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Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2013

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Executive Summary

Single state agencies (SSAs) and *state mental health agencies* (SMHAs) are the state government organizations responsible for planning, organizing, delivering, and monitoring critical mental health and substance use disorder services in each state. SSAs and SMHAs provide safety-net services to individuals with mental and substance use disorders (M/SUDs) who lack insurance and/or have high levels of service needs. In fiscal year (FY) 2012, state governments spent more than $44 billion providing mental health services to more than 7 million individuals and SUD services to 2.5 million individuals. In addition to the M/SUD services, substance use disorder prevention services provided by SSAs reached 189 million individuals.

The purpose of this study is to integrate into one report disparate information available from federal, state, and national association sources about the organization, policies, services, and financing of mental health and substance use disorder services by SSAs and SMHAs. Numerous information systems are available that describe consumers served by these agencies as well as agency funding, organization, and policies; however, all of this information is contained in different reporting systems. Integrating this information will help readers reach a comprehensive understanding of SSAs and SMHAs.

The development of this report was guided by an expert panel of federal officials, SSA and SMHA leaders, and stakeholder groups such as national M/SUD provider associations, consumers, and other potential data users. This report was developed using existing information sources whenever possible, and it was supplemented by information compiled directly from SSAs and SMHAs by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) and the National Association of State Alcohol/Drug Abuse Directors (NASADAD).

Organization and Structure of Single State Agencies and State Mental Health Agencies

All SSAs and SMHAs are responsible for administering block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Community Mental Health Block Grant (MHBG) requires SMHAs to develop and implement plans for comprehensive community mental health systems and to report a set of standardized utilization and outcome measures. SSAs are responsible for administering the Substance Abuse Prevention and Treatment Block Grant (SABG) and for monitoring and reporting quality and outcome measures related to SUD services.

The location of the SSA and SMHA in state governments varies widely. Most SMHAs are now part of a larger umbrella Department of Human Services or Department of Health, but 14 SMHAs are independent agencies.

The SSAs and SMHAs are each located within a single agency in 36 states and within the same larger umbrella agency in 11 states. The SSA and SMHA are combined with intellectual disability services into a single agency in 10 states.

State Mental Health Agency and Single State Agency Activities to Implement Health Insurance Reform

The Patient Protection and Affordable Care Act is expected to change the way that behavioral health benefit services are financed and administered across the nation. Through the Affordable Care Act and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, 30.4 million individuals will now have expanded behavioral health benefits. SAMHSA estimates that more than 1 million adults with a serious mental illness (SMI), almost 4 million adults with any mental illness, and 2.5 million individuals with a SUD will be eligible for expanded Medicaid. SAMHSA estimates that more than 900,000 adults with an SMI, 4 million individuals with any mental illness, and 2.8 million individuals with a SUD will be eligible for subsidized insurance through a marketplace exchange.

Not all state governments have decided to expand Medicaid or to build a state-operated health insurance marketplace exchange. In the states that are participating in expanded Medicaid and/or building state-based insurance marketplace exchanges, the SMHAs and SSAs are engaging in activities that will help consumers with M/SUD enroll in the new insurance programs for which they are eligible. The activities that SMHAs and SSAs are undertaking include working with their state Medicaid agency to educate M/SUD consumers about eligibility for new coverage programs, providing training to M/SUD providers on how to work with consumers to apply for new coverage, and working with family and consumers on how to apply for new insurance coverage.

Section 2703 of the Affordable Care Act authorizes the development of health homes under Medicaid. Many SSAs and SMHAs have found that the Medicaid health home models are appealing, because they allow states to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions (including mental health and SUDs). As of September 2013, the status was as follows:

- Nine states (Alabama, Idaho, Kansas, Missouri, New York, North Carolina, Ohio, Oregon, and Rhode Island) already have approval for establishing health homes that address mental health; 4 states (Iowa, Maryland, Vermont, and Washington) have applied and are waiting for approval; and 16 additional states are preparing applications to establish health homes.

- Four states (Alabama, Idaho, North Carolina, and Oregon) already have approval for establishing health homes that address SUD services; Maryland and Vermont have applied and are waiting for approval; and 13 additional states are preparing applications to establish health homes.

Because the Affordable Care Act will increase the number of individuals with M/SUD who will gain insurance coverage, many SSAs and SMHAs are concerned about the availability of an appropriately trained behavioral health workforce to provide services. Only 11 SMHAs and 6 SSAs reported they have enough providers that accept private insurance to meet emerging demand for mental health and SUD services, respectively. Eight SMHAs and 7 SSAs reported they have enough providers that accept Medicaid to meet future demands of mental health and

SUD services. To help meet this demand, some SSAs and SMHAs have workforce capacity initiatives that include funding the training of their M/SUD workforce.

Financing of Mental Health and Substance Use Disorder Services

In state fiscal year (SFY) 2012, states spent more than $44.2 billion providing M/SUD services through their SMHAs and SSAs. States spent an average of $141.33 per capita (expenditures divided by the state's population) providing M/SUD services. States spent $39.3 billion on SMHA services (89 percent of combined SMHA and SSA expenditures), and they expended $4.9 billion (11 percent) on SSA services.

State government general revenues were the largest source of funding for SSAs, whereas Medicaid (the joint state–federal program) was the largest source for SMHAs. The SABG was the second-largest funding source for SSAs, whereas state general revenues were the second-largest source for SMHAs.

Organization, Types, and Numbers of Mental Health and Substance Use Disorder Providers

Mental health services funded and operated by SMHAs are provided by 7,457 mental health providers in a variety of facilities: 6,330 community mental health centers (CMHCs), 231 nursing homes and other intermediate care providers, 196 state psychiatric hospitals, 212 private psychiatric hospitals, and 488 general hospitals with separate psychiatric units.

SSAs work with 8,121 providers of specialty SUD treatment that use funding from state, local, or federal government agencies to provide care for people who are uninsured or have low incomes. Almost 2,800 primary prevention providers were funded with SABG funds through SSAs.

States use several different mechanisms to pay for or deliver community-based mental health services. A total of 31 SMHAs directly fund (but do not operate) local community-based agencies. Fifteen SMHAs fund county or city mental health authorities that, in turn, fund providers or directly provide mental health services, and 4 SMHAs directly operate community-based programs.

Every state operates facilities that provide psychiatric inpatient services. Their services provide care and treatment to individuals with SMI who are at risk to themselves or to others. In 2012, 151,069 individuals were patients in state psychiatric hospitals, or 2.1 percent of all individuals served by the state and territorial SMHAs.

Publicly funded substance use disorder services are delivered primarily through private nonprofit or for-profit providers (72 percent and 12 percent, respectively), followed by county facilities (8 percent), tribal authorities (2 percent), and the federal government (3 percent). Only 4 percent of facilities are owned by states, and many of these are state mental health facilities that also have a subunit that provides substance use disorder services.

Characteristics of Consumers Served by State Mental Health Agency and Single State Agency Systems

The SSA-supported SUD treatment system served 2.5 million individuals in 2012. About 1.6 million of these individuals were new admissions in 2011 and 2012, whereas 710,000 initiated their treatment in a prior year. The total also includes 160,000 individuals who never accessed formal treatment services. These individuals used only support or recovery services, such as those provided through the Access to Recovery (ATR) initiative. Each state, the District of Columbia and the Commonwealth of Puerto Rico, U.S. territories and Freely Associated States receiving SAMHSA funding has at least one SMHA. (US Territories include American Samoa, Guam and the US Virgin Islands. The Freely Associated States include Palau, the Federated States of Micronesia and Republic of Marshall Islands). In some states, such as Connecticut and Delaware there are two SMHAs, one serving adults and a separate one serving children and adolescents. These SMHAs served 7,161,659 consumers (2.3 percent of the U.S. population) in 2012.

Among individuals served by SSAs, 72 percent of consumers were White, 21.4 percent were African-American, 2.9 percent were American Indian and Alaska Native, 2.6 percent had multiple races, and 0.8 percent were Asian.

Alcohol was the primary drug misused by 41 percent of individuals who were admitted to a substance use disorder treatment facility, and illicit drugs of different types were the primary problem for 59 percent, according to the 2010 Treatment Episode Data System (TEDS) online public use file. In addition, 60 percent of individuals who were admitted misused alcohol, whereas 76 percent misused some type of drug. Twenty-three percent of people who were admitted misused only alcohol, 39 percent misused only drugs, and 37 percent had problems with both alcohol and drugs.

Of the 2.3 million people using public treatment in the SSA system, about 1.64 million (71 percent) were between the ages of 25 and 64 years (based on the characteristics of individuals admitted to treatment). Young adults aged 18 through 24 years constituted another 450,000 (19.5 percent). Only 196,000 were aged 17 years and younger (8.5 percent), and 21,000 were aged 65 years and older (0.9 percent).

In the SMHA systems, 2,169,575 adults aged 25 through 44 years received mental health services, and they made up the highest percentage (30 percent) of consumers served. A total of 350,837 adults aged 18 through 20 years and 322,896 adults aged 65 years or older received mental health services; these age groups each represented only 5 percent of the SMHA caseloads.

Among consumers served by SMHAs, 62 percent of consumers were White and 20 percent were African-American. Native Hawaiians and Pacific Islanders made up the smallest percentage (0.2) of all consumers served.

In 2012, the vast majority of mental health consumers (96 percent of 6.8 million) received community mental health services in 59 SMHAs, with a utilization rate of 21.7 per 1,000 U.S. population. Six percent of all consumers served received services in other psychiatric inpatient

settings, with a utilization rate of 1.2 per 1,000. Only 2 percent of all clients served received services in state psychiatric hospitals, with a utilization rate of 0.5 per 1,000; 1 percent received services in residential treatment centers, with a utilization rate of 0.1 per 1,000.

Among consumers with SUDs, there were 1.22 million admissions to outpatient treatment. Of these admissions, 900,000 received standard outpatient care, 200,000 received intensive outpatient treatment, and about 100,000 received opioid replacement treatment (predominantly methadone; however, buprenorphine is being used more frequently than in the past). Residential treatment made up 650,000 (one-third) of admissions, and this was split almost equally between detoxification and care oriented at rehabilitation.

Health-Mental or Substance Use Disorder Service Integration Initiatives

Many SMHAs and SSAs are actively engaged in addressing behavioral health integration with primary health care.

- Forty-seven SMHAs (90 percent) have initiatives in place to improve the integration of mental health with primary health care.
- Forty-five SMHAs (87 percent) are supporting the location of primary care services into the mental health programs the SMHA operated or funded.
- Forty-five SMHAs (87 percent) are supporting the location of mental health services within primary care settings.

SSAs are also working on the integration of SUD and primary care services:

- Forty-eight states (94 percent) reported planning initiatives that will advance SUD and primary care services integration. Eighteen states (35 percent) designated SUD and primary care integration as a primary state priority. Another 10 (20 percent) indicated that integration was a secondary strategy supporting another state priority.
- Twenty-five states (49 percent) wrote in their SABG application about planning for health homes. Twenty-two states (43 percent) included plans for screening or Screening, Brief Intervention, and Referral to Treatment (SBIRT) services. Twenty-five states (49 percent) specified engagement in collaborative efforts with Medicaid, and 39 SSAs (76 percent) described collaboration with primary care providers in their state.
- SSAs described a variety of additional tactics to promote SUD and primary care integration. Sixteen states (31 percent) detailed workforce initiatives such as SBIRT training and education to primary care providers. In addition, 24 states (43 percent) reported working on health information technology (HIT) issues related to SUD and primary care service integration, such as linking SUD and primary care electronic health record (EHR) systems.

SMHAs in 50 states (96 percent) are screening for co-occurring M/SUDs. The move toward integrated mental health and substance use disorder departments is also supporting programs for

treatment of co-occurring conditions. States also noted that implementation of SBIRT is paving the way for statewide practices and standards.

Prevention of Mental Illness and Substance Use Disorders

Forty-five SMHAs (87 percent) collaborate with other systems and/or stakeholder groups on initiatives to prevent risk factors for mental health problems and to foster resilience. Some noted collaborations and partnerships within the states, and these groups are partnering with planning councils, child welfare programs and services, disability councils, local school boards, the military, juvenile justice and public health agencies, system of care services and supports, primary care services, peer support services, and legislatures.

Most SMHAs operated, funded, or participated in suicide prevention programs for children and adolescents, adults of all ages, veterans and military personnel, and individuals who are lesbian, gay, bisexual, or transgender (LGBT). Forty-three SMHAs (83 percent) supported crisis hotlines to ensure that individuals at risk for suicide, including those who had made a suicide attempt, could readily access high-quality crisis support services.

States have developed substantial networks of primary prevention and treatment or other prevention providers to address substance use disorders. Almost 2,800 primary prevention providers were funded with SABG funds through SSAs. In addition, about 8,000 providers of specialty SUD treatment used funding from the state, local, or federal government to provide care for people who were underinsured or had low income. Funded providers are required to compile and report data about the numbers and characteristics of individuals served and the general nature of preventive services received, which are tabulated and reported elsewhere in this document.

Recovery Support for Mental or Substance Use Disorders

Many SMHAs are actively engaged in promoting health- and recovery-oriented service systems for individuals in recovery from M/SUDs. A majority of states are promoting health and recovery through different services and supports. SMHAs in 48 states (96 percent) are improving access to mainstream benefits (those not specific to individuals with mental illnesses) such as housing assistance programs and supportive behavioral health services. Almost all SMHAs promote peer support and social inclusion. Forty-eight SMHAs (96 percent) work on increasing the number and quality of consumer and peer recovery support specialists, 44 (88 percent) promote social inclusion, and 46 (92 percent) increase the number and quality of recovery support service provider organizations operated by consumers and run by peers.

A vast majority of SSAs are employing recovery-oriented services, and nearly all states have given consideration to Recovery-Oriented Systems of Care (ROSC) transformation or have embarked on the initial stages of reforms. However, only a small group of states is in the midst of comprehensive reform. SSAs are engaged in reforming their systems of care, and 96 percent of SSAs participating in an ROSC survey have implemented one or more recovery-oriented services, such as peer support services, employment services, case management, faith-based support, and recovery housing.

1. Introduction

Purpose

This report integrates information from a myriad of existing federal, state, and other data systems into one source, to allow readers to understand the organizational structure, major policy initiatives, services provided, and financing of single state agencies (SSAs) and state mental health agencies (SMHAs). The goal of this report is to allow the reader to identify common national trends in services for individuals with mental and substance use disorders (M/SUDs) and to understand the mental health and/or substance use disorder systems of states. Readers may also use this report to identify individual states that may have a policy, service, or financing approach of interest. The glossary (see page 112) includes definitions and descriptions of acronyms used in this report.

Background

SMHAs and SSAs are the parts of state government that are designated by governors to coordinate and ensure the delivery of high-quality services to individuals with mental illnesses and/or SUDs. SSAs and SMHAs serve an essential safety net function by providing critical care to individuals with the most severe illnesses and to those without insurance coverage for their treatments.

SSAs and SMHAs are often administratively combined into a single state agency to promote the coordination and delivery of services to individuals with mental or substance use disorders—particularly for individuals with co-occurring M/SUDs. SSAs and SMHAs also have a set of unique and different funding requirements, service treatments, and reporting requirements, and they often have different state legal requirements.

SMHAs organize, coordinate, and directly operate some mental health services and reimburse community providers for additional mental health services. SMHAs served more than 7.1 million individuals in 2012, at a cost of $39.2 billion. The services provided by SMHAs included direct psychiatric treatments and medications, but also included a variety of critical supports such as housing, employment, education, and primary care coordination to help consumers recover and live in their own communities.

As this report highlights, SMHAs vary widely in how they are organized within state government, how they pay for and organize their mental health service delivery systems, the scope and eligibility requirements to access public mental health services, and their fiscal and staffing resources. However, nearly all SMHAs share certain functions:

- Operate and/or fund inpatient psychiatric beds that provide critical intensive services to individuals at risk of harm to themselves or others.

- Organize, coordinate, fund, and (in some states) directly operate a comprehensive system of community-based mental health services to meet the mental health needs of individuals in their state.

- Plan the development of a comprehensive array of mental health services—including coordination with other state government agencies and local health and substance use disorder agencies—and submit an annual comprehensive community Mental Health Block Grant (MHBG) plan to SAMHSA.

- Monitor the performance and outcomes of their service system by collecting data and evaluating services.

- Serve a public safety function in providing and coordinating services to individuals with mental illnesses who are determined by courts to be dangerous to themselves or others.

- Educate the public about mental illness, combat stigma surrounding mental illness, and support public health prevention activities for mental health.

SSAs are a vital cog in the national system for providing substance use disorder services to the nation. Although SSAs dedicate a large majority of their resources to providing SUD treatment to individuals who are uninsured or have low income (a shared responsibility with Medicaid), they are responsible for providing substance use disorder prevention services and leadership to the entire population. In FY 2012, SSAs expended $4.9 billion on SUD and prevention services. Eight-two percent of SSA expenditures were for SUD treatment, 11 percent for primary prevention, and 7 percent for administration and infrastructure.

The SSA-supported SUD treatment system served 2.46 million individuals in FY 2012. About 1.6 million of these individuals were new admissions during the year, whereas 710,000 initiated their treatment during a prior year.

States have developed substantial networks of primary prevention and treatment or other prevention providers over the years. There were almost 2,800 primary prevention providers funded with Substance Abuse Prevention and Treatment Block Grant (SABG) funds through the SSAs and about 8,000 providers of specialty SUD treatment that used funding from state, local, or federal government to provide care for people who were underinsured or had low income.

SSAs provided individual-based prevention services to 10.8 million people during FY 2012. SSA-supported, population-based prevention strategies reached an estimated 189 million individuals. These population-based prevention strategies included public service campaigns with mass media messages.

2. Methods

The major content areas of this report were identified through a series of expert panel meetings convened during 2012 and 2013 that included leadership from the SAMHSA Center for Mental Health Services (CMHS), SSAs, SMHAs, mental health and substance use disorder provider organizations, advocacy groups, and primary consumers. The expert panel determined what information would be most useful to know about SSAs and SMHAs and helped identify existing sources of information. Development of this report was based on the use of existing information whenever possible and augmented through additional information compiled by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) and the National Association of State Alcohol/Drug Abuse Directors (NASADAD).

The following are the primary sources of mental health information used for this report to describe the consumers served by the SMHAs:

- The 2013 cycle of the SMHA Profiling System (SPS)[1]
- The FY 2012 State Mental Health Revenues and Expenditures Study Results (hereinafter referred to as the Revenue and Expenditure Study)[2]
- The 2012 Uniform Reporting System (URS)[3]

Leaders in every SMHA were sent a draft of their state's information as used in the two-page State Appendix A and in the full report for review. The leaders were provided with an opportunity to update and correct all of their state data.

The information about state substance use disorder prevalence, services, agencies, and policies came from several distinct sources; however, all information was ultimately collected and maintained (if not published) by SAMHSA. The information in the profile of each state was submitted to the respective SSAs for review and verification. Corrections have been made as noted.

2.1. State Mental Health Agency 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

[1] National Association of State Mental Health Program Directors Research Institute, Inc. (NRI). (2013). *2013 state mental health agency profiling system results*. Retrieved from http://www.nri-incdata.org/
[2] National Association of State Mental Health Program Directors Research Institute, Inc. (NRI). (2013). *The FY 2012 state mental health revenue and expenditure study results*. Retrieved from http://www.nri-incdata.org/
[3] Center for Mental Health Services. (2013). *2012 CMHS uniform reporting system output tables.* Retrieved from Substance Abuse and Mental Health Services Administration website: http://media.samhsa.gov/dataoutcomes/urs/

resources, client issues, information management, and research and evaluation structures. Questions are grouped into components by topic area to facilitate SMHA review and completion of the profiles. Questions within each component address the specific needs of SMHA leaders, SAMHSA and other federal officials, and others interested in public mental health systems. The information supports decision making, policy analysis, and research and evaluation.

The Center for Financing Reform and Innovations (CFRI) team—composed of SAMHSA, Truven Health Analytics, NRI, and NASADAD—identified the highest priority topics for inclusion in this report. The CFRI team had guidance from a focus group composed of SMHA and SSA leaders, state program staff, and advocates from the mental health and substance use disorder systems. NRI staff then developed the 2013 SMHA profile components to capture from SMHAs the information needed for this report. In April 2013, eight profile components were sent to all SMHA commissioners or directors and the agencies' designated SPS contacts for completion during spring or summer 2013.

Leaders at a total of 52 SMHAs completed various components: SMHA and SSA Health Reform Activities (n=49), Health–Mental Health and Prevention (n=52), Organization and Structure (n=52), Policy (n=51), Involuntary Inpatient Treatment (n=48), Information Management (n=52), Finance (n=52), and Managed Behavioral Healthcare (n=52). The 52 SMHAs were comprised of one SMHA for the District of Columbia and one for each of the states except Connecticut, which has two SMHAs: one agency for children and adolescents and one for adults.

2.2. Single State Agency Profiling System

There is no distinct profiling system, per se, for SSAs. Note that SAMHSA collected a large majority of the data in the state profiles. States were asked to report on activities related to health finance reform through the State Mental Health and Substance Abuse Agency Profiling system.

2.3. State Mental Health Agency: Controlled Revenue and Expenditure Study

The Revenue and Expenditure Study describes the major expenditures and funding sources of the SMHAs. Each year, NRI works with the SMHAs to document the expenditures for mental health services that are controlled by the SMHAs and to determine the major funding sources of these expenditures. The methodology of 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 fiscal year (SFY) is completed and billing is fully reconciled—is necessary for reporting valid and reliable data. Without reference to specific financial reports indicating actual expenditures, it is difficult (if not impossible) to verify figures and have an accessible database for follow-up and/or analysis. The fiscal year for most states ends on June 30, whereas the federal fiscal year ends on September 30 of each year (see http://www.ncsl.org/research/fiscal-policy/basic-information-about-which-states-have-major-ta.aspx).

We used a set of Microsoft® Excel spreadsheets containing four tables 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 SMHAs control, and the total expenditures and revenues of the community mental health and state psychiatric hospital systems. For this report, we used the FY 2012 cycle of the Revenue and Expenditure Study data received from 44 states, the District of Columbia, and Puerto Rico to present the expenditures and funding sources of SMHAs.

2.4. Single State Agency: Controlled Revenue and Expenditure

High-quality budget data about state substance use disorder agencies are submitted by states each year, per requirement of the SAMHSA SABG legislation and regulations. NASADAD staff pulled SSA expenditure and revenue data from the SAMHSA Web Block Grant Application System (WebBGAS) with the assistance of the SAMHSA Division of State and Community Assistance, Center for Substance Abuse Treatment. The data include total funding of primary and other prevention and treatment as well as amounts spent on set-aside funds for women's treatment and tuberculosis and HIV (only in states that exceed specified threshold values). State funding is also differentiated from SABG funding. The forgoing values are all required to be reported and are subject to review and verification by SAMHSA.

