	5,601,640
Number of Persons Served (2008):	91,966
Utilization Rate for Adults:	18.6 per 1,000
Utilization Rate for Children:	9.2 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$585.8 million
Revenue From Medicaid	$154.3 million
Expenditures for Community Mental Health Services (69% of Total Mental Health Agency Revenues)	$401.1 million
Per Capita State Mental Health Expenditures	$104.69

New Financing Initiatives:

Wisconsin is planning or implementing a change in how the delivery of mental health services is financed.

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 Services	Part of the SMHA
Brain Impaired Services	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
Prisons and Jails	Partial responsibility

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
Housing Agency	Different state department
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	1	3
Community Mental Health Providers	0	67	67

Primary Mechanism Used To Deliver Community Mental Health Services:

The SMHA funds county or city mental health authorities statewide.

The SMHA is undertaking initiatives to restructure Wisconsin's community-based system of mental health service delivery. Starting in the fall of 2005, there was a shift in focus in Wisconsin away from a proposed managed care model that included behavioral health services that are beyond outpatient services, to an integrated model of services and supports. These services and supports braid together Medicaid HMO services including both psychiatric inpatient and outpatient care with psychosocial rehabilitation services provided by local counties.

Interagency Collaboration:

The SMHA is working with other Wisconsin government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. Collaborative efforts include: combined funding to do mental health screening in the child welfare system; combined funding and collaborating with the Department of Public Instruction (education) to train schools to reduce the use of seclusion and restraint.

Wisconsin has the following initiatives to transform the way it delivers mental health services:

- Comprehensive Community Services (CCS) programs (psychosocial rehab option) have been implemented in new counties every year since 2005. The CCS program requires collaborative agreements with mental health programs and other agencies involved with consumers.
- The Coordinated Service Team (CST), the wraparound program for children, also requires collaborative agreements with mental health, schools, child welfare, juvenile justice, and any other agency with which a child is involved.
- Providers and consumers across Wisconsin are being trained in Person-Centered Planning.
- The Trauma-Informed Care Initiative is an effective approach for providers working with trauma survivors.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	No	Yes	Yes
Employment	Yes	No	No	No
Juvenile Justice	Yes	No	No	Yes
Criminal Justice	Yes	Yes	Yes	Yes
Education (Department of Instruction)	Yes	No	Yes	Yes*
Child Welfare	Yes	Yes	Yes	Yes
Medicaid	Yes	Yes	Yes	Yes
Substance Abuse	Yes	No	Yes	Yes
National Guard	Yes	No	No	No

*CCS and CST in many cases coordinate with the Department of Public Instruction.

The SMHA collaborates with the state health department, Medicaid agency, and the University of Wisconsin Medical School to increase the recognition and treatment of persons with mental illness by primary care providers. There is a collaborative effort between the state Medicaid agency and DMHSAS to work with the HMO provider to improve services and supports to people with mental illness. DMHSAS and child welfare are collaborating to screen for mental health and substance abuse among the child welfare population and create needed linkages to mental health services through the primary care HMO provider network. DMHSAS and the Division of Public Health (Public Health) completed a report describing the prevalence of mental health needs and co-occurring physical health disorders. In collaboration with the Medicaid agency, the SMHA intends to apply for a 1915(i) Medicaid State Plan Amendment in the fall of 2009.

The SMHA works with public and private providers to increase the recognition and treatment of the physical health needs of persons with mental illnesses. DMHSAS, in conjunction with the Bureau of Aging and Disability Resources, helps train mental health consumers and professionals in the Chronic Disease Self-Management Program and take it to community mental health programs.

The SMHA has the following initiatives to promote the understanding that mental health is essential to overall health: Wisconsin United for Mental Health and the Behavioral Risk Factor Surveillance System (BRFSS) report collaboration with Public Health describing the rates of co-occurring mental health/ physical health disorder and the implications.

Evidence-Based Services:

Evidence-Based Practices	Implementation	Number of Programs
Assertive Community Treatment (ACT)	Parts of the state	78
Supported Employment	Parts of the state	18
Family Psychoeducation	Pilot program	10
Integrated Mental Health/Substance Abuse Services	Parts of the state	22
Illness Self-Management	Parts of the state	13
Supported Housing	Parts of the state	19
Consumer-Operated Services	Parts of the state	10

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Wraparound Systems of Care	Available in parts of the state	48
Psychosocial Rehab Services (Children)	Available in parts of the state	10
Psychosocial Rehab Services (Adults)	Available in parts of the state	25

Staffing and Workforce Development Initiatives:

The SMHA has special university-based training initiatives and offers trainings at mental health programs/ providers to address staffing shortages.