2.5. The Uniform Reporting System

The Uniform Reporting System (URS) is a reporting system used by SMHAs to compile and report annual data as part of the SAMHSA CMHS MHBG. The URS is part of the Mental Health Services Block Grant Implementation Report—approved by the Office of Management and Budget—that SMHAs are required to submit to CMHS every December 1. The URS is part of an effort to use data in decision support and planning in public mental health systems and to support program accountability.

The URS, composed of 21 tables developed by the federal government in consultation with SMHAs, compiles state-by-state and national aggregate information. The data include numbers and sociodemographic characteristics of individuals 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 for state and national reporting. For this report, the 2012 data submitted by the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico, U.S. territories and Freely Associated States were used to describe the clients served by the SMHAs. (Data can be accessed from the SAMHSA website at http://www.samhsa.gov/dataoutcomes/urs/.)[4]

[4] US Territories include American Samoa, Guam and the U.S. Virgin Islands. The Freely Associated States include Palau, the Federated States of Micronesia and Republic of Marshall Islands.

2.6. Substance Use Disorder Prevalence, Client, and Provider Data

Data about the prevalence of SUD problems and attitudes come from SAMHSA's most recent (2011) annual National Survey on Drug Use and Health (NSDUH), which produces state-level and national statistics. NSDUH is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. NSDUH provides accurate data on the level and patterns of alcohol, tobacco and illegal substance use and misuse; tracks trends in the use of alcohol, tobacco, and various types of drugs; assesses the consequences of substance use and misuse; and identifies those groups at high risk for substance misuse. (Data can be access from the SAMHSA website at http://www.samhsa.gov/data/population-data-nsduh.)

Information about state prevention and treatment service systems, individuals served, and the nature of services delivered is collected by SSAs and reported to SAMHSA as per requirements under the SABG. The "treatment" data (i.e., characteristics of those served and service outcomes) are reported to SAMHSA through the Drug and Alcohol Services Information System or submitted to SAMHSA through the annual Block Grant Report. The prevention data and SSA financing information are likewise reported by states in their annual Block Grant Report. Data submitted to SAMHSA as part of their application or report are subject to review and verification by SAMHSA through periodic technical reviews.

2.7. Limitations

Although there was a high response rate for each of the SPS components, the level of completion within each survey 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 fewer than the total number of reporting SMHAs.

Although 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 that may not be included in this report (e.g., criminal justice agencies, public health agencies).

The majority of state government expenditures not fully depicted in this report are from Medicaid—one of the fastest growing expenditures of state governments in the past 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. However, many of these expenditures are outside the control of the SMHA or the community mental health system that the SMHA funds. The Medicaid expenditures included in this report are limited to the portion of Medicaid expenditures that is controlled or administered by the SMHAs. Studies by CMHS on Medicaid suggest that total Medicaid expenditures for mental health may be double those controlled by SMHAs. For additional detail on Medicaid spending for behavioral health services, see SAMSHA's Spending Estimates Initiative (see SAMHSA Spending Estimates Initiative, http://www.samhsa.gov/health-financing/enrollment-initiatives-research).

Much of the data in the SUD profiles only pertain to "public-sector" services and to individuals who are medically indigent and lack adequate insurance coverage and/or those who have low income. It should be noted that states have different standards as to financial eligibility for subsidized public-sector treatment services, and (to large extent) this is reflected in the major differences across states in the amount of funds dedicated to public treatment and prevention. Another major issue is that very few SSAs capture Medicaid-related data on spending or services delivered. This is in marked contrast to mental health, where a substantial number of SMHAs manage Medicaid funding for mental health services; therefore, they capture data on spending as well as on individuals who receive those services.

A further limitation on the scope of SSA reporting across states is that, as for mental health services, additional funding for SUD services occurs through other health and human services agencies—such as child and family services and community health centers—as well as through various justice agencies, including courts, prisons, and jails offering probation, parole, and pretrial services. Again, there are remarkable differences across states as to how services are organized, delivered, and financed.

2.8. Overview of the Remainder of the Report

- Section 3 discusses SMHA and SSA activities to implement health insurance reform.
- Section 4 discusses the organization and structure of SMHAs, including their location within a state government, relationships with other state agencies, mental health and substance use disorder service responsibilities, and eligibility requirements for SMHA services.
- Section 5 reviews how SMHAs and SSAs finance mental health services and describes the roles of Medicaid, managed care, and SMHA-controlled revenues and expenditures.
- Section 6 presents information on the characteristics of consumers served by SMHAs and SSAs.
- Section 7 discusses the organization of community mental health and substance use services as well as policies on the use of state psychiatric hospitals and forensic services.
- Section 8 presents major policies of SMHAs and SSAs.

Appendices A and B to this report provide individual SMHA and SSA profiles describing how each SMHA and SSA is organized within a state government, the SMHA and SSA responsibilities and roles, the number of individuals served, and the financing of services. Appendix C lists the report authors.

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3. State Mental Health Agency and Single State Agency Activities to Implement Health Insurance Reform

The Affordable Care Act will affect the financing and delivery of behavioral health services. This law has several provisions to help individuals with low or moderate incomes obtain health insurance through an expanded Medicaid program or through federally subsidized insurance. The law also strengthens mental health parity provisions, eliminates preexisting conditions, and removes limitations from purchasing private insurance.

An estimated total of 32.1 million Americans will gain access to coverage that includes mental health and/or substance use disorder benefits that comply with federal parity requirements, and an additional 30.4 million Americans who currently have some mental health and substance use disorder benefits will gain from the federal parity protections. By building on the structure of the Mental Health Parity and Addiction Equity Act, the Affordable Care Act will extend federal parity protections to 62.5 million Americans (see Table 1).

Table 1. Estimated Number of Individuals Gaining M/SUD Benefit Coverage Through Affordable Care Act and Parity Protections

	Individuals who will gain mental health, substance use disorder, or both benefits under the Affordable Care Act, including federal parity protections	Individuals with existing mental health and substance use disorder benefits who will benefit from federal parity protections	Total individuals who will benefit from federal parity protections as a result of the Affordable Care Act
Individuals currently in individual plans	3.9 million	7.1 million	11 million
Individuals currently in small group plans	1.2 million	23.3 million	24.5 million
Individuals currently uninsured	27 million	n/a	27 million
Total	**32.1 million**	**30.4 million**	**62.5 million**

Note: These estimates include individuals and families who are currently enrolled in grandfathered coverage. Grandfathered plans are not required to comply with the Essential Health Benefits provisions of the Affordable Care Act. As the Affordable Care Act is implemented, we expect grandfathered coverage to diminish, particularly in the individual market. See http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm

Abbreviation: M/SUD, mental and substance use disorder

The workforce of SSAs and SMHAs and their treatment and service provider systems may need to expand to meet the service needs of individuals with mental illnesses and SUDs who gain new

insurance eligibility. Some SSAs and SMHAs are assessing their workforces and are proactively working to increase the number of trained professionals available to serve these individuals.

Other provisions within the Affordable Care Act will allow for the development of newly integrated services and funding mechanisms to improve the delivery of behavioral health services and their coordination with primary health care. Many SSAs and SMHAs are already taking advantage of new demonstration programs and service delivery mechanisms, such as health homes and Accountable Care Organizations (ACOs), to improve the coordination of M/SUD services with primary care.

States will play a significant role in implementing the Affordable Care Act. They will make decisions about whether or not to expand Medicaid, establish Marketplaces for the purchase of health care coverage, use new waivers and options under Medicaid, and apply for various new demonstrations, programs, and evaluations. States have discretion about implementing this law in two major areas:

1. Deciding whether to expand Medicaid to cover adults with incomes of up to 138 percent of the federal poverty level (FPL).

2. Determining their role in the Marketplaces: build a state health insurance marketplace exchange, partner with the federal government, or rely on the federal government to build and operate the insurance marketplace. States will also decide how they want to help residents enrolling in coverage through Marketplaces.

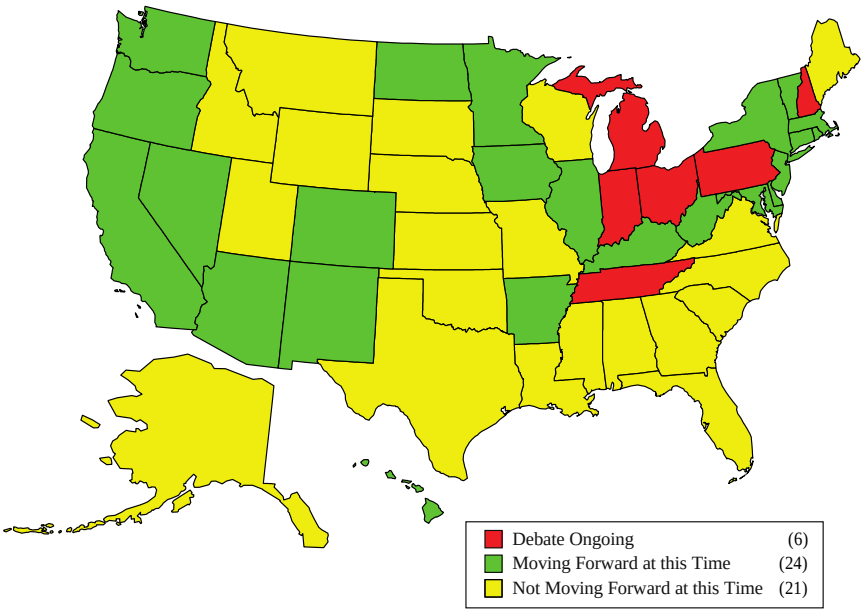
Figure 1 shows that, as of July 1, 2013, 24 states had decided to expand Medicaid, 21 states had decided not to expand Medicaid, and 6 states were still debating over this decision.[5]

Figure 2 shows that, as of June 20, 2013, 17 states had decided to operate a state-based exchange, 7 states will participate with the federal government in operating a partnership exchange, and 27 states will default to a federal exchange.[6]

[5] The Henry J. Kaiser Family Foundation. (2014a). *State decisions on health insurance marketplaces and the Medicaid expansion, 2014*. Retrieved from http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/. Updated information (as of February 1, 2014) on the status of state decisions on Medicaid expansion is available at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act

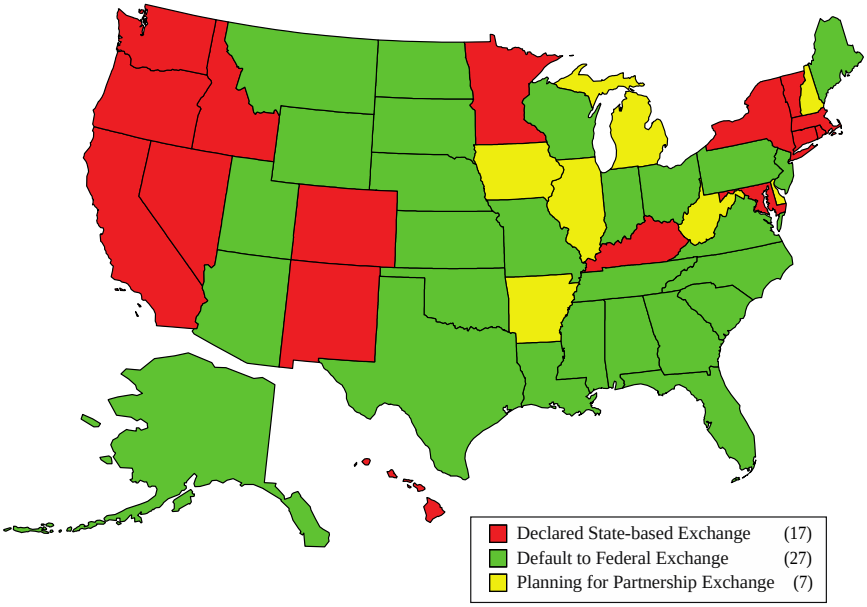
[6] The Henry J. Kaiser Family Foundation. (2014b). *Status of state action on the Medicaid expansion decision, 2014*. Retrieved from http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. Updated information (as of February 1, 2014) on the status of state decisions on health insurance exchanges is available at http://kff.org/health-reform/state-indicator/health-insurance-exchanges/

Figure 1. Status of State Decisions on Expanded Medicaid, as of July 1, 2013



Note: For current expansion status, see statereforum, *Map: Where states stand on Medicaid expansion decisions*. Updated April 8, 2015. Retrieved from https://www.statereforum.org/Medicaid-Expansion-Decisions-Map

Figure 2. Status of State Decisions on Health Insurance Exchanges, as of June 20, 2013



Single State Agency and State Mental Health Agency Roles in Health Insurance Reform

Although the Affordable Care Act will provide insurance coverage to millions of individuals, many SMHAs and SSAs are undertaking activities to help individuals with M/SUD access and enroll in new coverage options for which they will be eligible. Variations in state responses to the Affordable Care Act can have profound implications for how the SSA and SMHA in each state are working on programs related to this law. For example, at the time of this study, 21 states were not electing to implement the expanded Medicaid program. As a result, the SSAs and SMHAs do not have a major role in increasing the pool of providers who are able to bill Medicaid for expanded benefits or in helping eligible consumers enroll in expanded Medicaid. However, in the 24 states that are expanding Medicaid, SSAs and SMHAs report a number of initiatives to help individuals with M/SUD enroll in and use these new benefits.

SMHAs and SSAs in states that are participating in expanded Medicaid and/or building state-based insurance marketplace exchanges are helping consumers with M/SUD enroll in new insurance programs for which they are eligible. Their activities include working with their state Medicaid agency to educate consumers about eligibility for new coverage programs and to provide training to M/SUD providers about how to work with consumers or families of consumers to apply for new insurance coverage (see Table 2).

Table 2. Number of SMHAs and SSAs Engaged in Activities to Help Consumers Apply for Insurance, 2013 (47 States Reporting)

Activity	SMHA		SSA	
	Number	%	Number	%
a. Develop public awareness efforts about new coverage opportunities targeting individuals with mental illness or substance abuse	13	27	11	22
i. Design outreach campaign for individuals with mental health and/or substance abuse needs	12	24	10	20
ii. Conduct outreach campaign to individuals with mental illness and/or substance abuse problems	10	20	9	18
iii. Create mechanisms to obtain mental health and/or substance abuse consumer input into implementation process	12	24	9	18
iv. Establish a system to track and report mental health and/or substance abuse consumer complaints	11	22	10	20
b. Develop or provide mental health and/or substance abuse providers training on how to work with consumers to apply for new coverage programs	16	33	16	33
c. Work with family/consumer groups to provide information about eligibility for new coverage programs	17	35	16	33
d. Work with the Insurance Commissioner's office to educate consumers about eligibility for new coverage programs	11	22	10	20
e. Work with health insurance marketplace in the state to provide information about eligibility for new coverage programs	12	24	11	22
f. Work with the state Medicaid agency to educate consumers about eligibility for new coverage programs	20	41	19	39
g. Educate or train health navigators on how to provide information about eligibility for insurance coverage to consumers with mental health and or/substance abuse problems	9	18	9	18
h. Help providers become health navigators	8	16	9	18
i. Help consumers become health navigators	5	10	5	10
j. Help others become health navigators	1	2	1	2
k. Work with enrollment brokers	5	10	6	12

Note: References to *substance abuse* rather than *substance use disorder* reflect language from the survey questions originally posed in 2013.

Abbreviations: SMHA, state mental health agency; SSA, single state agency

Among the 28 states (60 percent) that are preparing to expand Medicaid and/or develop their own state health insurance marketplace, SMHAs and SSAs are working on a variety of steps to help mental health and substance use disorder consumers apply for insurance coverage that meets their needs. The most common SMHA activities were working with their state Medicaid agency to educate consumers about eligibility for new coverage programs, working with mental health providers, and working with family and consumer groups about new coverage programs. The most common SSA activities were working with their state Medicaid agency to educate mental health consumers about eligibility for new coverage programs, working with substance use disorder providers, and working with family and consumer groups about new coverage programs.

Health navigators are trained to help individuals determine their eligibility for specific insurance options and to match the insurance plans to their needs. SMHAs in eight states (28 percent of states expanding Medicaid or developing their own insurance marketplace) are helping mental health providers and mental health consumers become health navigators, and SMHAs in five states (18 percent of states expanding Medicaid or developing their own insurance marketplace) are helping mental health consumers become health navigators. SSAs in nine states (32 percent of states expanding Medicaid or developing their own insurance marketplace) are helping substance use disorder providers become health navigators, and SSAs in five states (18 percent of states expanding Medicaid or developing their own insurance marketplace) are helping individuals in recovery from substance use disorders become health navigators.

3.1. Single State Agencies and State Mental Health Agencies Working on Expanded Medicaid

The Medicaid expansion program will provide Medicaid coverage to adults with incomes up to 138 percent of the FPL. SAMHSA has estimated that almost 1.2 million adults with a serious mental illness (SMI), 2.6 million individuals with any mental illness, and more than 2.5 million individuals with a SUD will be eligible for expanded Medicaid. In the 24 states (47 percent) that are moving forward with Medicaid expansion, an estimated 456,274 individuals with an SMI and 970,262 individuals with an SUD will be eligible for expanded Medicaid. In the six states (12 percent) still debating whether to expand Medicaid, an additional 250,057 adults with SMI and 472,022 adults with SUD will be eligible for expanded Medicaid.

Both SMHAs and SSAs are working with their state Medicaid agencies regarding which M/SUD benefits to include in new Medicaid benefit plans. Slightly more SMHAs than SSAs are working with Medicaid on including M/SUD providers within the new Medicaid plans and assisting individual providers to be eligible for Medicaid reimbursable services. Most SMHAs in the states that are expanding Medicaid are working to ensure that individuals with M/SUD who are potentially eligible for expanded Medicaid are able to enroll in Medicaid and to ensure that expanded Medicaid plans cover appropriate M/SUD benefits.

- Twenty-three SMHAs (82 percent of states expanding Medicaid or developing their own insurance marketplace) are working with their state Medicaid agencies regarding which mental health benefits will be included in alternative benefit plans, whereas 22 SSAs (79 percent of states expanding Medicaid or developing their own insurance marketplace) are

working with their state Medicaid agencies regarding which SUD benefits will be included.

- Twenty-four SMHAs (86 percent of states expanding Medicaid or developing their own insurance marketplace) are working to include SMHA-funded or SMHA-operated mental health providers within expanded Medicaid, whereas 22 SSAs (79 percent of states expanding Medicaid or developing their own insurance marketplace) are working to include SSA-funded or SSA-operated SUD providers.
    - Twenty-one SMHAs (75 percent of states expanding Medicaid or developing their own insurance marketplace) are helping mental health provider agencies become certified Medicaid providers who will be able to bill Medicaid for mental health services. Twenty-one SSAs (75 percent of states expanding Medicaid or developing their own insurance marketplace) are helping SUD provider agencies become certified Medicaid providers who will be able to bill Medicaid for SUD services.
    - Nine SMHAs (32 percent of states expanding Medicaid or developing their own insurance marketplace) are helping private practitioners, individual mental health counselors, and other clinicians become certified to bill Medicaid for mental health services, and nine SSAs (32 percent of states expanding Medicaid or developing their own insurance marketplace) are helping private practitioners, individual SUD counselors, and other clinicians become certified to bill Medicaid for SUD services.
    - Two SMHAs (7 percent of states expanding Medicaid or developing their own insurance marketplace) and five SSAs (18 percent of states expanding Medicaid or developing their own marketplace) are working on other activities related to Medicaid expansion.

3.2. Medicaid Health Homes for Individuals With Mental or Substance Use Disorders

Section 2703 of the Affordable Care Act authorizes the development of health homes under Medicaid. Many SMHAs and SSAs have found the Medicaid health home model appealing because it allows states to provide comprehensive care coordination for Medicaid beneficiaries with chronic conditions, including M/SUD. States are required to consult with SAMSHA as they develop their health home State Plan Amendments.

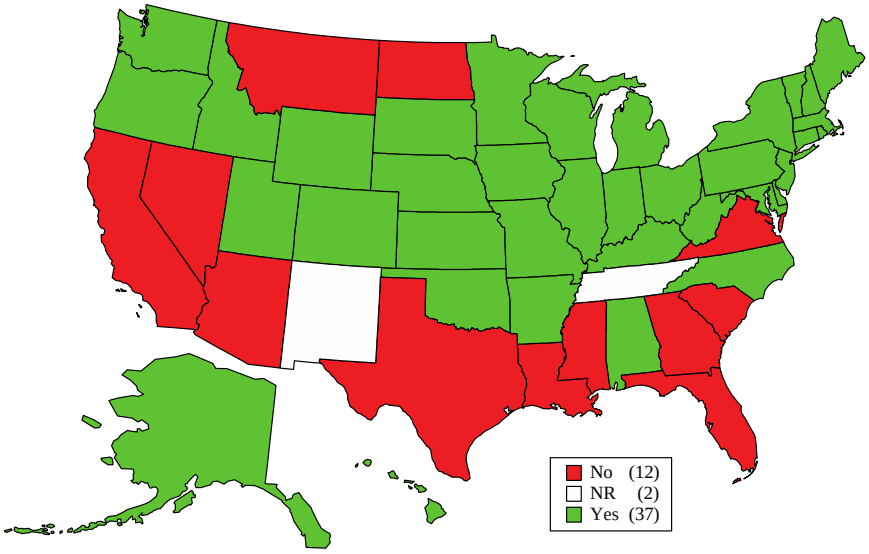
A health home model is a model of service delivery that coordinates and integrates all types of care needed by an enrollee—physical health care, behavioral health care, and long-term services and supports. Additionally, §2703 of the Affordable Care Act identified six health home services that are also delivered through the health home model. Health homes services provide:

1. Comprehensive care management
2. Care coordination and health promotion
3. Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

4. Individual and family support
5. Referral to community and social support services, if relevant
6. Linkage of services using health information technology, as feasible and appropriate.

As Figure 3 shows, the majority of states are working on plans to use health homes to provide behavioral health services, with more states using health homes to address mental health than SUDs.

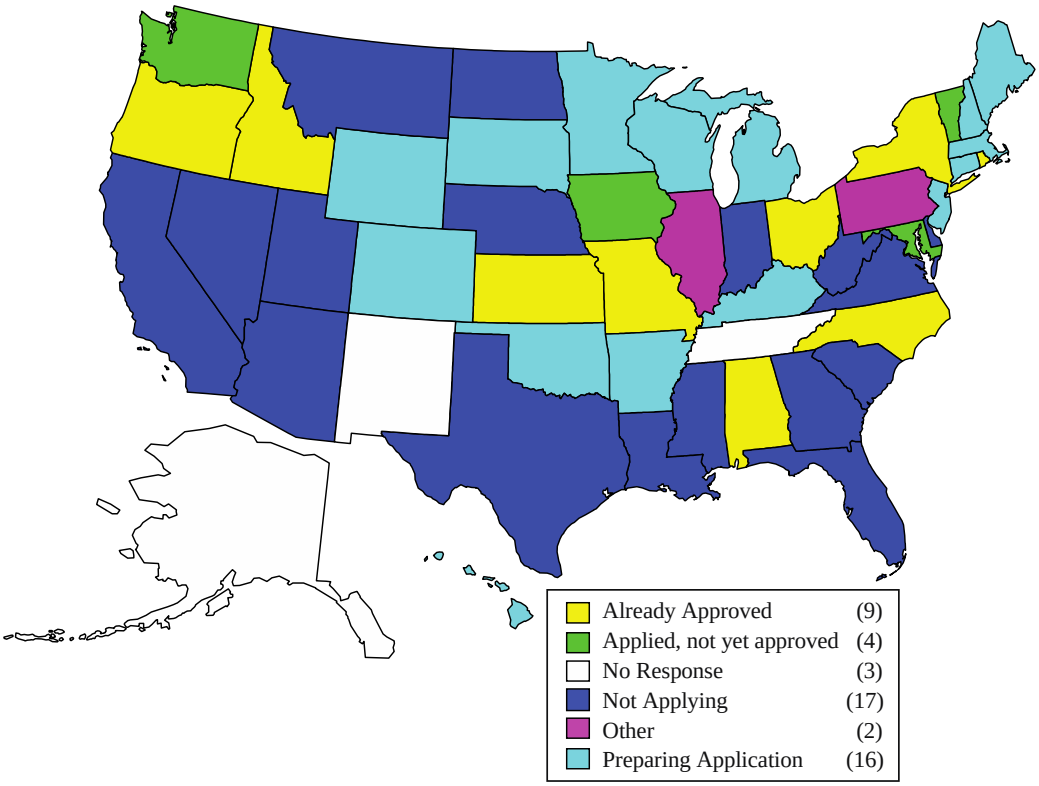
Figure 3. States Working on Plans to Use Medicaid Health Homes to Provide Services to Individuals With Chronic Substance Use Disorders or Mental Health Conditions, 2013



Medicaid Health Homes for Individuals With Mental Illness

As Figure 4 shows, the majority of states are working on plans to use health homes to provide behavioral health services. Nine states (Alabama, Idaho, Kansas, Missouri, New York, North Carolina, Ohio, Oregon, and Rhode Island) have already been approved to establish a health home that addresses mental health; 4 states (Iowa, Maryland, Vermont, and Washington) have applied and are waiting for approval; and 16 states are preparing applications to establish health homes.

Figure 4. Status of State Medicaid Plan Amendments That Will Include Providing Health Home Services Targeting Beneficiaries With Mental Illness, 2013



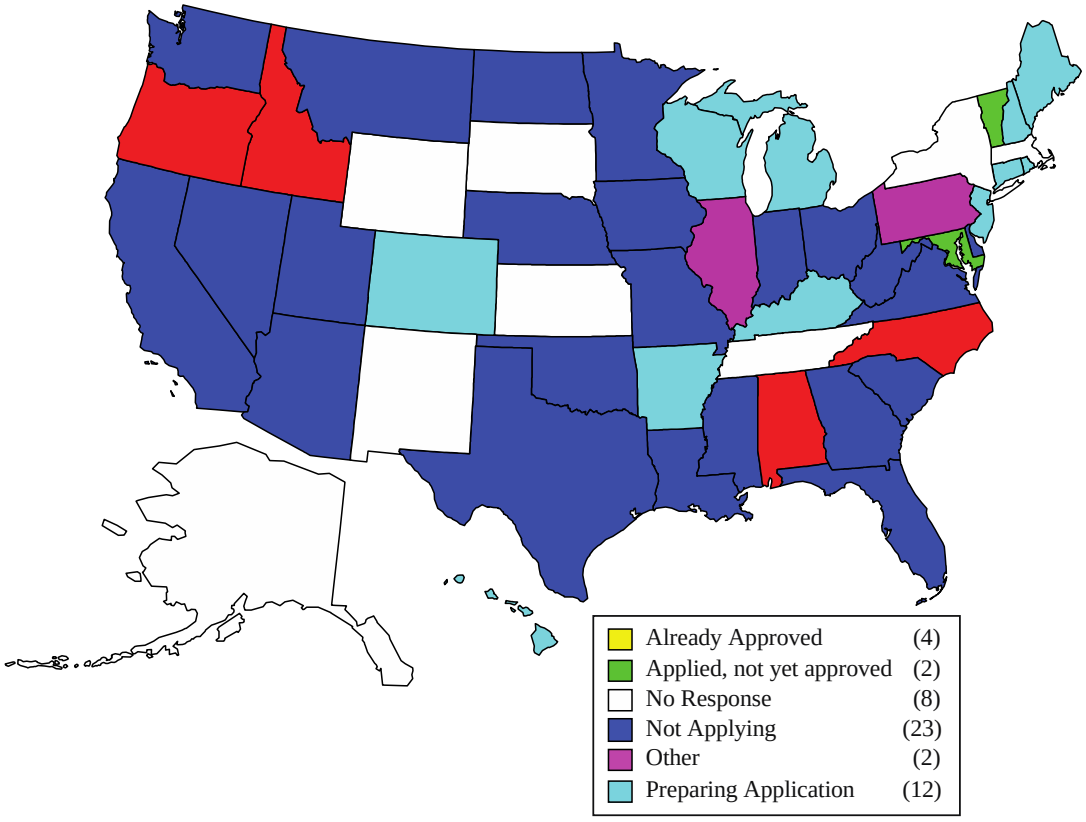
SMHAs in 26 states are working with mental health providers to help the providers become part of a health home under Medicaid. Thirteen SMHAs reported they are working with 1,952 mental health providers to become part of a health home. SMHAs are assisting providers by providing technical assistance in 26 states and by funding providers in 14 states. Mental health providers are partnering with Federally Qualified Health Centers (FQHCs) in 23 states to establish health homes that address mental health services.

Thirty SMHAs are working with FQHCs to improve the provision of mental health services. For example, Utah held a summit with all FQHCs and behavioral health providers to facilitate better coordination of services. In Montana, approved providers in FQHCs are eligible to bill for the state-funded Mental Health Services Plan for adults with serious disabling mental illness.

Medicaid Health Homes for Individuals With Substance Use Disorders

As depicted in Figure 5, states are working on plans to use health homes to provide SUD services. Four states (Alabama, Idaho, North Carolina, and Oregon) have been approved to establish Medicaid health homes that address SUD services; Maryland and Vermont have applied and are waiting for approval; and 12 states are preparing applications to establish health homes that provide SUD services.

Figure 5. Status of State Medicaid Plan Amendments That Will Include Providing Health Home Services Targeting Beneficiaries With a Substance Use Disorder, 2013



Fifteen SSAs are working with SUD providers to help the providers become part of a health home under Medicaid. Three SSAs reported they are working with 291 SUD providers to become part of a health home. SSAs are assisting providers by providing technical assistance in 15 states and by funding providers in 7 states. SUD providers are partnering with FQHCs in 14 states to establish health homes that address SUD services.

SSAs in 30 states are working with FQHCs to improve the provision of SUD services. For example, Vermont is involved in a Buprenorphine Learning Collaborative in conjunction with the Vermont Blueprint for Health.[7] In South Carolina, the Department of Alcohol and Other Drug Abuse Services has worked with the South Carolina Primary Care Association on issues related to health homes and recovery-oriented systems of care. Additionally, several local providers in South Carolina are coordinating provisions of SUD services with several corresponding local FQHCs.

[7] Vermont's Health Care Reform Agency of Administration. *Vermont blueprint for health.* Updated 2014. Retrieved from http://hcr.vermont.gov/blueprint

3.3. Single State Agency and State Mental Health Agency Workforce Capacity

With the increase in the number of individuals with M/SUD who will gain insurance coverage, many SSAs and SMHAs are concerned about ensuring that an appropriately trained behavioral health workforce is available to provide services. Only 11 SMHAs and 6 SSAs reported that they have enough providers who accept private insurance to meet emerging demand for mental health and SUD services, respectively. Eight SMHAs and 7 SSAs reported that they have enough providers who accept Medicaid to meet future demands of mental health and SUD services.

Because of concerns about having an adequate workforce, SMHAs and SSAs in 32 states are implementing programs focused on workforce capacity issues. Only the SMHAs in the District of Columbia, Maine, and Rhode Island and SSAs in Idaho, Maine, North Carolina, and Rhode Island reported that they have a sufficient workforce to meet their state's anticipated future demand for mental health and SUD services.

The SMHAs in 24 states are funding the training of the mental health workforce; the SSAs in 24 states are funding the training of the SUD workforce. The SMHAs in 13 states expended an average of $50.5 million to support the training of the mental health workforce; this amount ranged from $167,304 in Utah to $37.7 million in California. SSAs in 12 states spent an average of $6.4 million to support the training of the SUD workforce; this amount ranged from $10,000 in Hawaii to $2.3 million in New Jersey.

SMHAs and SSAs are also using telemedicine to help address the workforce shortages. Regulations or policies permit the use of telemedicine for mental health services in 30 states and for SUD services in 21 states.

In 21 states, policies or regulations permit peer specialists—mental health consumers who have received special training and serve as part of a mental health treatment team—to bill Medicaid for provision of mental health services. In addition, 22 SMHAs have certification programs that qualify peer specialists to bill Medicaid. Thirteen states permit peer specialists to bill Medicaid for provision of SUD services, whereas 10 SSAs have certification programs that qualify peer specialists to bill Medicaid.

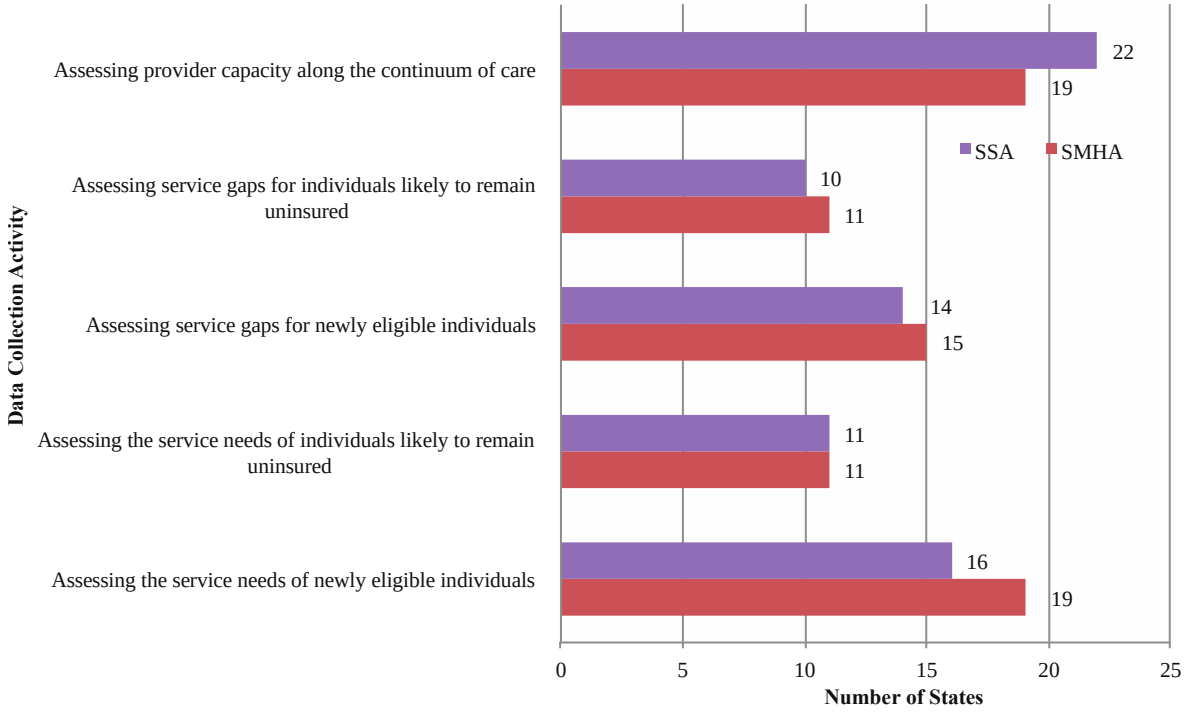
SMHAs and SSAs are also engaged in a variety of additional workforce development activities they are undertaking to prepare for future M/SUD services demand. For example, Alaska is conducting a major behavioral health system study and review to determine the state's overall M/SUD treatment capacity. In Mississippi, the Department of Mental Health is working with the Mississippi Insurance Department on initiatives to educate the workforce and to potentially assist individuals in securing insurance coverage. In Nebraska, the SSA and SMHA have efforts to implement workforce development activities, partly through the Behavioral Health Education Center of Nebraska and partly as a result of the Co-Occurring Roadmap strategic plan efforts, which include provider training and capacity development. In addition, further exploration of the formalization of a peer certification credential is occurring, with the expectation that a formal credential must be developed and billable under new Medicaid managed care. In West Virginia,

the SMHA is working on a certification program to train recovery coaches for M/SUD. The SMHA is also working on a behavioral health conference to train providers.

3.4. Single State Agency and State Mental Health Agency Data Collection Related to Health Insurance Reform

With the increase in the number of individuals with M/SUD who will potentially gain new insurance coverage and the development of new treatment programs such as health homes, many SMHAs and SSAs have the need for new data about consumers and service needs. Nineteen SMHAs are collecting data on mental health provider capacity, and 19 are collecting data on the mental health service needs of individuals who are newly eligible for insurance coverage. SSAs are collecting data on SUD provider capacity in 22 states, and 16 states are collecting data on the SUD service needs of individuals who are newly eligible for insurance coverage (see Figure 6).

Figure 6. Number of SSAs and SMHAs Collecting Data Related to the Impact of Health Insurance Reform on M/SUD Consumers and Systems, 2013



Abbreviations: SMHA, state mental health agency; SSA, single state agency; M/SUD, mental and substance use disorder

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4. Organization and Structure of State Mental Health Agencies

The SMHA is the part of state government that is primarily responsible for the organization and delivery of publicly funded mental health services. In every state, the SMHA administers the federal MHBG, including preparing, implementing, and overseeing the state's mental health plan (as required by the MHBG and by state statute, when applicable). The SMHA also funds and sometimes directly operates community mental health services. Every state also operates psychiatric inpatient beds, although these services are generally (but not always) operated by the SMHA.

4.1. State Mental Health Agency Location in State Government

The organizational location of SMHAs varies across states. The SMHA is part of the Department of Human Services in 19 states. It is an independent/stand-alone state agency in 14 states. It is in the state's health department in 7 states, and it is located in a combined health and human services department of 9 states (see Table 3).

The SMHA director reports to a cabinet secretary in 25 of the states. The director is two or more organizational layers removed from the governor in 18 states. The director reports directly to the governor as a cabinet member in 9 states. SMHA directors report to a mental health board or council charged with oversight of the SMHA in 14 states.

4.2. State Mental Health Agency Relationship With Other State Agencies

SMHAs work with other state agencies in planning and/or delivering mental health services (see Table 4). SMHAs may work with SSAs, the state intellectual disability agency, Medicaid, and housing and public health agencies. In some cases, the SMHA is in the same umbrella department as the other state agency; in others, it is in a different state department but the SMHA has an active interagency agreement.

State Medicaid Agency

The state Medicaid agency is located in the same umbrella department as the SMHA in 28 states. In 20 states, the State Medicaid agency is located in a different state department; however, in 19 of these states, the SMHA has an interagency agreement with the state Medicaid agency for planning and delivering mental health services. In California, Michigan, and Pennsylvania, the SMHA is part of the state Medicaid agency.

State Housing Agency

The state housing agency is located in a different state department outside the SMHA in 48 states. The SMHA has an interagency agreement with the state housing agency for planning and delivering mental health services in 14 of these states.

Table 3. Organization of State Mental Health Agencies (SMHAs) in State Government, 2013

State	Organization and Structure		
	SMHA Located in State Department	Levels Between Commissioner and Governor	Mental Health Board or Council Has Direct Oversight of SMHA
Alaska	Health and Human Services	2	No
Alabama	Independent	Directly	No
Arkansas	Human Services	2	No
Arizona	Health Department	1	No
California	No Response	3	No
Colorado	Human Services	1	No
Connecticut	Independent	Directly	Yes
District of Columbia	Independent	1	No
Delaware	Human Services	1	No
Florida	Human Services	2	No
Georgia	Independent	Directly	Yes
Hawaii	Health Department	2	No
Iowa	Human Services	2	No
Idaho	Human Services	2	No
Illinois	Human Services	3	No
Indiana	Human Services	1	No
Kansas	No Response	2	No
Kentucky	Human Services	1	No
Louisiana	Health Department	2	Yes
Massachusetts	Health and Human Services	1	Yes
Maryland	Health Department	2	No
Maine	Health and Human Services	Directly	Yes
Michigan	Independent	Directly	No
Minnesota	Human Services	2	No
Missouri	Independent	Directly	Yes
Mississippi	Independent	1	Yes
Montana	Health and Human Services	3	Yes
North Carolina	Health and Human Services	1	Yes
North Dakota	Human Services	1	No
Nebraska	Health and Human Services	1	No
New Hampshire	Human Services	2	No
New Jersey	Human Services	1	No
New Mexico	Human Services	1	Yes
Nevada	Health and Human Services	1	Yes
New York	Independent	1	No
Ohio	Independent	Directly	No
Oklahoma	Independent	1	Yes
Oregon	Health Department	1	No
Pennsylvania	Human Services	1	No
Rhode Island	Independent	Directly	No
South Carolina	Independent	1	Yes
South Dakota	Human Services	1	No
Tennessee	Independent	Directly	No

Table 3. Organization of State Mental Health Agencies (SMHAs) in State Government, 2013 (continued)

State	Organization and Structure		
	SMHA Located in State Department	Levels Between Commissioner and Governor	Mental Health Board or Council Has Direct Oversight of SMHA
Texas	Health Department	2	No
Utah	Human Services	1	No Response
Virginia	Independent	1	No
Vermont	Human Services	1	Yes
Washington	Human Services	2	No
Wisconsin	Health Department	2	No
West Virginia	Health and Human Services	1	No
Wyoming	Health and Human Services	2	No
Totals	Independent=14	Direct to Governor=9	Yes=14
	Human Service=19	One Level=25	No=36
	Health Department=7	Two Levels=15	No Response=1
	Health and Human Services=9	Three+ Levels=3	No Data
	No Response=2	No Response=0	No Data

Table 4. SMHA Relationship With Other State Agencies, 2013

State	SMHA Relationship With Other State Agencies				
	Substance Use Disorder	Intellectual Disabilities	Medicaid	Housing	Public Health
Alabama	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
Alaska	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	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	Same Umbrella	Other Agency	Part of SMHA	Other Agency	Other Agency
Colorado	Part of SMHA	Same Umbrella	Other Agency	Other Agency	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	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Georgia	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
Hawaii	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Same Umbrella
Idaho	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Illinois	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Other Agency
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	Part of SMHA	Same Umbrella	Other Agency	Other Agency	Other Agency
Kentucky	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
Louisiana	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Maine	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Maryland	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Massachusetts	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Michigan	Part of SMHA	Part of SMHA	Part of SMHA	No Response	Part of SMHA
Minnesota	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Other Agency
Mississippi	Part of SMHA	Part of SMHA	Other Agency	No Response	Other Agency
Missouri	Part of SMHA	Same Umbrella	Other Agency	Other Agency	Other Agency
Montana	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Nebraska	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Nevada	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Part of SMHA
New Hampshire	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
New Jersey	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Other Agency
New Mexico	Part of SMHA	Other Agency	Same Umbrella	Other Agency	Other Agency

Table 4. SMHA Relationship With Other State Agencies, 2013 (continued)

State	SMHA Relationship With Other State Agencies				
	Substance Use Disorder	Intellectual Disabilities	Medicaid	Housing	Public Health
New York	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Other Agency
North Carolina	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
North Dakota	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Other Agency
Ohio	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Oklahoma	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Oregon	Part of SMHA	Other Agency	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	Same Umbrella	Other Agency	Same Umbrella
South Carolina	Other Agency	Other Agency	Other Agency	Other Agency	Other Agency
South Dakota	Part of SMHA	Other Agency	Same Umbrella	No Response	Other Agency
Tennessee	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Texas	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Utah	Part of SMHA	Same Umbrella	Other Agency	Other Agency	Other Agency
Vermont	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Virginia	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
Washington	Part of SMHA	Same Umbrella	Other Agency	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	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
Totals	Part of SMHA=36	Part of SMHA=10	Part of SMHA=3	Part of SMHA=0	Part of SMHA=2
	Same Umbrella=11	Same Umbrella=29	Same Umbrella=28	Same Umbrella=0	Same Umbrella=21
	Other Agency=4	Other Agency=12	Other Agency=20	Other Agency=48	Other Agency=28
	No Response=0	No Response=0	No Response=0	No Response=3	No Response=0

Abbreviation: SMHA, state mental health agency

State Public Health Agency

The state public health agency is located in a different state department outside the SMHA in 28 states. In 21 states, the state public health department is located within the same umbrella department as the SMHA; however, in 17 of these states, the SMHA has an interagency agreement with the state public health department for planning and delivering mental health services. In Nevada, the state public health agency is part of the SMHA.

Single State Agency

The SSA and the SMHA are combined into a single agency in 36 states. In 11 states, the SSA and the SMHA are each located in the same umbrella department as the SMHA; however, 5 SMHAs have active interagency agreements with the SSA. The SMHA and the SSA are located in different state departments in only 4 states.

Intellectual Disability Agency

The SMHA and the state intellectual disability/developmental disability agency are combined into a single agency in 10 states. Such agencies may, in addition to persons with mental health conditions, assist those with intellectual disabilities, autism, cerebral palsy, fetal alcohol spectrum disorders and other conditions. In 29 additional states, the SMHA and the intellectual disability agency are located within the same umbrella department as the SMHA. The state intellectual disability agency is located in different state departments outside of the SMHA in 12

states; however, in 10 of these states, the SMHA has an interagency agreement with the state intellectual disability agency for planning and delivering mental health services.