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

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through online trainings and video conferencing.

DMHSAS has a 3-year grant from the Centers for Medicare and Medicaid Services (CMS) to implement Person-Centered Planning. This grant is training professionals in Person-Centered Planning, one tool that assists consumers in having a successful recovery.

The SMHA has relationships with professional schools to provide training in disciplines including psychiatry. Its relationships with professional schools include Wisconsin's contract with the University of Wisconsin School of Psychiatry for a psychiatrists' time to consult on state mental health and Medicaid policy and to train providers.

Wisconsin reimburses adult consumer peer specialists through Medicaid for providing mental health services. This is an option through the state's psychosocial rehabilitation Medicaid benefit. Some counties have not yet been certified to provide this benefit.

Managed Behavioral Healthcare:

Mental health and substance abuse services are being delivered through managed care. These behavioral health services are administered through a Medicaid 1915(b) waiver. Services are carved in and are provided by the primary healthcare provider networks or an HMO. Services are carved out to either a specialty behavioral healthcare network or a managed behavioral health organization. Approximately 4,000 persons received behavioral health services under the managed care plan in 2008.

Custody Relinquishment:

Wisconsin 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 funding opportunities and technical assistance are provided to local providers. An assessment is being done to determine whether there is a need for video equipment.

Electronic Health Records (EHRs):

The SMHA is considering the adoption of an EHR in community mental health programs. The SMHA is operating 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.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

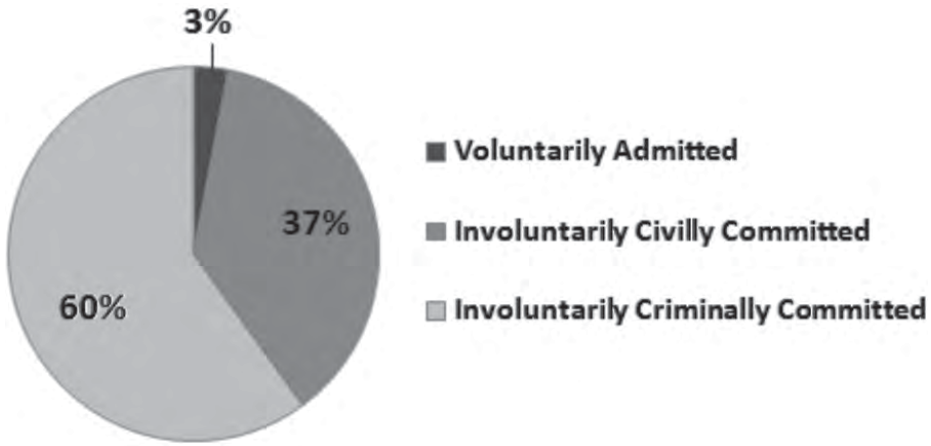
State Psychiatric Hospitals:

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.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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

State Psychiatric Hospital Patient Legal Status on the Last Day of FY 2008:



Psychiatric Inpatient Bed Shortages:

Wisconsin is experiencing a shortage of psychiatric beds. There have been declines in general hospital specialty unit psychiatric beds since 2008.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed National Guard members, the Reserve, and family members of military personnel to expedite the referral process.

Wisconsin has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services.

Wyoming 2009

Mental Health & Substance Abuse Services Division Department of Health 6101 North Yellowstone Road, Suite 220 Cheyenne, WY 82002 http://wdh.state.wy.us/mhsa/index.html	The Wyoming public mental health system comprises the Mental Health Division (MHD), 15 community mental health centers (CMHCs), and the Wyoming State Hospital (WSH). MHD, as the state mental health authority, oversees the operations of CMHCs and acts as the conduit for state and federal funding for community mental health services.

Statistics:

State Population (2007):	522,830
Number of Persons Served (2008):	20,287
Utilization Rate for Adults:	35.3 per 1,000
Utilization Rate for Children:	49.9 per 1,000

Revenues and Expenditures:

Revenues and Expenditures (FY 2007)	Dollars
Total Mental Health Agency-Controlled Revenue	$65.4 million
Revenue From Medicaid	$8.2 million
Expenditures for Community Mental Health Services (61% of Total Mental Health Agency Revenues)	$31.6 million
Per Capita State Mental Health Expenditures	$99.55

New Financing Initiatives:

The state is planning a change in how the delivery of mental health services is financed. Wyoming is currently undergoing a Rate Study to determine options for how services are purchased.