4.3. State Mental Health Agency Service Responsibilities: 2013

SMHAs vary in the types of mental health services they provide and the populations they are funded to serve. In most states, the SMHA is responsible for providing community and hospital-based services for children and adults.

State Psychiatric Hospitals

In 46 states, the SMHA operates state psychiatric hospitals; in only 5 states is the operation of the state hospitals overseen by agencies other than the SMHA. In North Carolina, state psychiatric hospitals are operated by the Division of State Operated Healthcare Facilities. Funding, financial operations, contracting, information technology, and other administrative supports are provided by the SMHA. Both agencies are under the aegis of the North Carolina Department of Health and Human Services. In New Hampshire, the state hospital is operated by the Department of Health and Human Services, Division of Community Based Care Services. In New Mexico, the state hospitals are operated by the Department of Health. In South Dakota, the state hospital is operated by the Department of Social Services.

Mental Health Services for Children and Adolescents

The provision of mental health services to children and adolescents is the responsibility of the SMHA in 32 states; it is shared with another agency in 17 States. In Connecticut and Delaware, the responsibility for providing mental health services to children and adolescents resides in a separate state agency.

Mental Health Services for Older Adults

The provision of mental health services to adults aged 85 years and older is the responsibility of the SMHA in 32 states. The SMHA shares the responsibility for providing mental health services to older adults with another state agency in 17 states.

Alzheimer's Disease, Organic Brain Syndrome, and Traumatic Brain Injury Services

The SMHA is not responsible for providing services to individuals with Alzheimer's disease (36 states), organic brain syndrome (40 states), and traumatic brain injury (32 states). In a few states, the SMHA shares the responsibility to provide services to individuals with Alzheimer's disease (14 states), organic brain syndrome (8 states), and traumatic brain injury (17 states). In North Carolina and Washington, the SMHA has the sole responsibility for providing services to individuals with traumatic brain injuries and organic brain syndrome, respectively.

Court Evaluation of Mental Health Status

The SMHA is responsible for evaluating mental health status in courts in 33 states. In 13 additional states, this responsibility is shared with another agency. The SMHAs in Iowa, New Hampshire, South Dakota, and Texas do not have this responsibility.

Services for Individuals With Mental Illnesses in Prisons or Jails

Providing mental health services to individuals in prison or jail is a responsibility shared by the SMHA and another state agency in 29 states. The SMHA has no responsibility for providing services in these settings in 18 states. In Arkansas, Louisiana, New York, and Utah, providing services to individuals in prison or jail is the responsibility of the SMHA.

Services for Sex Offenders

The SMHA has no responsibility for providing services to sex offenders in 22 states. In states that provide services to sex offenders, the SMHA either shares responsibility (n=20) or is solely responsible for the services (n=8).

Substance Use Disorder Services

The SMHA is responsible for providing substance use disorder services as the SSA in 36 states. The SMHA shares the responsibility with the SSA in 8 states. The SSA is responsible for providing substance use disorder services and the SMHA has no responsibility in 6 states.

Intellectual Disability Services

SMHAs in 27 states have no responsibility for providing services that address intellectual disabilities. SMHAs in 14 states share the responsibility for providing these services with another agency, and 9 SMHA have the sole responsibility for providing these services.

4.4. State Mental Health Agency Data Systems

Data Outcomes and Quality

Every SMHA has a management information system that collects information about the clients served by the public mental health system. They also collect outcome and performance measurements that are used internally and for reporting to SAMHSA and other agencies. In some states, the mental health information management functions focus only on mental health services, whereas other states combine mental health service information with substance use disorder and/or intellectual disability services. Data from 50 reporting SMHAs reveal:

- Information management systems from 12 SMHAs focus only on mental health services.
- Twenty-three states combine mental health and substance use disorder information systems.

- Ten states combine mental health, substance use disorder, and intellectual disability service information systems.
- Two states combine mental health and intellectual disability information systems.
- Three states combine mental health with other disability services; for example, in New York, information management functions were combined statewide for all executive branch agencies in November 2012.

The 41 states that responded to the item about information management spent more than $135.8 million to operate mental health information management systems each year, with an average expenditure of $3.3 million per state. The range was from $75,874 in New Hampshire to $58.8 million in New York. Fifty-three percent of the SMHA expenditures for mental health management information systems were for personnel, and other expenses (primarily for contracted information management services and equipment) represented 47 percent of expenditures.

The funding source for 84 percent of the SMHA management information systems was from the state; federal funds contributed 6 percent, and other funds contributed 10 percent. State funds for mental health management information ranged from $52,867 in Virginia to $58.8 million in New York. Federal funds for mental health management information ranged from $17,500 in North Dakota to $1.03 million in Arizona.

A total of 920 full-time equivalent (FTE) staff worked in mental health information systems management. These FTEs were divided between staff who worked directly within the SMHA (55 percent) and those who worked outside the SMHA (45 percent) and were usually located in a centralized department-level information services office. The number of FTEs devoted to mental health management information systems averaged 19.6 per state, ranging from 1.5 in Nebraska to 255 in New York.

Health Information Technology

Since 2007, SMHAs have made substantial progress in implementing electronic health records (EHRs) within their state psychiatric hospitals and community mental health service provider agencies. Among the 50 states that reported on the status of EHR implementation in state psychiatric hospitals in 2007 and 2013, there was an increase in the number of states operating EHRs in their state psychiatric hospitals (from 17 states in 2007 to 28 states in 2013). Several additional states are currently implementing EHR systems certified to meet meaningful use criteria.

In 2013, SMHAs were working with state health information exchanges (HIEs) to share electronic health information between other mental health providers and with primary health care providers. Additionally, several SMHAs were developing personal health records (PHRs) that allow consumers to access elements of their medical records and to control and share that information with family members and providers.

Implementation of Electronic Health Records by State Psychiatric Hospitals in 2013

Twenty-eight SMHAs were operating an EHR in state psychiatric facilities in 2013. Of these 28 states, a total of 95 facilities had implemented an EHR. State psychiatric hospitals use different hosting options for implementing EHRs: 34 percent are hosted by the state psychiatric hospitals, 40 percent are hosted by the SMHA centrally, and 23 percent are hosted by a vendor.

State Hospital Electronic Health Record Costs

In FY 2012, the 26 SMHAs that reported on this item expended $83.5 million implementing and operating EHRs. The costs of EHR software for state psychiatric hospitals (including customization required by the SMHA) averaged $2.6 million per state. Based on 17 states reporting EHR costs, the median cost was $1.5 million, and the costs ranged from $100,000 in Ohio to $10 million in Oregon. In addition to the cost of purchasing EHR systems, most EHRs have an annual maintenance fee. Maintenance fees for state psychiatric hospital EHR systems averaged $453,465 per year (median was $300,108 per year). In addition, states spent an average of $1.6 million (median was $100,000 per state) to train staff to use and maintain the EHR system. SMHAs expended an average of $167,117 in additional costs (mostly for hardware, consulting services, and other accessories to operate EHRs in their state psychiatric hospitals).

Community Mental Health Provider Use of Electronic Health Records

Implementation of EHRs by community mental health programs was more difficult for SMHAs to track, because many community mental health service providers are private not-for-profit agencies responsible for their own EHR systems. Twenty-eight SMHAs reported implementing EHRs in CMHCs. Of the 28 states reporting on the implementation of EHRs, 95 CMHCs have an EHR. SMHAs reported that 63 percent of CMHC EHRs are hosted by the provider, 23 percent are hosted by the SMHA (centrally), and 69 percent are hosted by a vendor.

Certification for Meaningful Use of State Mental Health Agency Electronic Health Record Systems

The American Recovery and Reinvestment Act of 2009 (ARRA) provided more than $19 billion to incentivize medical providers to use health information technology (HIT) to help foster the adoption and meaningful use of EHRs and other types of HIT. ARRA, through the Health Information Technology for Economic Clinical Health (HITECH) Act (http://www.healthit.gov/policy-researchers-implementers/behavioral-health) authorizes the Centers for Medicare & Medicaid Services (CMS) to provide a reimbursement incentive for physician and hospital providers that meet standards for meaningful use of an EHR. Even if state psychiatric hospitals and CMHCs use certified EHR systems and meet the meaningful use criteria, however, they are not eligible providers for incentive payments. However, many state psychiatric hospitals and community mental health providers are upgrading to or requiring new EHRs that are certified to meet meaningful use criteria to facilitate future exchanges of EHR information.

In 2013, 21 states reported that all of their state hospitals were using a certified EHR system. In 2 states, some of the state psychiatric hospitals were using a certified EHR system. Seventeen additional states reported that their EHRs are not certified, but most reported working toward certifications.

Despite being ineligible to receive ARRA meaningful use incentive payments directly, many community mental health providers are installing certified EHRs. All EHR systems used by community mental health programs are certified in 9 states. In 18 additional states, some community providers had EHRs that were certified, and 5 additional states reported that their EHRs were not certified.

Implementation of Electronic Health Record Components

EHRs address many aspects of documenting health care, including admissions, diagnoses, clinical assessments, ordering and reviewing of medical test results, pharmacy, diet, billing, and additional functions traditionally recorded in paper records. State psychiatric hospitals and CMHCs were in various stages of implementing different EHR components.

The most commonly implemented EHR components for state psychiatric hospitals were patient admission, discharge, and transfer; reporting; treatment and recovery planning; progress and case documentation; and billing. The most commonly implemented EHR components for CMHCs were patient admission, discharge, and transfer; progress and case documentation; reporting; and treatment and recovery planning. See Table 5 for a list of EHR component implementation for state hospitals and CMHCs.

Table 5. Electronic Health Record Components Implemented in State Psychiatric Facilities and CMHCs, 2013

EHR Function	State Hospitals	CMHCs
Reporting	26	37
Progress and case documentation	23	37
Treatment and recovery planning	23	36
Clinical assessments	23	36
Patient admission, discharge, transfer	30	35
Billing	25	35
Scheduling	15	31
Physician order entry	19	23
Pharmacy	26	22
External consultants	6	17
Exchanging client information with providers	7	17
Patient trust or representative payee	10	14
Medication algorithms	10	12
Dietary	16	5
Other	0	3

Abbreviations: CMHC, community mental health center; EHR, electronic health records

Sharing Electronic Health Record Information and State Mental Health Agency Involvement

Some states have agreements in the community and inpatient systems to share all EHR client data to improve the coordination of care. Data-sharing agreements in 24 SMHAs allowed different state psychiatric hospitals within the state to share EHR information. These agreements allowed the sharing of EHR client data between community mental health providers and state psychiatric hospitals in 11 SMHAs. EHR client data were shared between community mental health service providers in 8 SMHAs, and EHR data were shared through an HIE in 11 SMHAs.

Consumer Access to Their Own Electronic Health Record Data and Personal Health Records

PHRs are records designed to help consumers track their health care services, medications, and medical history. The consumer can also elect to share these records with providers and others to facilitate communication. Three SMHAs have implemented a PHR for consumers, and 13 are designing a PHR or working with other providers to support a PHR.

Mental health consumers in 18 states had access to their EHR data through the individual mental health provider. Consumers in seven states had access to their EHR data through the SMHA, and two states (Alaska and New Jersey) provided consumers access to their EHR data through an HIE.

The federal Healthcare Insurance Portability and Accountability Act (HIPAA) specifies a minimum level of protection for the privacy of consumer medical records, but HIPAA also permits states to pass laws with additional privacy protections for mental health consumers. Twenty-six states have laws or rules providing confidentiality and privacy protections for mental

health records that are more extensive than those required by the federal laws. In 17 states, the SMHA has client authorizations in place for sharing EHR data between mental health providers and an HIE. SMHAs reported that opt-in models for exchange of EHR data are used in 15 states; for these models, consumers must agree to share their EHR data. Opt-out models are used in six states; in these models, data are shared unless the consumer elects to opt out of such sharing.

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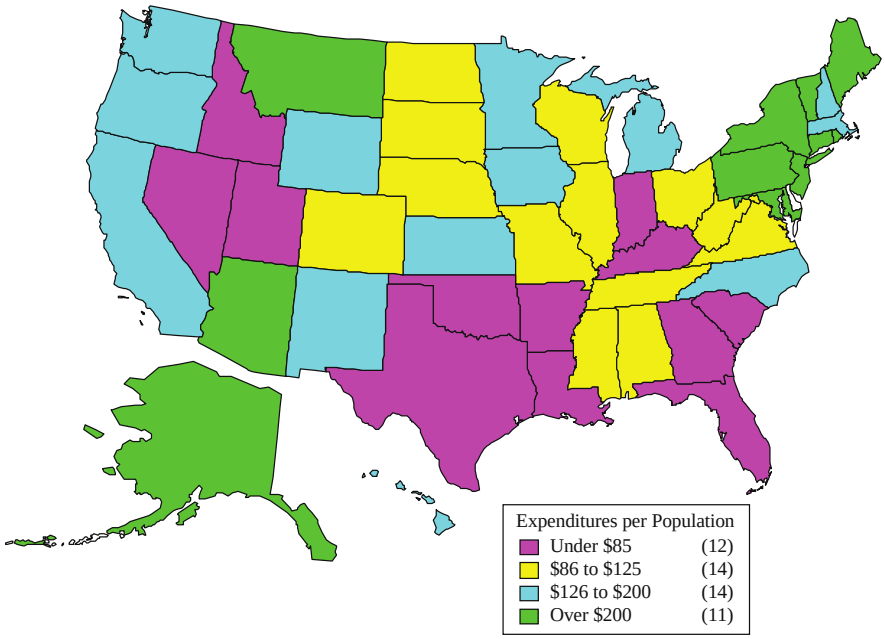
5. Financing of Mental or Substance Use Disorder Services

In SFY 2012, states expended more than $44.2 billion providing M/SUD services through their SMHAs and SSAs. States expended an average of $141.33 per capita (expenditures divided by the state's population) providing M/SUD services, ranging from $44.62 per capita in Texas to $417.31 in Alaska. States expended $39.3 billion on SMHA services (89 percent of combined SMHA/SSA expenditures) and $4.9 billion (11 percent) on SSA services (see Figure 7 and Table 6).

Figure 7. SSA and SMHA Per Capita Expenditures for M/SUD Services, FY 2012



Abbreviations: FY, fiscal year; M/SUD, mental and substance use disorder; SMHA, state mental health agency; SSA, single state agency

State government general revenues were the largest source of funding for SSAs, whereas Medicaid (joint state-federal program) was the largest source for SMHAs (see Figure 8). The SABG was the second largest funding source for SSAs, whereas state general revenues were the second largest source for SMHAs.

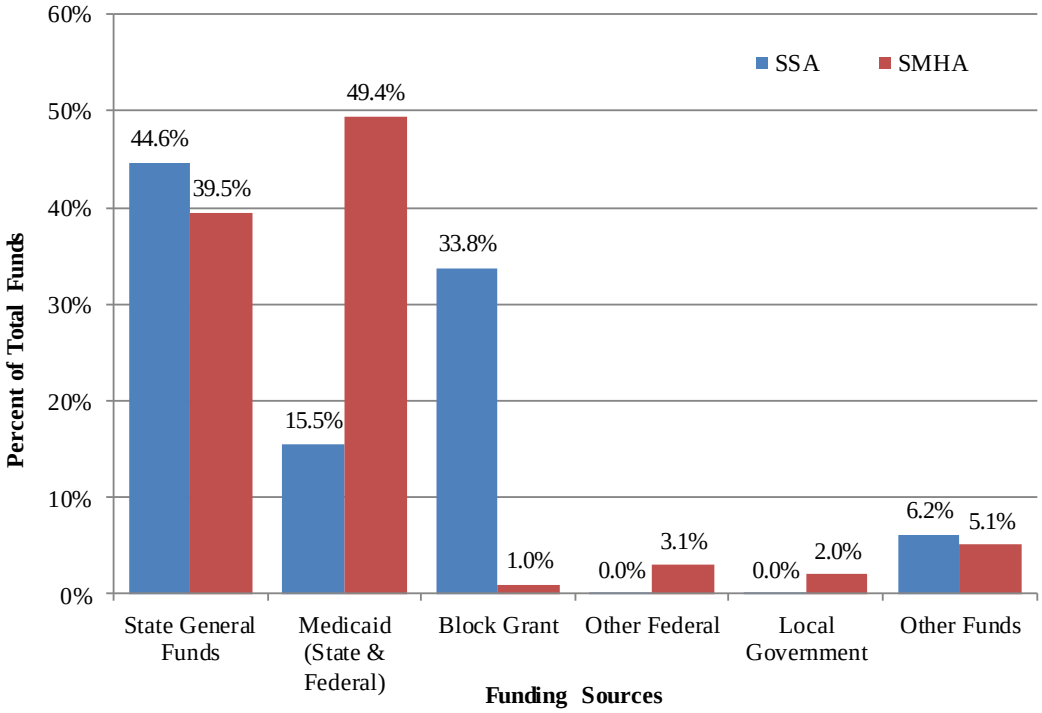
Table 6. SSA and SMHA Expenditures for M/SUD Services, FY 2012

State	Total SMHA Expenditures, $	SMHA	SSA Expenditures, $	SSA	Combined SMHA and SSA Total $	Combined Per Capita, $
Alabama	366,898,613	89	43,100,000	11	409,998,613	85.23
Alaska	238,174,700	80	58,200,000	20	296,374,700	417.31
Arizona	1,367,300,000	89	170,400,000	11	1,537,700,000	235.37
Arkansas	122,468,795	83	24,900,000	17	147,368,795	50.08
California	6,427,441,175	92	587,500,000	8	7,014,941,175	185.15
Colorado	489,512,645	89	59,200,000	11	548,712,645	106.50
Connecticut	764,700,000	77	223,600,000	23	988,300,000	275.83
Delaware	91,331,448	80	22,800,000	20	114,131,448	124.99
District of Columbia	192,258,671	82	41,600,000	18	233,858,671	371.45
Florida	717,602,739	80	177,200,000	20	894,802,739	46.49
Georgia	552,406,718	82	120,200,000	18	672,606,718	68.29
Hawaii	176,860,012	85	30,400,000	15	207,260,012	153.70
Idaho	51,800,000	64	29,600,000	36	81,400,000	51.13
Illinois	961,900,000	82	210,200,000	18	1,172,100,000	91.24
Indiana	461,207,000	90	49,200,000	10	510,407,000	78.11
Iowa	441,900,000	92	37,900,000	8	479,800,000	156.15
Kansas	385,000,000	90	41,500,000	10	426,500,000	148.99
Kentucky	239,800,000	87	35,500,000	13	275,300,000	63.23
Louisiana	300,116,414	81	72,600,000	19	372,716,414	81.36
Maine	449,185,236	93	35,600,000	7	484,785,236	365.04
Maryland	1,081,300,000	89	127,500,000	11	1,208,800,000	206.39
Massachusetts	721,300,000	86	121,800,000	14	843,100,000	126.97
Michigan	1,186,500,000	89	151,300,000	11	1,337,800,000	135.42
Minnesota	904,062,333	86	150,800,000	14	1,054,862,333	196.19
Mississippi	316,626,000	94	19,800,000	6	336,426,000	113.28
Missouri	553,639,069	83	111,500,000	17	665,139,069	110.79
Montana	198,154,573	92	16,900,000	8	215,054,573	214.77
Nebraska	156,826,196	81	37,400,000	19	194,226,196	105.04
Nevada	163,200,000	87	25,300,000	13	188,500,000	68.62
New Hampshire	179,617,352	93	13,800,000	7	193,417,352	146.60
New Jersey	1,864,588,000	93	144,700,000	7	2,009,288,000	226.92
New Mexico	272,400,000	87	39,400,000	13	311,800,000	150.45
New York	5,055,600,000	90	541,200,000	10	5,596,800,000	286.41
North Carolina	1,566,165,795	91	162,600,000	9	1,728,765,795	179.23
North Dakota	59,633,673	75	20,400,000	25	80,033,673	115.65
Ohio	843,055,168	80	211,300,000	20	1,054,355,168	91.41
Oklahoma	213,124,000	76	67,100,000	24	280,224,000	73.92
Oregon	692,800,000	93	48,200,000	7	741,000,000	190.17
Pennsylvania	3,764,500,000	97	108,400,000	3	3,872,900,000	303.57
Rhode Island	111,280,955	82	24,600,000	18	135,880,955	129.86
South Carolina	267,300,000	89	32,000,000	11	299,300,000	63.91
South Dakota	70,990,051	78	20,000,000	22	90,990,051	109.69
Tennessee	571,600,000	90	62,000,000	10	633,600,000	98.49
Texas	986,500,000	85	170,300,000	15	1,156,800,000	44.62
Utah	183,500,000	81	44,200,000	19	227,700,000	79.90
Vermont	158,400,000	84	29,100,000	16	187,500,000	299.81
Virginia	746,600,000	89	91,100,000	11	837,700,000	103.76
Washington	773,900,000	83	158,700,000	17	932,600,000	136.15
West Virginia	155,500,000	89	19,800,000	11	175,300,000	94.55
Wisconsin	589,000,394	94	34,600,000	6	623,600,394	108.95
Wyoming	63,870,600	60	42,800,000	40	106,670,600	186.18
Average (mean)	**769,988,202**	**85**	**96,466,667**	**15**	**866,454,869**	**150.06**
Median	**441,900,000**	**87**	**48,200,000**	**13**	**479,800,000**	**124.99**
Number of states reporting	**51**	**51**	**51**	**51**	**51**	**51**

Abbreviations: M/SUD, mental and substance use disorder; SMHA, state mental health agency; SSA, single state agency

Sources: SMHA data are from the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI) 2012 Revenues and Expenditures Study. SSA data are from WebBGAS Table 4a (extracted March 2013).

Figure 8. Funding Sources of SSA and SMHAs, FY 2012



Abbreviations: FY, fiscal year; SMHA, state mental health agency; SSA, single state agency

5.1. Single State Agency and State Mental Health Agency Funding Over Time

From FY 1985 to FY 2012, combined SSA and SMHA expenditures for M/SUD services increased from $9.8 billion to $43.8 billion—an annual increase of 5.7 percent over the 27-year time period. During that time, SSA expenditures increased by an average of 4.8 percent per year, and SMHA expenditures increased an average of 5.8 percent per year (see Table 7).

Table 7. SSA and SMHA Funding, FY 1985 Through FY 2012

	1985		2012		FY 1985 to FY 2012 Annual Change	
Funding Source	SSA, $	SMHA, $	SSA, $	SMHA, $	SSA, %	SMHA, %
State Funds	0.71	6.17	2.19	15.02	4.2	3.3
SAMHSA Block Grants	0.24	0.24	1.66	0.40	7.2	1.9
Medicaid	NA	1.09	NA	19.49	NA	11.3
Other	0.47	0.91	1.07	3.98	3.0	5.6
Total	1.36	8.42	4.92	38.89	4.8	5.8

Abbreviations: FY, fiscal year; NA, not available; SAMHSA, Substance Abuse and Mental Health Services Administration; SMHA, state mental health agency; SSA, single state agency

SMHAs have experienced most of their increases in funding from Medicaid—which grew at an average annual rate of 11.3 percent from FY 1985 to FY 2012—followed by other funds and state general funds. FY 1985 data for SSA Medicaid funds are not available, but the SABG had the highest rate of annual increase (7.2 percent per year), followed by state funds (4.2 percent).

5.2. Financing State Mental Health Agency Services

SMHAs use a variety of approaches to finance their public mental health system. Although all SMHAs receive state general revenue funds, Medicaid is often the largest single payer for SMHA mental health services. Medicaid is a joint state-federal program that includes some required services offered by all states and allows each state to elect from a variety of Medicaid options and waivers to provide health and support services, expand eligibility groups for Medicaid, and use various payment approaches, prior authorizations, and cost controls.

Thirty-one SMHAs use a combination of fee-for-service and managed care approaches to pay for mental health services with Medicaid, 15 rely only on fee-for-service approaches, and 4 use only managed care (see Figure 9).

Figure 9. Medicaid Reimbursement Approaches for Mental Health Services, by State, 2013

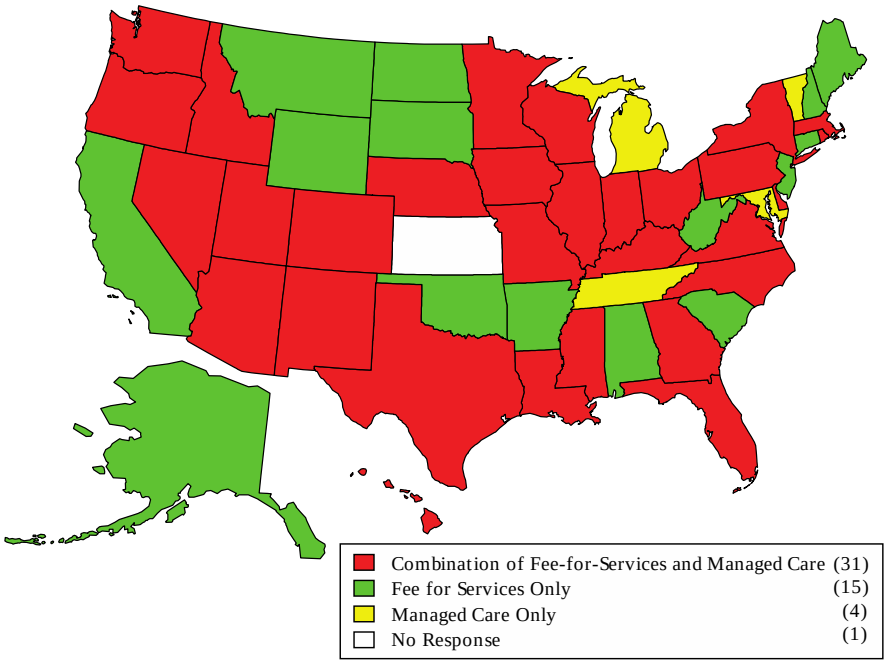


Table 8 shows that 31 states use managed care, to some extent, to provide mental health and SUD services; however, 6 states use managed care to provide mental health services but not SUD services. Managed care is most often provided by states using a Medicaid waiver, but in some states, managed care plans are supported with state general and other funds. Twenty states use Medicaid 1115 Research and Demonstration waivers, and 19 states use Medicaid 1915(b) managed care waivers (note that some states may use multiple 1915(b) waivers). Ten states use Medicaid 1915(c) Home and Community-Based Services waivers to support mental health or SUD services.

Table 8. Use of Managed Care and Medicaid Waivers to Provide Behvioral Health Services, 2013

State	State Uses Managed Care to Provide Behavioral Health Services	Type of Medicaid Waivers Used to Provide Behavioral Health Services			
		1115 Waiver	1915(b)	1915(c) Waiver	Other Managed Care
Alabama	No Managed Care	No	No	No	No
Alaska	No Managed Care	No	No	No	No
Arizona	M/SUD	Yes	No	No	No
Arkansas	No Managed Care	No	No	No	No
California	Mental Health	No	Yes	No	No
Colorado	Mental Health	No	Yes	No	No
Connecticut	M/SUD	No	No	Yes	Yes, see Table 8a
Delaware	M/SUD	Yes	No	No	No
District of Columbia	M/SUD	No	No	No	Yes, see Table 8a
Florida	Mental Health	Yes	Yes	No	Yes, see Table 8a
Georgia	M/SUD	No	No	Yes	Yes, see Table 8a
Hawaii	M/SUD	Yes	No	No	No
Idaho	M/SUD	No	Yes	No	No
Illinois	M/SUD	No	No	No	Yes, see Table 8a
Indiana	M/SUD	Yes	No	Yes	No
Iowa	M/SUD	Yes	Yes	No	No
Kansas	M/SUD	Yes	No	No	No
Kentucky	Mental Health	No	Yes	No	No
Louisiana	M/SUD	No	Yes	Yes	Yes, 1915 (i)
Maine	No Managed Care	No	No	No	Yes, see Table 8a
Maryland	M/SUD	Yes	No	Yes	No
Massachusetts	M/SUD	Yes	Yes	No	Yes, see Table 8a
Michigan	M/SUD	No	Yes	Yes	No
Minnesota	M/SUD	Yes	Yes	No	No
Mississippi	Mental Health	No	No	No	Yes, see Table 8a
Missouri	M/SUD	No	Yes	No	No
Montana	No Managed Care	No	No	No	No
Nebraska	M/SUD	No	Yes	No	No
Nevada	M/SUD	Yes	No	No	Yes, see Table 8a
New Hampshire	No Managed Care	No	No	No	No
New Jersey	No Managed Care	Yes	No	No	No
New Mexico	M/SUD	Yes	Yes	No	No
New York	M/SUD	Yes	No	Yes	No
North Carolina	M/SUD	No	Yes	No	No
North Dakota	No Managed Care	No	No	No	No
Ohio	No Managed Care	No	No	No	No
Oklahoma	No Managed Care	No	No	No	No
Oregon	M/SUD	Yes	No	No	Yes, 1915 (i)
Pennsylvania	M/SUD	No	Yes	No	No
Rhode Island	M/SUD	Yes	No	No	No
South Carolina	M/SUD	No	No	Yes	Yes, see Table 8a
South Dakota	No Managed Care	No	No	No	No
Tennessee	M/SUD	Yes	No	No	No
Texas	M/SUD	Yes	Yes	Yes	Yes, see Table 8a
Utah	No Managed Care	No	No	No	Yes, see Table 8a
Vermont	M/SUD	Yes	No	No	No
Virginia	M/SUD	No	Yes	No	No
Washington	Mental Health	No	Yes	No	No
West Virginia	No Managed Care	No	No	No	Yes, see Table 8a
Wisconsin	M/SUD	Yes	Yes	Yes	Yes, see Table 8a
Wyoming	No Managed Care	No	No	No	No
Totals	31=M/SUD	20=Yes	19=Yes	10=Yes	15=Yes
	6=Mental Health Only	31=No	32=No	41=No	36=No
	14=No Managed Care	No Data	No Data	No Data	No Data

Abbreviation: M/SUD, mental and substance use disorder

Table 8a. Description of Other Managed Care, 2013

State	Description of Other Managed Care Initiatives
Connecticut	Connecticut has formed a Behavioral Health Partnership with the Departments of Social Services and Children and Families and has contracted with an administrative services organization (ASO) to manage the behavioral health Medicaid benefit.
District of Columbia	The District does not operate a 1915(b) waiver per se; rather the authority is incorporated into the State Plan and allows the District to enroll certain beneficiaries on a mandatory basis.
Florida	The Department of Children and Families has contracted with behavioral health managing entities statewide to administer behavioral health services. The entities are defined as Florida corporations that are exempt from taxation under a 501(c) (3). These corporations contract with the Department to manage the daily delivery of behavioral health services (i.e., substance use disorder prevention and treatment and mental health services) through the establishment of local networks. The goal of these entities is to promote improved access to care and service continuity by creating a more efficient and effective management system of substance use disorder and mental health services.
Georgia	Georgia uses an external review organization.
Illinois	The Illinois Medicaid Authority Healthcare and Family Services has initiated several managed care initiatives in preparation for health reform and Medicaid reform.
Massachusetts	MassHealth is participating in the CMS Duals Demonstration, which includes all Medicare services, Medicaid State Plan services, some additional behavioral health diversionary services, and other flexible supports such as peers.
Maine	Currently, APS Healthcare acts as an ASO for designated mental health and substance use disorder services. The department is embarking on a value-based purchasing strategy model and is considering an interface with an ACO model for all Medicaid-related services. There are currently no waivers in place related to managing behavioral health services.
Mississippi	Mississippi Coordinated Access Network (CAN) is being conducted under the 1932 State Plan Authority by the Mississippi Division of Medicaid. Legislation allows up to 45% of participants to be enrolled in managed care in certain mandated categories.
Nevada	Nevada Medicaid requires managed care organizations to provide behavioral health services to their enrollees (among other medical services). Managed care is mandatory in urban Clark (Las Vegas) and Washoe (Reno) counties for all recipients who are not categorically excluded. Certain groups of Nevada Medicaid recipients are allowed to voluntarily disenroll from managed care, such as populations with serious emotional disturbance (SED) and SMI. Nevada submitted an 1115 Research and Demonstration Waiver to CMS in April 2012. CMS is considering initially approving part of the waiver: the section that focuses on the implementation of a care management organization (CMO). Recipients in the fee-for-service Medicaid program with chronic conditions will be mandatorily enrolled in the CMO. Eligible chronic conditions include mental and substance use disorders. Recipients in the CMO will receive medical case management and care coordination services. All other services will continue to be billed through the fee-for-service system.
South Carolina	By entering into managed care contracts with private managed care organizations, the SMHA is providing direct services for behavioral health needs.
Texas	Texas provides capitated health and behavioral health services to children in foster care through the state under 1915(a) authority. This is an option to the regular Medicaid delivery system and thus did not require a waiver to implement. The program is called STARHealth.
Utah	Local mental health and substance use disorder authorities are capitated providers under Medicaid and are “at-risk” for the populations they serve.
Wisconsin	Wisconsin uses 1915(a) Wraparound Milwaukee and Children Come First (Dane County), 1932(a) Wisconsin Partnership and Badger Care Plus, and Wisconsin Programs for All-Inclusive Care of the Elderly (PACE)
West Virginia	West Virginia uses an ASO for utilization management for their mental health and substance use disorder benefit.

Abbreviations: ACO, accountable care organization; CMS, Centers for Medicare & Medicaid Services; SMHA, state mental health agency; SMI, severe mental illness

In addition to the use of Medicaid waivers, Medicaid offers the 1915(i) Home and Community-Based Services options that allow states to offer additional home and community-based services through a state Medicaid plan amendment. Seventeen states are planning to use the 1915(i)

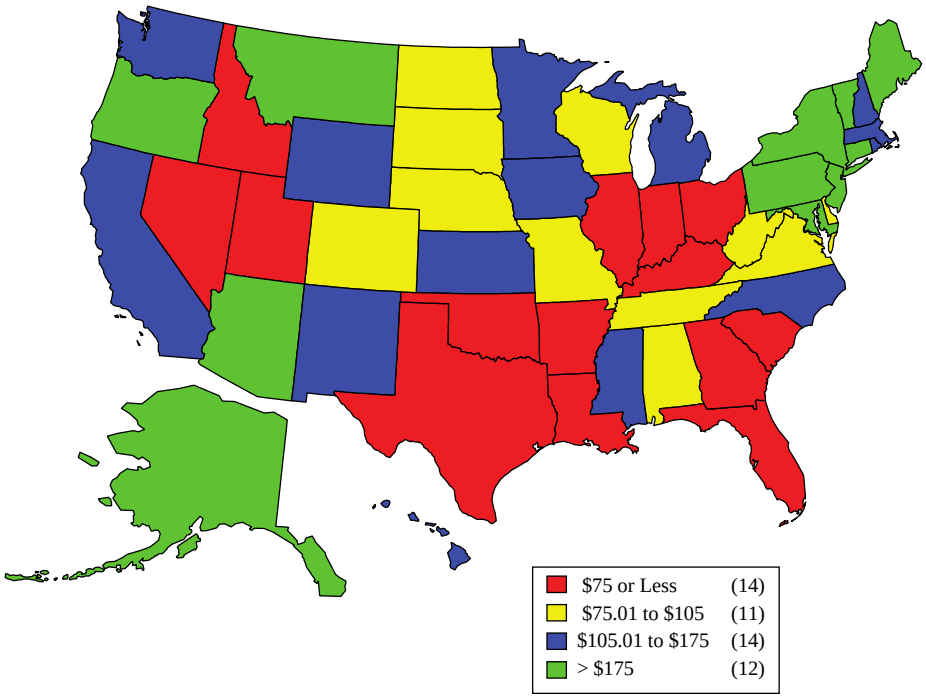
option to provide mental health services. As of 2013, four states (Iowa, Michigan, Oregon, and Wisconsin) have approved 1915(i) options for mental health; three states (Delaware, Indiana, and Nevada) have applied to use the 1915(i) option; and seven states (Alabama, District of Columbia, Georgia, Missouri, New York, North Dakota, and Texas) are preparing applications.

Nineteen SMHAs are responsible for setting the Medicaid rates for mental health services. Sixteen SMHAs are responsible for setting rates for mental health services provided by SMHA-funded providers, and 15 SMHAs set Medicaid rates for mental health services provided by SMHA-operated providers. Only four SMHAs are responsible for setting Medicaid rates for mental health services provided by organizations that do not receive SMHA funding.

State Mental Health Agency Expenditures and Revenues for Mental Health Services

SMHAs in the 50 states and the District of Columbia administered more than $39.2 billion for mental health services and supports. These funds came from a variety of state, federal, and local government sources, as well as from first- and third-party (insurance) payments. The funds covered expenditures for state psychiatric hospitals, community mental health services, and the SMHAs' central office administration, research, training, prevention, licensing, and data systems, among other functions. SMHAs expended $125.59 per civilian resident of the United States, with a median per capita expenditure of $106.35. SMHA per capita expenditures ranged from less than $50 per capita in Florida, Idaho, and Texas to more than $300 in Alaska, the District of Columbia, and Maine (see Figure 10 and Table 9).

Figure 10. Total SMHA-Controlled per Capita Expenditures for Mental Health Services, FY 2012



Abbreviation: FY, fiscal year; SMHA, state mental health agency

Table 9. SMHA-Controlled Mental Health Actual Dollar and Per Capita Expenditures, FY 2012

State	Total Expenditure, $	Per Capita Expenditures, $	Per Capita (<135% Poverty), $
Alabama	366,898,613	76.27	358.30
Alaska[a]	238,174,700	335.36	1,920.76
Arizona	1,367,300,000	209.29	834.23
Arkansas[a,b]	122,468,795	41.62	153.28
California[a,c]	6,427,441,175	169.65	694.26
Colorado[a]	489,512,645	95.01	524.10
Connecticut	764,700,000	213.43	1,487.74
Delaware[a,c]	91,331,448	100.02	516.00
District of Columbia	192,258,671	305.37	1,273.24
Florida	717,602,739	37.28	164.97
Georgia[d]	552,406,718	56.08	223.10
Hawaii	176,860,012	131.16	710.28
Idaho	51,800,000	32.54	136.68
Illinois	961,900,000	74.88	366.30
Indiana	461,207,000	70.58	330.61
Iowa	441,900,000	143.81	869.88
Kansas	385,000,000	134.49	651.44
Louisiana	300,116,414	65.51	231.57
Maine[d]	449,185,236	338.24	1,754.63
Maryland[d]	1,081,300,000	184.62	1,351.63
Massachusetts[a]	721,300,000	108.62	688.26
Michigan	1,186,500,000	120.10	576.81
Minnesota	904,062,333	168.15	1,194.27
Mississippi	316,626,000	106.61	422.17
Missouri	553,639,069	92.21	409.19
Montana	198,154,573	197.89	808.79
Nebraska	156,826,196	84.82	538.92
Nevada	163,200,000	59.41	269.75
New Hampshire	179,617,352	136.14	1,205.49
New Jersey[d]	1,864,588,000	210.58	1,288.59
New Mexico	272,400,000	131.44	450.99
New York[e]	5,055,600,000	258.71	1,152.67
North Dakota	59,633,673	86.17	621.18
Ohio[b]	843,055,168	73.09	344.39
Oklahoma	213,124,000	56.22	267.41
Oregon	692,800,000	177.80	849.02
Pennsylvania[a]	3,764,500,000	295.08	1,579.73
Rhode Island	111,280,955	106.35	535.00
South Carolina	267,300,000	57.07	209.48
South Dakota	70,990,051	85.58	417.59
Tennessee	571,600,000	88.85	382.85
Texas	986,500,000	38.05	151.51
Utah[d]	183,500,000	64.39	340.45
Vermont	158,400,000	253.28	1,480.37
Virginia[d]	746,600,000	92.48	579.66
Washington	773,900,000	112.98	564.07

Table 9. SMHA-Controlled Mental Health Actual Dollar and Per Capita Expenditures, FY 2012 (continued)

State	Total Expenditure, $	Per Capita Expenditures, $	Per Capita (<135% Poverty), $
West Virginia[a,c]	155,500,000	83.87	331.56
Wisconsin[d]	589,000,394	102.90	545.37
Wyoming[a]	63,870,600	111.48	651.74
Total	39,269,398,325	125.59	580.23
Average (mean)	769,988,202	129.27	673.33
Median	441,900,000	106.35	545.37
Number of states reporting	51	51	51

Abbreviation: FY, fiscal year; SMHA, state mental health agency

[a] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[b] SMHA expenditures are from FY 2010.

[c] Children's mental health expenditures are not included in SMHA controlled expenditures.

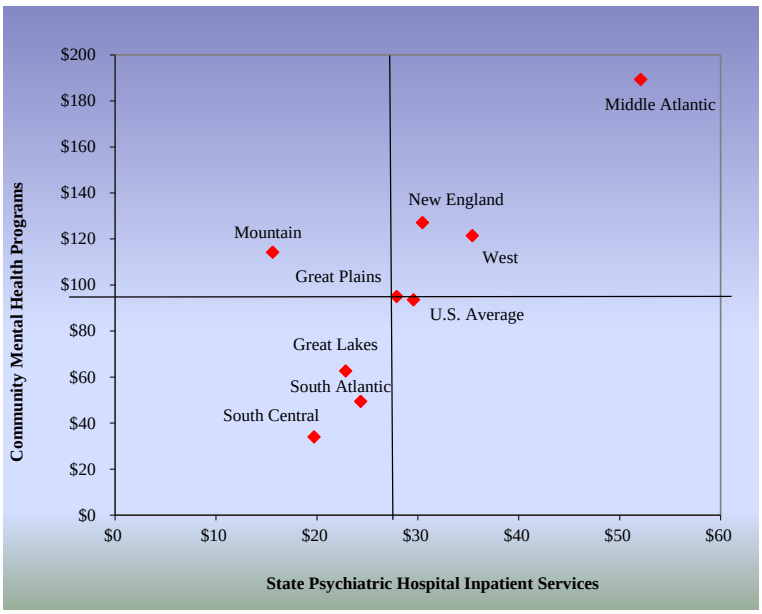
[d] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[e] SMHA expenditures are from FY 2011.

State Mental Health Agency Expenditures for Mental Health Services, by Region

State mental health expenditures vary by region of the country. States in the Mid-Atlantic and New England regions had the highest levels of mental health expenditures, and states in the South Central and South Atlantic regions had the lowest (see Figure 11).

Figure 11. SMHA-Controlled Mental Health Expenditures, by Region, 2012



Notes:
Great Lakes = Illinois, Indiana, Michigan, Ohio, and Wisconsin
Great Plains = Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota
Middle Atlantic = Delaware, District of Columbia, Maryland, New Jersey, New York, and Pennsylvania

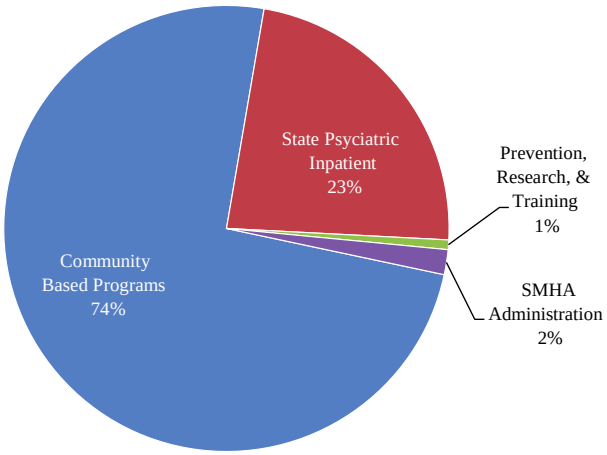
Mountain = Arizona, Colorado, Idaho, Montana, New Mexico, Utah, and Wyoming
New England = Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
South Atlantic = Florida, Georgia, North Carolina, South Carolina, Virginia, and West Virginia
South Central = Alabama, Arkansas, Kentucky, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas
West = Alaska, California, Hawaii, Nevada, Oregon, and Washington

Abbreviation: SMHA, state mental health agency

Expenditures by Type of Mental Health Programs

SMHAs operate state psychiatric hospitals and either operate or fund community-based mental health services. In FY 2012, SMHAs expended $29.2 billion providing community mental health services, which represented 74 percent of total SMHA expenditures. SMHAs expended an additional $9.2 billion providing state psychiatric hospital inpatient services, which represented 23 percent of SMHA expenditures. SMHAs spent an additional $796 million (2.0 percent of total SMHA expenditures) on administration (at SMHAs' central and regional offices) and on prevention, research, and training activities (see Figure 12 and Table 10).