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 Services	No responsibility
Brain Impaired Services	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

Location of Other State Agencies in Relation to the SMHA:

Agency	Location
Medicaid Agency	Same umbrella department as the SMHA
Substance Abuse Agency	Part of the SMHA
Health Department	The umbrella department for 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 Used To Deliver Community Mental Health Services:

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

The SMHA is evaluating initiatives to restructure Wyoming's community-based system of mental health service delivery specifically through a Rate Study and integration of children's mental health services.

Interagency Collaboration:

The SMHA is working with other Wyoming government agencies to coordinate, reduce, or eliminate barriers between delivery systems and funding streams for the provision of appropriate mental health services. The SAMHSA Children's Mental Health Initiative is closing out.

Wyoming has initiatives to transform the way it delivers mental health services. An example is the utilization of high fidelity wraparound services for youth with serious emotional and behavioral challenges and their families.

Agency	Working To Reduce Fragmentation	Client Eligibility Determination	Combine or Coordinate Funding Streams	Combine or Coordinate Service Delivery
Housing Services	Yes	Yes	Yes	No
Employment	No	No	No	No
Juvenile Justice	Yes	No	Yes	Yes
Criminal Justice	Yes	No	Yes	Yes
Education	Yes	No	Yes	Yes
Child Welfare	Yes	No	Yes	Yes
Medicaid	Yes	No	Yes	Yes
Substance Abuse	Yes	No	No	Yes
National Guard	Yes	No	No	Yes

The SMHA collaborates with the state health department and Medicaid agency to increase the recognition and treatment of persons with mental illness by primary care providers. The SMHA also collaborates in providing general physician training.

Wyoming has several initiatives to integrate mental health services into public health programs.

Evidence-Based Services:

Evidence-Based Practices	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 Mental Health/Substance Abuse Services	Statewide
Illness 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
Functional Family Therapy	Parts of the state

Emerging Evidence-Based and Innovative Practices:

Evidence-Based Practices	Implementation	Number of Programs
Wraparound Services	Available in parts of the state	15
Psychosocial Rehab	Available in parts of the state	7
Consumer-Run Services	Available in parts of the state	9
Gatekeeping	Available in parts of the state	1

Staffing and Workforce Development Initiatives:

The SMHA is currently experiencing shortages of psychiatrists, other physicians, psychologists (doctoral level), social workers (master's level and above), advanced practice nurses, nurse practitioners and clinical specialists (master's level and above), and registered nurses in state psychiatric hospitals and community mental health programs.

The SMHA is using technology (e-learning) to improve the training of the workforce while limiting travel through video conferencing.

The SMHA has relationships with professional schools to provide training in disciplines including social work.

The state reimburses adult consumer peer specialists through Medicaid for providing mental health services.

Managed Behavioral Healthcare:

Neither mental health nor substance abuse services are being delivered through managed care.

Custody Relinquishment:

Wyoming 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. The Children's Mental Health Waiver is the main avenue for assistance for children to obtain mental health services.

Telemedicine:

The SMHA promotes the use of telemedicine and has currently funded telemedicine projects.

Electronic Health Records (EHRs):

The state does not use a single EHR system for all community mental health providers. Local providers use a variety of EHR systems.

The SMHA does not have a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE) that includes mental health in its plans to share electronic health information.

Client-Level Data:

The SMHA maintains an individual client-level database for consumers served in community mental health settings. The SMHA receives information for all community providers.

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 hospital.

The SMHA uses its state psychiatric hospital beds for:

Target Population	Acute Inpatient (less 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 on the Last Day of FY 2008:

Psychiatric Inpatient Bed Shortages:

Wyoming is experiencing a shortage of psychiatric beds. There have been declines in state psychiatric hospital beds in the last 5 years.

Services for Armed Forces Veterans and National Guard Members:

There have been specific initiatives to address the need for mental health services for returning veterans and their families. These initiatives have addressed Active Duty military, veterans, National Guard members, the Reserve, and family members of military personnel.

Wyoming has appropriated funds specifically to address the mental health service needs of returning veterans and their families. There is an arrangement in place to refer or pay for the mental health needs of returning veterans or their families who do not have access to military reimbursed or provided services. Funding is available to address the mental health/substance abuse needs of Wyoming Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) veterans. The funding can also be used to assist veterans in accessing mental health/substance abuse services; training for physicians, nurses, and other health professionals; and reimbursement for physicians to use the Post-Traumatic Stress Disorder (PTSD) screening tool. The funding can further be used to contract with two veteran advocates to make contact with returning veterans and assist them in accessing services.

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