Figure 12. SMHA-Controlled Expenditures by Type of Program, FY 2012



Abbreviations: FY, fiscal year; SMHA, state mental health agency

Table 10. SMHA-Controlled Mental Health Total and Per Capita Expenditures, by Type of Program, FY 2012 (Totals in Millions)

State	State Psychiatric Hospital-Inpatient Expenditures			Community-Based Programs Expenditures			Prevention, Research, Training, and SMHA-Administration Expenditures			Total SMHA-Controlled Expenditures	
	Total $	Per Capita $	%	Total $	Per Capita $	%	Total $	Per Capita $	%	Total $	Per Capita $
Alabama	132.7	27.59	36	225.8	46.94	62	8.4	1.75	2.3	366.9	76.27
Alaska[a]	32.2	45.36	14	200.2	281.93	84	5.7	8.08	2.4	238.2	335.36
Arizona	70.2	10.75	5	1,280.2	195.96	94	16.9	2.59	1.2	1,367.3	209.29
Arkansas[a,b]	43.8	14.87	36	73.7	25.05	60	5.0	1.69	4.1	122.5	41.62
California[a,c]	1,316.8	34.76	20	5,065.5	133.70	79	45.1	1.19	0.7	6,427.4	169.65
Colorado[a]	108.7	21.10	22	380.8	73.91	78	0.0	0.00	0	489.5	95.01
Connecticut	194.4	54.26	25	518.8	144.80	68	51.5	14.37	6.7	764.7	213.43
Delaware[a,c]	38.8	42.48	42	50.2	55.01	55	2.3	2.53	2.5	91.3	100.02
District of Columbia	82.6	131.23	43	79.0	125.43	41	30.7	48.71	16.0	192.3	305.37
Florida	319.4	16.60	45	377.9	19.63	53	20.3	1.05	2.8	717.6	37.28
Georgia[d]	205.1	20.82	37	347.3	35.27	63	0.0	0.00	0	552.4	56.08
Hawaii	58.0	43.01	33	106.4	78.88	60	12.5	9.27	7.1	176.9	131.16
Idaho	26.5	16.65	51	22.7	14.26	44	2.6	1.63	5.0	51.8	32.54
Illinois	267.0	20.78	28	672.6	52.36	70	22.3	1.74	2.3	961.9	74.88
Indiana	153.6	23.51	33	301.4	46.12	65	6.2	0.95	1.3	461.2	70.58
Iowa	43.8	14.24	10	402.5	131.00	91	4.9	1.59	1.1	441.9	143.81
Kansas	93.3	32.59	24	290.4	101.45	75	1.3	0.45	0.3	385.0	134.49
Kentucky	114.1	26.20	48	115.6	26.55	48	10.1	2.32	4.2	239.8	55.07
Louisiana	124.7	27.21	42	135.7	29.63	45	11.1	2.42	3.7	300.1	65.51
Maine[d]	48.8	36.78	11	389.2	293.10	87	11.1	8.36	2.5	449.2	338.24
Maryland[d]	229.4	39.17	21	821.4	140.24	76	30.5	5.21	2.8	1,081.3	184.62
Massachusetts[a]	90.4	13.61	13	611.4	92.07	85	19.5	2.94	2.7	721.3	108.62
Michigan	231.1	23.39	19	949.1	96.07	80	6.3	0.64	0.5	1,186.5	120.10
Minnesota	112.0	20.83	12	786.1	146.21	87	5.9	1.10	0.7	904.1	168.15
Mississippi	133.8	45.06	42	179.2	60.34	57	3.6	1.21	1.1	316.6	106.61
Missouri	226.2	37.67	41	305.8	50.94	55	21.1	3.51	3.8	553.6	92.21
Montana	27.2	27.13	14	167.0	166.75	84	4.0	4.01	2.0	198.2	197.89
Nebraska	46.4	25.10	30	107.9	58.33	69	2.6	1.38	1.6	156.8	84.82
Nevada	65.5	23.84	40	93.0	33.86	57	4.7	1.71	2.9	163.2	59.41
New Hampshire	53.7	40.67	30	123.9	93.90	69	2.1	1.58	1.2	179.6	136.14
New Jersey[d]	549.9	62.10	29	1,292.5	145.96	69	22.2	2.51	1.2	1,864.6	210.58
New Mexico	24.3	11.73	9	248.1	119.71	91	0.0	0.00	0	272.4	131.44
New York[e]	1,271.1	65.05	25	3,554.9	181.92	70	229.6	11.75	4.5	5,055.6	258.71
North Carolina[b,d]	298.1	30.91	19	1,256.2	130.23	80	11.9	1.23	0.8	1,566.2	162.37
North Dakota	12.9	18.57	22	46.6	67.35	78	0.2	0.25	0.3	59.6	86.17
Ohio[d]	209.1	18.13	25	606.6	52.59	72	27.3	2.37	3.2	843.1	73.09

Table 10. SMHA-Controlled Mental Health Total and Per Capita Expenditures, by Type of Program, FY 2012 (Totals in Millions) (continued)

State	State Psychiatric Hospital-Inpatient Expenditures			Community-Based Programs Expenditures			Prevention, Research, Training, and SMHA-Administration Expenditures			Total SMHA-Controlled Expenditures	
	Total $	Per Capita $	%	Total $	Per Capita $	%	Total $	Per Capita $	%	Total $	Per Capita $
Oklahoma	52.6	13.87	25	149.7	39.49	70	10.8	2.86	5.1	213.1	56.22
Oregon	202.3	51.92	29	482.3	123.78	70	8.2	2.10	1.2	692.8	177.80
Pennsylvania[a]	356.7	27.96	9	3,394.8	266.10	90	13.0	1.02	0.3	3,764.5	295.08
Rhode Island[f]	36.8	35.16	33	72.2	69.04	65	2.2	2.15	2.0	111.3	106.35
South Carolina	95.3	20.35	36	158.0	33.74	59	14.0	2.99	5.2	267.3	57.07
South Dakota	42.7	51.45	60	26.7	32.19	38	1.6	1.93	2.3	71.0	85.58
Tennessee	141.3	21.96	25	417.9	64.96	73	12.4	1.93	2.2	571.6	88.85
Texas	357.2	13.78	36	601.8	23.21	61	27.5	1.06	2.8	986.5	38.05
Utah[d]	51.8	18.18	28	130.6	45.83	71	1.1	0.39	0.6	183.5	64.39
Vermont	18.8	30.06	12	133.2	212.98	84	6.4	10.23	4.0	158.4	253.28
Virginia[d]	329.3	40.79	44	395.5	48.99	53	21.8	2.70	2.9	746.6	92.48
Washington	216.5	31.61	28	543.3	79.31	70	14.1	2.06	1.8	773.9	112.98
West Virginia[a,c]	50.9	27.45	33	104.1	56.15	67	0.5	0.27	0.3	155.5	83.87
Wisconsin[d]	202.0	35.29	34	386.1	67.46	66	0.9	0.16	0.2	589.0	102.90
Wyoming[a]	0.0	0.00	0	30.0	52.33	47	2.3	4.03	3.6	63.9	111.48
Total	9,209.7	29.51	23	29,211.9	93.43	74	796.2	2.69	2.0	39,269.4	125.59
Average (mean)	180.6	31.05	29	572.8	93.39	68	15.6	3.69	2.7	770.0	129.27
Median	108.7	27.21	NA	301.4	67.46	NA	8.2	1.93	NA	441.9	106.35

Note: Community services include expenditures from state psychiatric hospitals for ambulatory and residential services.

Abbreviations: FY, fiscal year; NA = Not Applicable; SMHA, state mental health agency

[a] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[b] SMHA expenditures are from FY 2010.

[c] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[d] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[e] SMHA expenditures are from FY 2011.

[f] Rhode Island does not have a state psychiatric hospital. Reported figures are expenditures spent on psychiatric services at a state-run hospital (Eleanor Slater Hospital).

Expenditures by Client Age Group

SMHAs expended $24.1 billion (61.3 percent of total expenditures) on mental health services for individuals aged 18 years and older and $9.8 billion (24.8 percent) for children aged 0 through 17 years (Table 11). Almost 14 percent, or $5.5 billion, of SMHA expenditures were not allocated to specific age groups. These expenditures were for SMHA central office administration, research, training, and other such activities that are not categorized by age groups, or they were for community expenditures that the state was unable to allocate to specific age groups (see Table 26). Per capita expenditures for children's mental health services averaged $132.35 per child in the country, whereas per capita expenditures for adults averaged $100.59 per adult in the country (see Table 11).

Expenditures for children's community mental health services were $9.3 billion, representing 32 percent of total community mental health spending. Spending for children was much lower in state psychiatric hospitals, where many states no longer serve children. Total expenditures for children were $429.1 million, which represented 4 percent of state psychiatric hospital expenditures (see Figure 13). Nineteen states reported no ($0) expenditures for inpatient services for children in their state psychiatric hospitals.

Expenditures by Type of Mental Health Service

SMHAs provide a variety of mental health services in different settings, including hospitals, other residential settings, and community-based ambulatory service facilities. Inpatient services are provided in state psychiatric hospitals or purchased from private psychiatric hospitals, general hospital psychiatric units, or other inpatient settings. Ambulatory services include a variety of services that are provided for less than 24 hours per day, such as individual and group therapy, medication monitoring, and case management. Ambulatory services may also include much more intensive community-based services, such as Assertive Community Treatment (ACT) teams, supported employment, supported housing, and psychosocial rehabilitation programs.

In FY 2012, SMHAs expended 49 percent of their funds for ambulatory services, 32 percent for psychiatric inpatient care, and 10 percent for other 24-hour residential care (see Figure 14).

Table 11. SMHA-Controlled Mental Health Expenditures, by Age Group, FY 2012 (Totals in Millions)

State	Children and Adolescents			All Adults			Unallocated By Age			Total SMHA	
	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Expenditures, $	Per Capita, $
Alabama	32.6	28.95	9	154.9	42.0	42	179.5	37.31	49	366.9	76.27
Alaska[a]	103.0	550.53	43	129.4	247.4	54	5.7	8.08	2	238.2	335.36
Arizona	432.2	266.64	32	918.2	186.9	67	NA	0.00	NA	1,367.3	209.29
Arkansas[a,b]	10.2	14.38	8	78.3	35.1	64	33.9	11.53	28	122.5	41.62
California[a,c]	2,020.0	218.62	31	3,782.0	132.0	59	625.4	16.51	10	6,427.4	169.65
Colorado[a]	142.9	116.07	29	346.6	88.4	71	NA	0.00	NA	489.5	95.01
Connecticut	0.0	0.00	0	713.2	255.7	93	51.5	14.37	7	764.7	213.43
Delaware[a,c]	0.0	0.00	0	89.0	125.7	97	2.3	2.53	3	91.3	100.02
District of Columbia	35.4	323.56	18	126.2	242.6	66	30.7	48.71	16	192.3	305.37
Florida	88.6	22.13	12	608.8	39.9	85	20.3	1.05	3	717.6	37.28
Georgia[d]	105.3	42.28	19	447.1	60.8	81	NA	0.00	NA	552.4	56.08
Hawaii	30.7	101.18	17	133.7	127.9	76	12.5	9.27	7	176.9	131.16
Idaho	10.7	25.08	21	38.5	33.0	74	2.6	1.63	5	51.8	32.54
Illinois	233.8	76.31	24	705.8	72.2	73	22.3	1.74	2	961.9	74.88
Indiana	106.9	67.16	23	348.1	70.4	75	6.2	0.95	1	461.2	70.58
Iowa	155.3	214.81	35	281.7	119.9	64	4.9	1.59	1	441.9	143.81
Kansas	141.9	195.91	37	211.5	98.9	55	31.6	11.04	8	385.0	134.49
Kentucky	54.4	53.43	23	175.2	52.5	73	10.2	2.34	4	239.8	55.07
Louisiana	40.9	36.56	14	227.5	65.7	76	31.8	6.93	11	300.1	65.51
Maine[d]	192.6	724.18	43	245.5	231.2	55	11.1	8.36	2	449.2	338.24
Maryland[d]	308.2	229.35	29	670.6	148.6	62	102.5	17.50	9	1,081.3	184.62
Massachusetts[a]	89.2	63.65	12	612.6	116.9	85	19.5	2.94	3	721.3	108.62
Michigan	201.3	88.80	17	978.9	128.6	83	6.3	0.64	1	1,186.5	120.10
Minnesota	271.3	212.63	30	626.8	152.9	69	5.9	1.10	1	904.1	168.15
Mississippi	98.4	132.07	31	214.6	96.5	68	3.6	1.21	1	316.6	106.61
Missouri	77.8	55.45	14	454.8	98.9	82	21.1	3.51	4	553.6	92.21
Montana	95.4	429.65	48	98.8	126.7	50	4.0	4.01	2	198.2	197.89
Nebraska	11.7	25.24	7	142.6	102.9	91	2.6	1.38	2	156.8	84.82
Nevada	27.0	40.69	17	116.8	56.1	72	19.4	7.06	12	163.2	59.41
New Hampshire	43.6	158.73	24	133.9	128.2	75	2.1	1.58	1	179.6	136.14
New Jersey[d]	306.0	150.99	16	1,442.5	211.3	77	116.1	13.12	6	1,864.6	210.58
New Mexico	143.4	278.75	53	129.0	82.8	47	NA	0.00	NA	272.4	131.44
New York[e]	252.6	59.25	5	1,539.7	100.8	30	3,263.3	166.99	65	5,055.6	258.71
North Carolina[b,d]	712.7	311.72	46	832.2	113.1	53	21.2	2.20	1	1,566.2	162.37
North Dakota	3.5	22.72	6	55.9	104.1	94	0.2	0.25	0	59.6	86.17
Ohio[b]	208.6	78.31	25	607.2	68.4	72	27.3	2.37	3	843.1	73.09
Oklahoma	20.9	22.30	10	181.4	63.6	85	10.8	2.86	5	213.1	56.22
Oregon	148.7	172.78	21	535.9	176.5	77	8.2	2.10	1	692.8	177.80

Table 11. SMHA-Controlled Mental Health Expenditures, by Age Group, FY 2012 (Totals in Millions) (continued)

	Children and Adolescents			All Adults			Unallocated By Age			Total SMHA	
State	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Expenditures, $	Per Capita, $
Pennsylvania[a]	2,021.7	738.01	54	1,694.7	169.2	45	48.1	3.77	1	3,764.5	295.08
Rhode Island	0.0	0.00	0	109.0	131.4	98	2.2	2.15	2	111.3	106.35
South Carolina	66.8	61.86	25	186.5	51.8	70	14.0	2.99	5	267.3	57.07
South Dakota	14.0	68.57	20	35.1	56.1	49	21.9	26.44	31	71.0	85.58
Tennessee	180.5	120.82	32	378.7	76.7	66	12.4	1.93	2	571.6	88.85
Texas	121.1	17.34	12	837.9	44.2	85	27.5	1.06	3	986.5	38.05
Utah[d]	55.7	62.73	30	126.7	64.6	69	1.1	0.39	1	183.5	64.39
Vermont	72.6	585.72	46	79.4	158.3	50	6.4	10.23	4	158.4	253.28
Virginia[d]	123.3	66.41	17	601.5	96.8	81	21.8	2.70	3	746.6	92.48
Washington	132.2	83.41	17	500.2	95.0	65	141.5	20.66	18	773.9	112.98
West Virginia[a,c]	3.6	9.37	2	95.0	64.6	61	56.9	30.69	37	155.5	83.87
Wisconsin[d]	7.1	5.39	1	194.9	44.2	33	387.0	67.61	66	589.0	102.90
Wyoming[a]	1.4	10.66	2	60.1	137.4	94	2.3	4.03	4	63.9	111.48
Total	9,757.7	132.35	25	24,035.0	100.59	61	5,459.8	18.89	14	39,269.4	125.59
Average (mean)	191.3	NA	NA	471.3	NA	NA	116.2	NA	NA	770.0	NA
Median	95.4	68.57	NA	227.5	98.91	NA	19.4	2.86	NA	441.9	106.35

Note: In some states (Connecticut, Delaware, Rhode Island), a separate state agency is responsible for providing mental health services to children.

Abbreviations: FY, fiscal year; NA = not applicable; SMHA, state mental health agency

[a] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[b] SMHA expenditures from FY 2010.

[c] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[d] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[e] SMHA expenditures from FY 2011.

Figure 13. Expenditures for Mental Health Services in State Psychiatric Hospitals and Community Mental Health Programs, by Patient Age, 2012

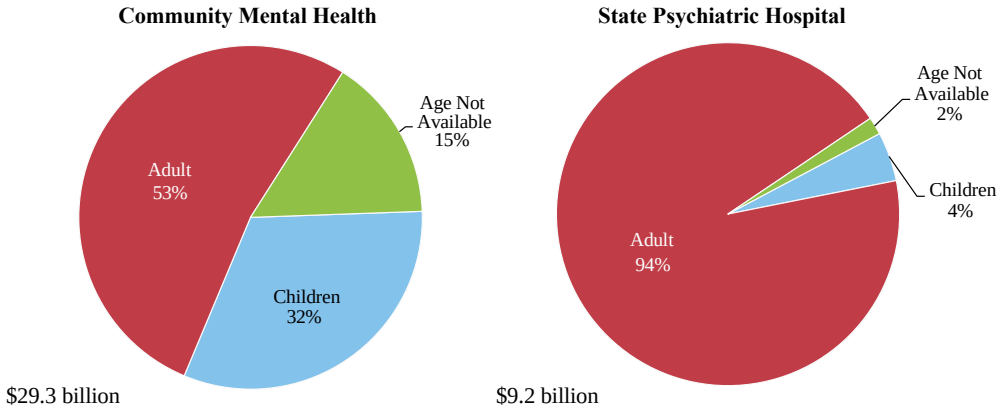
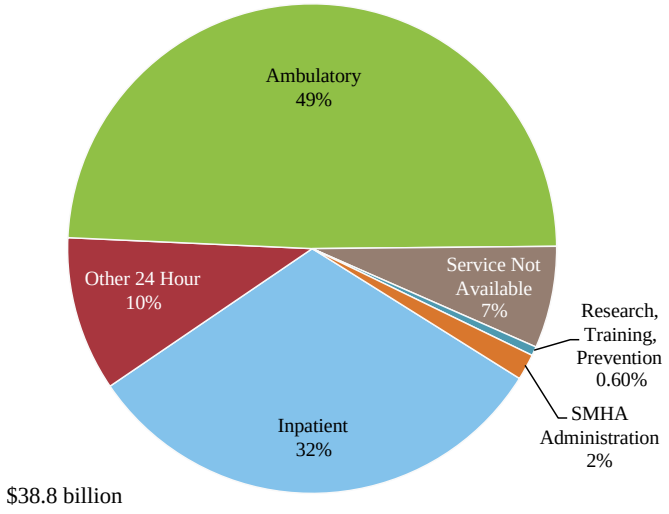


Figure 14. Total SMHA-Controlled Expenditures, by Type of Mental Health Service, FY 2012

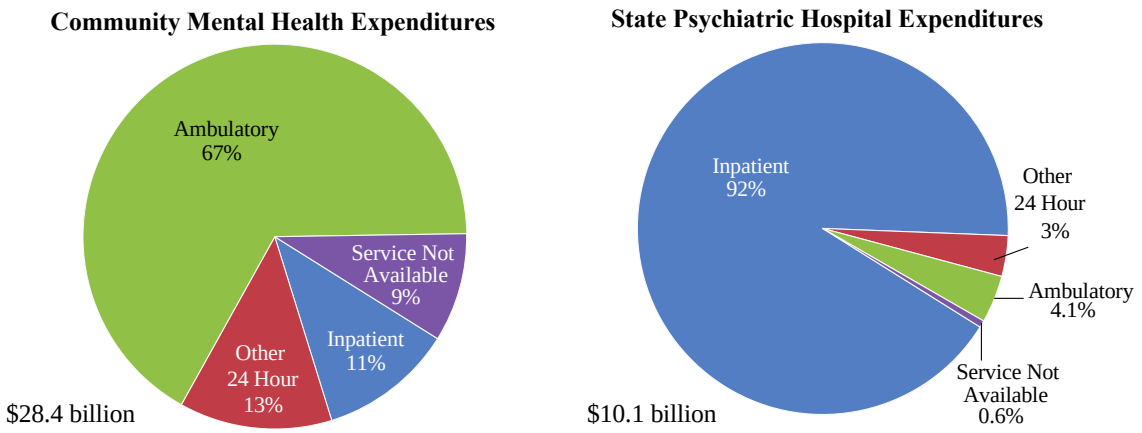


Abbreviation: SMHA, state mental health agency

Most of the ambulatory services were provided by community mental health providers, where ambulatory services represented 66.7 percent of total spending. State psychiatric hospitals in seven states provided ambulatory services, but expenditures for these services averaged only 4.1 percent of state psychiatric hospital expenditures.

Both psychiatric hospitals and community mental health providers provide inpatient psychiatric services. In state psychiatric hospitals, inpatient services represented almost all expenditures (91.7 percent), whereas inpatient service expenditures represented only 11.3 percent of community mental health expenditures (see Figure 15).

Figure 15. Community Mental Health Program and State Psychiatric Hospital Expenditures, by Type of Mental Health Service, FY 2012



Abbreviation: FY, fiscal year

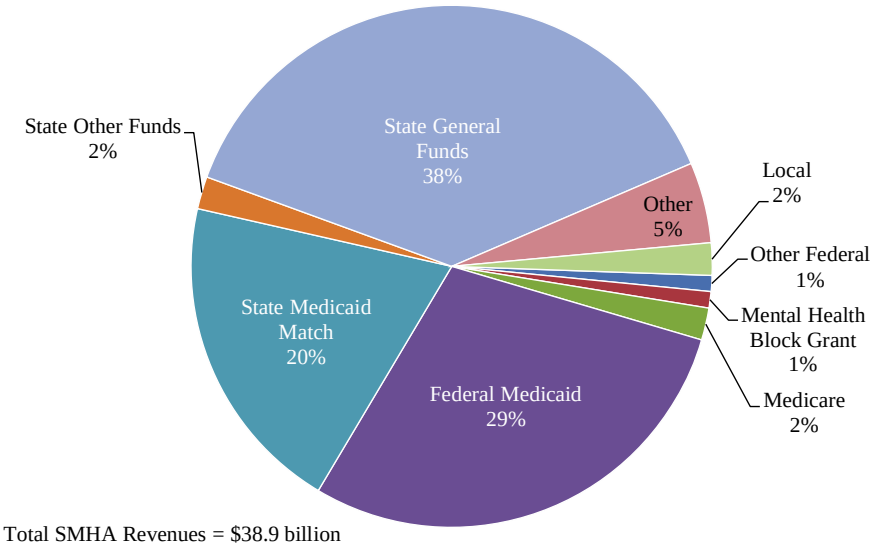
Funding Sources for State Mental Health Agency Mental Health Services

To finance the provision of mental health services, SMHAs rely on a mixture of state, federal, local, and other funding sources. In FY 2012, SMHAs reported $39.5 billion in total SMHA-controlled revenues for mental health services, of which 39 percent ($15.6 billion) came from state government sources. The large share of state government funding of mental health services was state general revenue funds (38 percent), state Medicaid match (20 percent), and state special funds (2 percent), such as special funding sources dedicated to mental health. An example of state special funds is interdepartmental funds received by the SMHA from other state government agencies or entities via fund transfer, contract, or memorandum of agreement.

The federal government was the second largest (33 percent) source of funding. The federal share of Medicaid (29 percent) was the largest single federal source, followed by Medicare (2 percent), the MHBG (1 percent), and other federal funds (1 percent). Local county and city governments contributed 2 percent. In 12 states, cities and counties spent their own additional tax dollars to provide mental health services, and these areas are counted as part of the SMHA-controlled system. SMHAs received only 1 percent of revenues from first-party and third-party (consumer copays and private insurance) payments. Other sources, which included donations, totaled 4 percent.

Total Medicaid revenue—a combination of the state matches and federal contribution—equaled $19.5 billion (49 percent) and was the largest single funding source for the SMHAs. See Figure 16 and Table 13 for details of total revenues by funding sources.

Figure 16. Percentage of SMHA-Controlled Revenues for Mental Health Services, by Funding Sources, 2012



Total SMHA Revenues = $38.9 billion
(50 states, the District of Columbia, and Puerto Rico reporting)

Abbreviation: SMHA, state mental health agency

As depicted in Table 12, states varied in their reliance on state general funds versus Medicaid. More than 80 percent of SMHA-controlled revenues were from state general funds in Wyoming (97 percent), the District of Columbia (91 percent), Massachusetts (84 percent), and Georgia (81 percent). More than 80 percent of SMHA-controlled revenues came from Medicaid in Maine and Vermont (89 percent), Rhode Island (87 percent), Arizona (86 percent), and New Mexico (81 percent). Two states that organize their community mental health systems through county governments reported the highest use of local government funds: Ohio (24 percent) and Wisconsin (14 percent).

Table 12. SMHA-Controlled Mental Health Revenues, by Revenue Source, FY 2012

State	State General Funds		Total Medicaid		Medicare		MHBG		Other Federal		Local Government		Other Funds		Total SMHA Revenues	
	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	$ Per Capita
Alabama	162.1	44	161.6	44	14.2	4	4.1	1.12	6.0	2	0.0	0	18.9	5	366.9	76.27
Alaska[a]	54.8	23	175.9	74	3.8	2	0.6	0.26	0.6	0	0.0	0	2.4	1	238.2	335.36
Arizona	117.6	9	1,178.5	86	0.3	0	9.7	0.71	5.3	0	0.0	0	54.2	4	1,365.6	209.03
Arkansas[a,b]	68.0	56	37.0	30	4.3	3	3.6	2.94	4.4	4	0.0	0	5.2	4	122.5	41.62
California[a,c]	2,653.3	41	2,525.5	39	36.3	1	56.1	0.87	19.2	0	0.0	0	1,137.0	18	6,427.4	169.65
Colorado[a]	135.5	28	335.8	69	8.2	2	5.5	1.12	1.4	0	0.6	0	2.5	1	489.5	95.01
Connecticut	736.4	93	12.4	2	9.4	1	4.2	0.53	16.9	2	0.0	0	9.1	1	788.4	220.04
Delaware[a,c]	73.0	78	17.4	19	1.2	1	0.5	0.54	1.1	1	0.0	0	0.4	0	93.6	102.49
District of Columbia	174.8	91	15.5	8	0.0	0	1.7	0.86	0.2	0	0.0	0	0.1	0	192.3	305.37
Florida	543.2	74	116.7	16	0.0	0	29.8	4.08	40.3	6	0.0	0	0.0	0	730.1	37.93
Georgia[d]	446.5	81	3.7	1	3.4	1	14.1	2.55	30.6	6	0.0	0	54.1	10	552.4	56.08
Hawaii	129.3	83	19.5	12	0.2	0	1.9	1.21	5.0	3	0.0	0	0.2	0	156.0	115.72
Idaho	39.4	76	5.0	10	2.1	4	1.5	2.90	2.8	5	0.0	0	1.0	2	51.8	32.54
Illinois	494.2	51	432.3	45	11.1	1	16.0	1.66	6.6	1	0.0	0	1.7	0	961.9	74.88
Indiana	167.4	36	274.6	60	3.7	1	6.6	1.44	8.0	2	0.0	0	1.0	0	461.2	70.58
Iowa	59.7	14	286.9	65	2.6	1	3.0	0.68	15.2	3	43.5	10	31.0	7	441.9	143.81
Kansas	100.2	26	269.3	70	11.2	3	3.5	0.91	0.8	0	0.0	0	0.0	0	385.0	134.49
Kentucky	127.6	53	85.2	36	13.9	6	5.0	2.09	3.3	1	0.0	0	4.8	2	239.8	55.07
Louisiana	204.0	68	76.0	25	2.1	1	3.4	1.14	8.9	3	0.0	0	5.8	2	300.1	65.51
Maine[d]	47.0	10	400.2	89	0.0	0	1.6	0.36	0.4	0	0.0	0	0.0	0	449.2	338.24
Maryland[d]	706.8	65	352.6	33	0.0	0	6.9	0.64	15.0	1	0.0	0	0.0	0	1,081.3	184.62
Massachusetts[a]	707.5	84	113.0	13	6.6	1	7.8	0.92	5.9	1	0.0	0	2.5	0	843.3	127.00
Michigan	251.8	21	880.1	74	12.3	1	14.8	1.25	0.7	0	23.9	2	2.9	0	1,186.5	120.10
Minnesota	237.1	26	569.1	63	3.3	0	8.1	0.90	10.4	1	47.4	5	28.6	3	904.1	168.15
Mississippi	145.3	46	146.4	46	11.8	4	4.2	1.33	2.9	1	0.0	0	6.0	2	316.6	106.61
Missouri	340.8	46	349.3	47	7.5	1	7.1	0.96	32.9	4	0.0	0	1.6	0	739.1	123.11
Montana	50.3	25	145.5	73	0.0	0	1.2	0.59	1.2	1	0.0	0	0.0	0	198.2	197.89
Nebraska	98.3	63	20.1	13	2.9	2	1.9	1.23	1.1	1	0.0	0	32.4	21	156.8	84.82
Nevada	123.8	76	21.3	13	5.2	3	3.5	2.14	7.9	5	0.2	0	1.3	1	163.2	59.41
New Hampshire	34.1	19	115.7	64	12.4	7	1.5	0.84	8.9	5	0.0	0	7.0	4	179.6	136.14
New Jersey[d]	945.0	51	560.7	30	51.6	3	10.0	0.54	5.9	0	205.2	11	86.3	5	1,864.6	210.58
New Mexico	46.9	17	220.8	81	1.0	0	2.2	0.81	1.2	0	0.0	0	0.0	0	272.1	131.29
New York[e]	1,212.9	26	2,581.5	56	281.1	6	23.7	0.52	90.3	2	69.9	2	330.5	7	4,589.9	234.88
North Carolina[b,d]	344.4	22	1,166.6	74	20.7	1	10.7	0.68	1.9	0	0.0	0	21.9	1	1,566.2	162.37
North Dakota	29.7	50	12.9	22	3.5	6	0.6	1.09	5.3	9	0.0	0	6.7	11	58.9	85.09
Ohio[b]	398.6	34	445.0	38	15.1	1	13.5	1.16	19.0	2	279.6	24	1.0	0	1,171.7	101.58
Oklahoma	168.9	79	12.8	6	7.1	3	4.5	2.11	8.0	4	0.0	0	11.8	6	213.1	56.22
Oregon	276.9	40	404.3	58	0.0	0	4.4	0.64	0.8	0	0.0	0	6.4	1	692.8	177.80
Pennsylvania[a]	765.7	20	2,887.4	77	21.5	1	13.4	0.36	45.9	1	20.3	1	10.3	0	3,764.5	295.08
Puerto Rico[a]	78.9	92	0.0	0	0.0	0	5.6	6.55	1.1	1	0.0	0	0.0	0	85.6	23.34
Rhode Island	6.4	6	96.9	87	0.0	0	1.4	1.28	6.5	6	0.0	0	0.0	0	111.3	106.35
South Carolina	114.8	43	127.6	48	0.5	0	8.8	3.29	3.2	1	3.6	1	8.8	3	267.3	57.07
South Dakota	36.7	52	25.8	37	4.8	7	0.8	1.10	1.6	2	0.0	0	0.4	1	70.2	84.58
Tennessee	176.5	31	365.4	64	6.8	1	9.8	1.71	9.3	2	0.0	0	3.8	1	571.6	88.85
Texas	658.1	67	133.7	14	28.7	3	35.3	3.58	42.7	4	24.7	3	63.3	6	986.5	38.05
Utah[b]	37.0	20	134.0	73	1.3	1	3.7	2.02	6.0	3	0.0	0	1.6	1	183.6	64.43

Table 12. SMHA-Controlled Mental Health Revenues, by Revenue Source, FY 2012 (continued)

State	State General Funds		Total Medicaid		Medicare	MHBG	Other Federal	Local Government	Other Funds	Total SMHA Revenues	State General Funds	Total Medicaid	Medicare	MHBG	Other Federal	Local Government
	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	$ Per Capita
Vermont	11.7	7	141.4	89	0.0	0	0.7	0.44	4.6	3	0.0	0	0.0	0	158.4	253.28
Virginia[d]	450.6	60	259.0	35	18.2	2	10.0	1.34	0.4	0	0.0	0	9.7	1	747.9	92.64
Washington	183.8	24	539.6	70	20.2	3	8.7	1.12	2.0	0	0.0	0	19.6	3	773.9	112.98
West Virginia[a,c]	83.9	54	64.8	42	3.4	2	2.0	1.29	0.9	1	0.0	0	0.5	0	155.5	83.87
Wisconsin[d]	300.1	51	177.5	30	4.2	1	7.4	1.26	8.4	1	85.1	14	6.3	1	589.0	102.90
Wyoming[a]	31.5	97	0.0	0	0.0	0	0.5	1.41	0.4	1	0.0	0	0.0	0	32.3	56.36
Total	15,588.8	39	19,499.7	49	679.7	1.7	407.2	1.0	529.3	1.3	804.0	2.0	2,000.6	5.1	39,509	124.89
Average (mean)	299.8	NA	375.0	NA	13.1	NA	7.8	NA	10.2	NA	15.5	NA	38.5	NA	760	NA
Median	153.7	NA	145.9	NA	4.0	NA	4.5	NA	5.3	NA	0.0	NA	3.4	NA	413	104.62

Abbreviations: FY, fiscal year; NA, not applicable; SMHA, state mental health agency

[a] Medicaid revenues for community programs are not included in SMHA-controlled revenues.

[b] FY 2010 revenues.

[c] Children's mental health revenues are not included in SMHA-controlled revenues.

[d] SMHA-controlled revenues include funds for mental health services in jail or prisons.

[e] FY 2011 revenues.

Financing State Mental Health Agency Community Mental Health Services

Table 13 shows the array of funding sources used by SMHAs to finance community mental health services. Although all states used state general funds to finance some mental health services, state general funds were used most often for case management, crisis services, outpatient services, and supported employment. States used Medicaid most frequently for outpatient testing and treatment, extensive or intensive services, and crisis and case management services. Peer and consumer-run services, inpatient hospital care, and residential board and care were more often funded with state general funds than with Medicaid.

The MHBG was used to fund a variety of services, with peer and consumer-run, case management, and outpatient services being the most common (see Figure 17). Block grant funds may be used to support a variety of programs though states are prohibited from applying MHBG funds directly toward inpatient treatment (see 42 U.S. Code § 300x–5).

In addition to paying for mental health services, some SMHAs provided income, housing, or employment supplements to help consumers live in their community. Twenty-seven SMHAs provided rental supplements to consumers. The SMHA provided employment supplements in six states, and the SMHAs provided income supplements in two states.

To help transition consumers from state hospitals to their communities, 10 SMHAs have portable benefits that follow a patient from a state psychiatric hospital to the community. For example, benefits follow consumers who are at high risk and have high need and are not enrolled in Medicaid after they leave state hospitals in Washington; they also follow all consumers who are eligible for Medicaid. In Pennsylvania, the Community Hospital Integration Projects Program allows money that would have been used for state hospital psychiatric treatment to be used for individuals discharged to the community.

State Mental Health Agency Community Mental Health Service Funding Sources, FY 2012

Community mental health programs were more likely to use Medicaid and other federal funding sources than state psychiatric hospitals, which rely much more heavily on state general revenue funds. In FY 2012, SMHAs controlled $28.5 billion in revenues (72 percent of total SMHA-controlled revenues) dedicated to community mental health programs. SMHAs received funding from a variety of sources, including state general funds, Medicaid, Medicare, local government, MHBG, and other state and federal sources. In FY 2012, 53 percent of SMHA-controlled community mental health funds came from state government sources. The largest share of state funds came from state general and other funds (28 percent) and the state Medicaid match (24 percent).

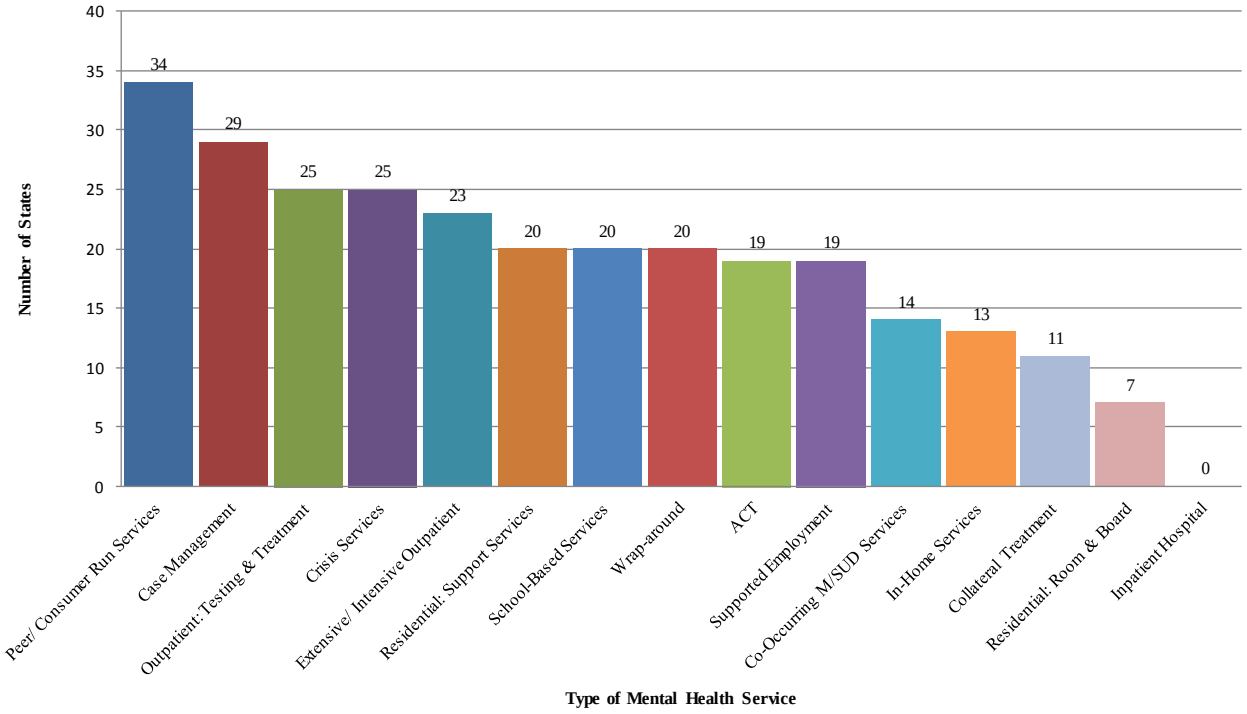
The federal government was the second-largest source of community mental health funds (40 percent) for the SMHAs' community mental health system. Federal Medicaid was the single largest source of revenues, accounting for about 36 percent. The MHBG (1 percent), Medicare (1 percent), social services block grant (<1 percent), other SAMHSA funds (<1 percent), and other federal funds (2 percent) together accounted for about 4 percent of the SMHA-controlled revenues. Total Medicaid revenue (combined state match and federal share) was the largest single funding source of SMHA-controlled community programs, at about 60% percent (see Figure 18 for a breakdown of community mental health service revenues by funding sources).

Table 13. Number of States Using Funding Sources for Community Mental Health Services, by Type of Service, 2013

Funding Sources	Inpatient Hospital	Residential: Room and Board	Residential: Support Services	Outpatient: Testing and Treatment	Extensive/ Intensive Outpatient	Collateral Treatment	Case Manage-ment	Crisis Services	ACT	Supported Employ-ment	School-Based Services	Wrap-around	In Home	Peer/ Consumer-Run Services	Co-occurring M/SUD Services
State General Fund	40	40	40	45	41	29	40	46	37	41	30	38	29	38	33
State Special Funds	7	8	11	10	8	5	7	8	8	6	5	6	6	6	6
State Medicaid Match	30	6	29	0	34	18	0	33	30	15	24	20	22	17	25
Medicaid (Federal)	24	12	31	46	44	21	40	41	36	23	29	28	28	22	27
Clinic Option	6	0	2	22	17	8	0	14	6	1	6	3	3	1	7
Rehabilitation Option	3	3	19	28	29	11	17	26	25	11	12	11	19	12	17
Targeted Case Management	1	0	2	1	0	3	20	2	3	1	1	4	2	1	1
1915(i) Option	1	0	2	3	2	0	2	2	3	2	0	0	2	2	1
1115 Waiver	6	1	3	7	6	3	6	6	4	4	2	1	4	3	4
1915(b) Waiver	9	3	7	11	10	0	9	8	8	6	8	8	9	6	6
1915(c) Waiver (HCBS)	0	3	9	4	3	5	9	6	0	5	4	6	9	1	1
EPSDT	6	3	6	13	10	0	7	6	2	2	8	5	7	2	5
Other Medicaid	7	1	2	4	4	0	4	5	1	4	2	3	3	3	1
Medicare	25	2	3	18	10	1	1	5	3	0	0	1	0	0	5
Veteran's Affairs	7	2	4	7	4	2	4	3	1	2	1	1	1	0	1
SAMHSA MHBG	NA	7	20	25	23	11	29	25	19	19	20	20	13	34	14
Social Services Block Grant	2	3	3	8	7	5	6	4	1	2	3	5	4	3	3
Housing & Urban Development	0	12	5	1	1	1	3	1	0	1	0	1	1	1	0
Other Federal	2	3	7	5	4	3	7	3	2	5	3	3	2	5	6
Local Government	12	13	14	17	14	9	17	17	15	12	12	10	12	12	13
First Party	22	13	12	24	18	9	16	15	11	6	6	7	7	6	9
Third Party	30	9	11	28	19	6	11	17	13	3	6	6	9	6	14
Charity	4	1	2	4	2	0	1	3	0	1	0	0	0	1	1
Other Funds	2	1	1	2	2	2	2	2	2	3	3	2	2	3	2

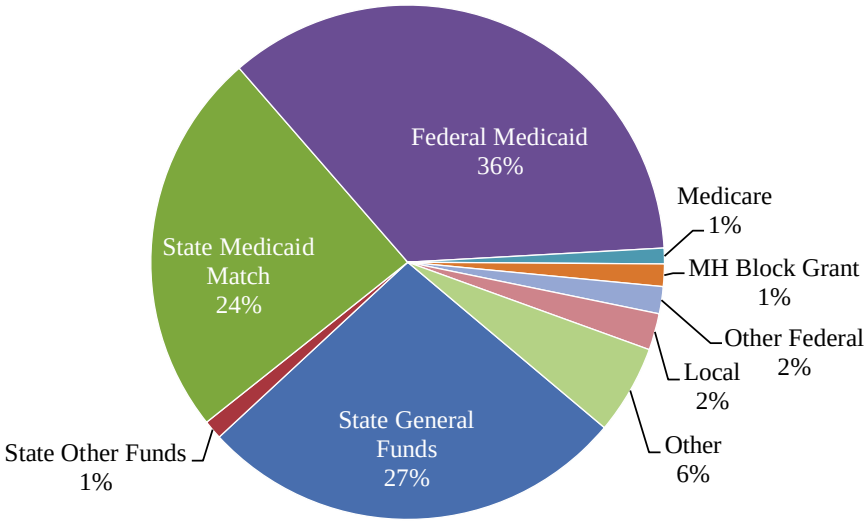
Abbreviations: ACT, Assertive Community Treatment; EPSDT, Early and Periodic Screening, Diagnosis, and Treatment; HCBS, home and community-based services; MHBG, Mental Health Block Grant; M/SUD, mental and substance use disorder; NA, not applicable; SAMHSA, Substance Abuse and Mental Health Administration

Figure 17. Mental Health Services Purchased by SMHAs Using the SAMHSA MHBG, 2012



Abbreviations: ACT, Assertive Community Treatment; M/SUD, mental and substance use disorder; MHBG, Mental Health Block Grant; SAMHSA, Substance Abuse and Mental Health Administration; SMHA, state mental health agency

Figure 18. Funding Sources for Community Mental Health, FY 2012



Community Mental Health Revenues = $28.5 billion

Abbreviation: FY, fiscal year; MH, Mental Health

Financig State Psychiatric Hospitals

The most common funding source for state psychiatric hospitals was state general funds, followed by Medicare, Medicaid, and third-party (insurance) payments. As Table 14 shows, state psychiatric hospital inpatient services for adults aged 21 through 64 years were typically funded by state general funds, followed by third-party (insurance) or first-party funds, and then Medicare. For children younger than 21 years, state general funds, Medicaid, and third-party payers were the most common funding sources for state psychiatric hospital inpatient services. Inpatient services for forensic patients and sex offenders were paid mostly by state general funds, with few states billing insurance, Medicaid, or Medicare for these services.

Table 14. Number of SMHAs Using Funding Sources for Mental Health Services in State Psychiatric Hospitals, by Hospital Patient Population and Type of Service, 2013

State	Children (<21 years)	Adults (21–64 years)	Older Adults (65+ years)	Forensic	Sex Offender	Other 24-Hour Care (residential)	State Hospital Ambulatory
State General Fund	32	47	44	44	26	19	12
State Special Funds	9	10	10	7	5	3	6
State Medicaid Match	29	14	27	10	6	11	8
Medicaid (Federal)	24	13	20	7	3	9	4
Medicare	7	25	34	13	6	6	4
Veteran's Affairs	0	10	11	3	1	3	2
Other Federal	5	8	6	0	0	4	3
Local Government	7	9	7	6	1	4	4
First Party	24	35	32	11	7	8	5
Third Party	30	38	36	12	8	10	7
Charity	5	5	5	1	1	2	3
Other Funds	3	3	4	5	3	2	2

Abbreviation: SMHA, state mental health agency

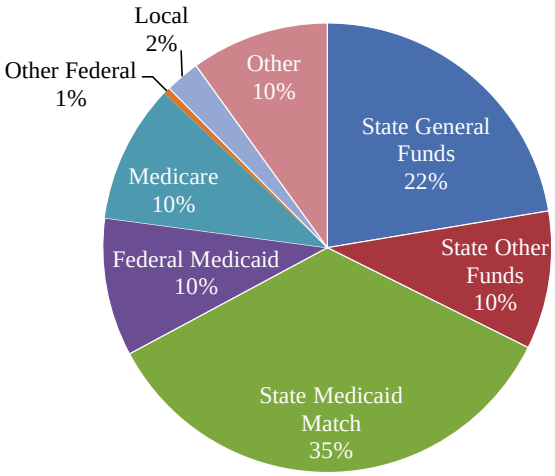
SMHAs controlled $10.2 billion in revenues dedicated to state psychiatric hospitals in FY 2012 (26 percent of total SMHA-controlled revenues). SMHAs received funding from a variety of sources, including state general funds, Medicaid, Medicare, other federal sources, local government, and first- and third-party payments (insurance).

In FY 2012, 77 percent of SMHA-controlled funds for state psychiatric hospital services came from state government sources. As depicted in Figure 19, the largest share of state funds came from state general funds (22 percent) and the state Medicaid match (35 percent).

Funding from the federal government accounted for 18.0 percent of the total SMHA-controlled state psychiatric hospital revenues. The federal Medicaid share was the single largest source of federal revenues, accounting for 14.0 percent of state psychiatric hospital revenues. Total Medicaid (state and federal shares combined) represented 23.3 percent of state psychiatric hospital revenues. Medicaid revenues as a percentage of mental health spending were much lower for state psychiatric hospitals than for community mental health services. This is largely due to the Medicaid Institutions for Mental Diseases exclusion rule that limits payment for inpatient treatment in psychiatric hospitals to children younger than 21 years and adults aged 65 years and older. Under this rule, services to adults aged 21 through 64 years in psychiatric hospitals are not eligible for Medicaid reimbursement. State psychiatric hospitals received

$395.2 million in Medicare payments (3.9 percent of revenues) in FY 2012, and they received 4.0 percent of revenues from first- and third-party payments and other sources combined.

Figure 19. Funding Sources for State Psychiatric Hospitals, FY 2012



State Psychiatric Hospital Revenues = $10.2 billion

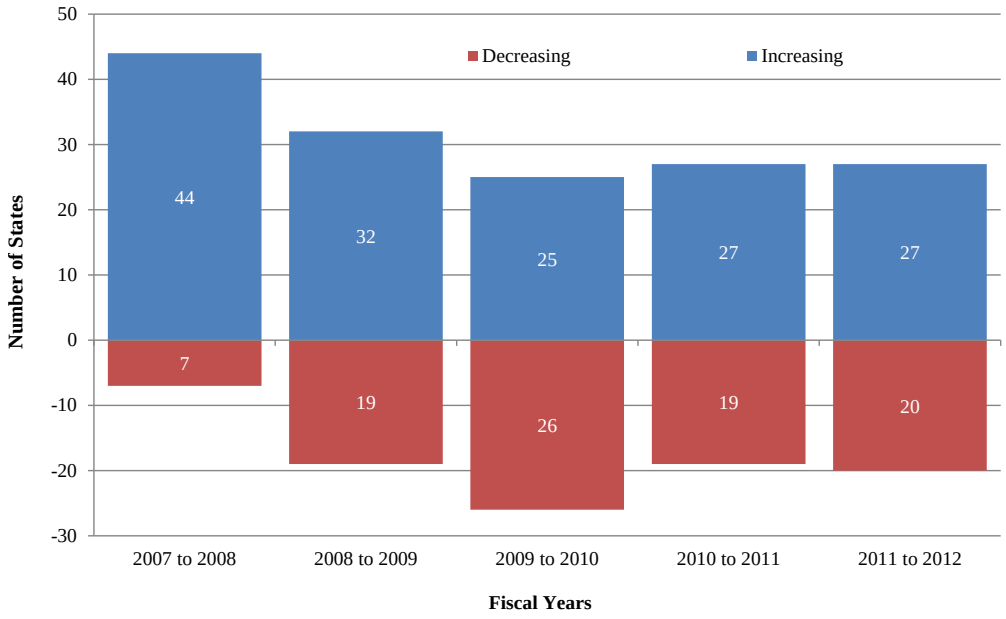
Abbreviation: FY, fiscal year

Trends in State Mental Health Agency Revenues and Expenditures

There was only a slight increase (1.2 percent) in total SMHA expenditures from FY 2011 through FY 2012. State psychiatric hospital expenditures decreased by 1.8 percent; community mental health expenditures increased by 1.9 percent; and SMHA administration and other central office expenditures decreased by 5.1 percent. Total SMHA expenditures for mental health decreased in 20 states, whereas they increased in 27 states (see Figure 20).

The overall drop in expenditures is likely due to the recession from 2007 through 2012 and the resultant deficits in state revenues. However, a shift in the proportion of expenditures from state psychiatric hospitals to community mental health is part of a 30-year, ongoing trend. Some states reported that when they were required to make budget reductions because of overall state budget shortages, they elected to cut state psychiatric hospital expenditures to protect community mental health services. It should be noted that state hospital expenditures rely much more on state general funds; community mental health expenditures rely primarily on Medicaid payments, which were supported during this time because of expanded federal financial participation in the ARRA.

Figure 20. Number of SMHAs With an Increase or Decrease in Total Mental Health Expenditures, FY 2007 to FY 2012



Abbreviations: FY, fiscal year, SMHA, state mental health agency

Most of the increase in SMHA revenues came from the federal Medicaid match and other federal funds. State general revenues for SMHA systems were decreased by 1.8 percent from FY 2011 through FY 2012 and by 8.4 percent from FY 2009 through FY 2012. From FY 2009 through FY 2012, 37 SMHAs experienced a reduction in general revenues for mental health services. Among states with reductions in general revenues from FY 2009 through FY 2010, 33 states had reductions totaling $0.9 billion. From FY 2010 through FY 2011, 32 states had decreases totaling $1.4 billion. In FY 2011 through FY 2012, 24 SMHAs had reductions in general revenues and experienced lower total cuts ($0.4 billion) in general revenues for mental health.

5.3. Financing of Single State Agency Substance Use Disorder Services

SSAs are a vital component of the national system for providing SUD services to the nation. Although SSAs dedicate a large majority of their resources to providing SUD treatment to people who are underinsured and/or have low incomes (a shared responsibility with Medicaid), they are also responsible for providing substance use disorder prevention services and leadership to the entire population. Medicaid has historically had a small role in purchasing and delivering substance use disorder services as most state programs did not cover childless adults and many states did not elect to offer substance use disorder services as an optional Medicaid benefit. However, the implementation of the Affordable Care Act, may serve to expand Medicaid funding for substance use disorder services.

This section presents the most current and complete financial data available about this vital component in the nation's substance use disorder effort and examines the broad trends in funding for SSA efforts.

The primary findings from this section are as follows:

- SSA expenditures were $4.9 billion in FY 2012, or about $19 per person aged 12 years and older.
- SUD treatment represented 82 percent of resources; primary prevention represented 11 percent; and administration and infrastructure represented 7 percent.
- SSA funding has only grown 0.8 percent annually since 1999.
- SSA prevention expenditures have decreased since 1999, falling from $580 million to $540 million, even when the impact of inflation is ignored.

Although Medicaid augments SSA treatment spending for people with low incomes, providing $3.9 billion in care in calendar year 2011, Medicaid does not typically support substance use disorder prevention activities.

Single State Agency Expenditures for Substance Use Disorder Services

SSAs were responsible for budgets that totaled $4.9 billion from all sources in SFY 2012 (July 2011 through June 2012; see Table 16). The two largest state budgets were in California and New York, at $588 million and $541 million, respectively. The smallest state budgets were in South Dakota and West Virginia, each at $20 million. The median SSA budget was $48 million, and the quartiles were $30 million and $130 million (see Table 15).

Table 15. Expenditures of Single State Agencies, by Service Provided, FY 2012 (in Millions)

State	Primary Prevention		Treatment and Other Prevention		Other		Total SSA $
	$	%	$	%	$	%	
Alabama	4.8	11	36.1	84	2.2	5	43.1
Alaska	14.3	25	37.3	64	6.6	11	58.2
Arizona	8.6	5	153.8	90	8.0	5	170.4
Arkansas	2.5	10	21.0	84	1.4	6	24.9
California	58.8	10	505.0	86	23.7	4	587.5
Colorado	11.5	19	46.5	79	1.2	2	59.2
Connecticut	12.1	5	194.6	87	16.9	8	223.6
Delaware	3.0	13	19.0	83	0.8	4	22.8
District of Columbia	2.5	6	29.4	71	9.7	23	41.6
Florida	25.4	14	140.1	79	11.7	7	177.2
Georgia	14.0	12	102.1	85	4.1	3	120.2
Hawaii	5.7	19	22.2	73	2.5	8	30.4
Idaho	2.1	7	27.0	91	0.5	2	29.6
Illinois	18.8	9	181.8	86	9.6	5	210.2
Indiana	8.2	17	39.5	80	1.5	3	49.2
Iowa	7.3	19	27.8	73	2.8	7	37.9
Kansas	4.0	10	36.3	87	1.2	3	41.5
Kentucky	6.0	17	28.5	80	1.0	3	35.5
Louisiana	5.1	7	64.9	89	2.6	4	72.6
Maine	2.5	7	31.1	87	2.0	6	35.6
Maryland	6.4	5	104.7	82	16.4	13	127.5
Massachusetts	9.1	7	110.8	91	1.9	2	121.8

Table 15. Expenditures of Single State Agencies, by Service Provided, FY 2012 (in Millions) (continued)

State	Primary Prevention		Treatment and Other Prevention		Other		Total SSA $
	$	%	$	%	$	%	
Michigan	14.0	9	135.3	89	2.0	1	151.3
Minnesota	6.7	4	122.9	81	21.2	14	150.8
Mississippi	2.8	14	15.3	77	1.7	9	19.8
Missouri	7.1	6	101.2	91	3.2	3	111.5
Montana	1.9	11	13.9	82	1.1	7	16.9
Nebraska	1.8	5	35.2	94	0.4	1	37.4
Nevada	5.9	23	18.1	72	1.3	5	25.3
New Hampshire	1.8	13	10.8	78	1.2	9	13.8
New Jersey	13.9	10	123.9	86	6.9	5	144.7
New Mexico	2.2	6	36.1	92	1.1	3	39.4
New York	51.9	10	420.6	78	68.7	13	541.2
North Carolina	9.8	6	147.4	91	5.4	3	162.6
North Dakota	1.2	6	18.7	92	0.5	2	20.4
Ohio	20.8	10	175.8	83	14.7	7	211.3
Oklahoma	6.6	10	56.6	84	3.9	6	67.1
Oregon	4.6	10	42.8	89	0.8	2	48.2
Pennsylvania	24.1	22	67.7	62	16.6	15	108.4
Rhode Island	3.4	14	18.4	75	2.8	11	24.6
South Carolina	6.8	21	23.5	73	1.7	5	32.0
South Dakota	4.0	20	14.8	74	1.2	6	20.0
Tennessee	9.9	16	39.7	64	12.4	20	62.0
Texas	43.3	25	114.3	67	12.7	7	170.3
Utah	6.5	15	33.5	76	4.2	10	44.2
Vermont	3.5	12	24.8	85	0.8	3	29.1
Virginia	9.1	10	79.0	87	3.0	3	91.1
Washington	8.7	5	143.8	91	6.2	4	158.7
West Virginia	2.4	12	16.7	84	0.7	4	19.8
Wisconsin	10.3	30	24.2	70	0.1	0	34.6
Wyoming	9.4	22	30.7	72	2.7	6	42.8
Total	527.1	4.0	4,065.2	4	327.5	4.0	4,919.8
Average (mean)	10.3	12.4	79.7	81	6.4	6.2	96.5
Median	6.7	10.0	37.3	83	2.6	5.1	48.2
Minimum	1.2	4.4	10.8	62	0.1	0.3	13.8
Maximum	58.8	29.8	505.0	94	68.7	23.3	587.5

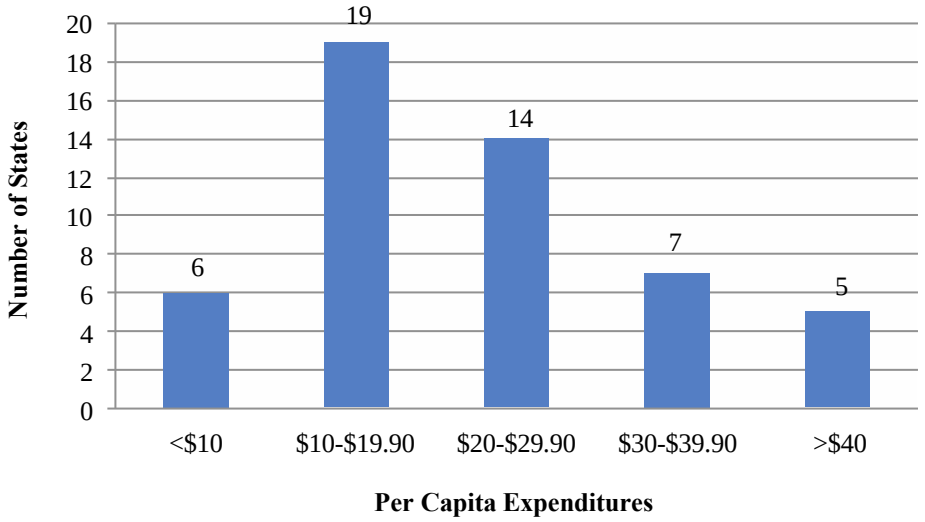
Abbreviation: SSA, single state agency

A different perspective is gained from examining per capita spending (see Figure 21). The average across all states was about $19 per capita, which is $4.9 billion divided by the 255 million individuals aged 12 years and older. This is the population primarily "at risk" for substance misuse and SUDs, because very little alcohol or illicit drug use is found in individuals younger than 12 years.

There are major differences across states, even on a per capita basis. The highest spending rate was in Alaska, where the SSA budget was $103 per capita for individuals aged 12 years and older. Indiana, Mississippi, South Dakota, Texas, and Wisconsin had spending less than $10 per capita. Half of the SSAs had budgets in the range of $12 to $28 per capita (the quartiles), and the median value was $20 per capita. Another fundamental feature of the SSAs is that they are responsible for funding primary prevention and treatment as well as other prevention.

Primary prevention services are those directed at individuals who do not require treatment for an SUD. The SABG requires SSAs to "set aside" at least 20 percent of their BG funds on primary prevention.

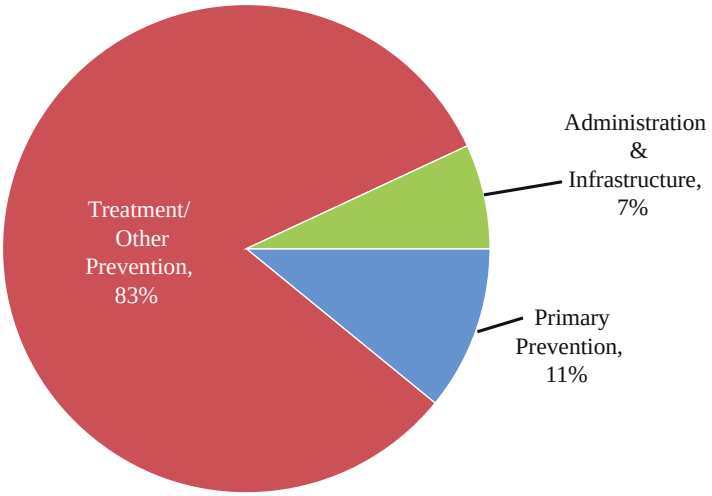
Figure 21. Frequency Distribution of Single State Agency per Capita Spending on Substance Use Disorder Services, SFY 2012



Abbreviation: SFY, state fiscal year

Figure 22 illustrates that SSAs spent $527 million (11 percent of their budget) for primary prevention versus $4.1 billion (83 percent) for treatment. They spent the remaining $328 million (7 percent) for infrastructure and support activities, including data and evaluation, training and other workforce support, and oversight and review of funded entities (e.g., providers, local and regional government).

Figure 22. How SSAs Spend Budgets on Primary Prevention and Other Services, SFY 2012



Note: Sum does not total to 100% because of rounding.
Abbreviation: SFY, state fiscal year; SSA, single state agency

Funding Sources for Substance Use Disorder Services

A review of SSA budgets shows that more than 60 percent of primary prevention spending by SSAs came from the BG, and an additional 20 percent came from other federal awards such as the Strategic Prevention Framework State Incentive Grants.

The sources of funding for SSAs varied from state to state. Overall, 45 percent ($2.2 billion) came from the state itself (see Table 16 and Figure 23), followed by the SABG at 34 percent ($1.7 billion), Medicaid at 16 percent ($760 million), and other sources at 6 percent ($300 million, largely other federal awards). In addition, Medicaid funds were a mixture of state (39 percent) and federal (61 percent) dollars; thus, across all funding sources, state and federal funding of SSAs was about equal in 2011 through 2012.

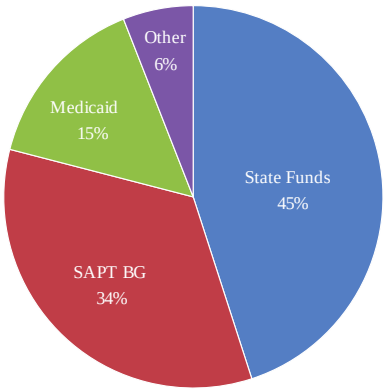
Support for SSAs through the BG was reasonably equivalent across states; however, there was substantial variability across SSAs in their levels of state general revenue and Medicaid funding. Because the SABG formula is largely based on population and prevalence of SUDs, funding for almost three-quarters of SSAs falls in the range of $5 to $7 per capita for adolescents and adults. In contrast, state general revenue support averaged about $8.6 per capita; the range was from about $1 per capita in Texas and Wisconsin to about $75 per capita in Alaska and Wyoming.

Table 16. Single State Agency Funding Sources, FY 2012

	State Funds		Medicaid		SABG		Other Funds		Total SSA
State	$	%	$	%	$	%	$	%	$
Alabama	15.5	36	3.6	8.4	23.9	55.5	0.1	0.2	43.1
Alaska	41.2	71	10.4	17.9	4.2	7.2	2.4	4.1	58.2
Arizona	12.3	7	117.1	68.7	37.9	22.2	3.1	1.8	170.4
Arkansas	7.1	29	5.3	21.3	12.3	49.4	0.2	0.8	24.9
California	104.5	18	222.0	37.8	251.5	42.8	9.5	1.6	587.5
Colorado	21.8	37	1.2	2.0	26.1	44.1	10.1	17.1	59.2
Connecticut	184.2	82	0.0	0.0	17.5	7.8	21.9	9.8	223.6
Delaware	14.5	64	0.0	0.0	6.7	29.4	1.6	7.0	22.8
District of Columbia	34.4	83	0.0	0.0	6.7	16.1	0.5	1.2	41.6
Florida	72.5	41	0.0	0.0	99.6	56.2	5.1	2.9	177.2
Georgia	46.1	38	0.4	0.3	50.7	42.2	23.0	19.1	120.2
Hawaii	18.8	62	0.0	0.0	7.7	25.3	3.9	12.8	30.4
Idaho	17.3	58	1.6	5.4	6.9	23.3	3.8	12.8	29.6
Illinois	88.5	42	50.1	23.8	62.6	29.8	9.0	4.3	210.2
Indiana	10.1	21	0.0	0.0	33.1	67.3	6.0	12.2	49.2
Iowa	17.9	47	0.0	0.0	13.6	35.9	6.4	16.9	37.9
Kansas	15.7	38	11.4	27.5	12.6	30.4	1.8	4.3	41.5
Kentucky	14.4	41	0.0	0.0	20.6	58.0	0.5	1.4	35.5
Louisiana	38.2	53	0.0	0.0	25.7	35.4	8.7	12.0	72.6
Maine	14.5	41	12.9	36.2	6.7	18.8	1.5	4.2	35.6
Maryland	75.9	60	4.1	3.2	32.1	25.2	15.4	12.1	127.5
Massachusetts	78.8	65	0.0	0.0	34.1	28.0	8.9	7.3	121.8
Michigan	43.3	29	44.4	29.3	56.2	37.1	7.4	4.9	151.3
Minnesota	72.7	48	32.3	21.4	24.6	16.3	21.2	14.1	150.8
Mississippi	5.1	26	0.0	0.0	14.2	71.7	0.5	2.5	19.8
Missouri	36.1	32	39.8	35.7	26.2	23.5	9.4	8.4	111.5
Montana	8.1	48	2.0	11.8	6.7	39.6	0.1	0.6	16.9
Nebraska	23.2	62	6.4	17.1	7.8	20.9	0.0	0.0	37.4
Nevada	10.5	42	0.0	0.0	13.9	54.9	0.9	3.6	25.3
New Hampshire	5.0	36	0.0	0.0	6.1	44.2	2.7	19.6	13.8
New Jersey	98.7	68	0.0	0.0	45.4	31.4	0.6	0.4	144.7
New Mexico	19.4	49	4.1	10.4	8.5	21.6	7.4	18.8	39.4
New York	413.7	76	0.0	0.0	119.4	22.1	8.1	1.5	541.2
North Carolina	103.8	64	15.9	9.8	40.0	24.6	2.9	1.8	162.6
North Dakota	7.7	38	6.1	29.9	4.8	23.5	1.8	8.8	20.4
Ohio	55.4	26	69.2	32.7	67.8	32.1	18.9	8.9	211.3
Oklahoma	41.7	62	2.7	4.0	17.6	26.2	5.1	7.6	67.1
Oregon	14.2	29	14.3	29.7	17.8	36.9	1.9	3.9	48.2
Pennsylvania	45.8	42	0.0	0.0	57.1	52.7	5.5	5.1	108.4
Rhode Island	5.6	23	5.6	22.8	6.9	28.0	6.5	26.4	24.6
South Carolina	6.2	19	1.3	4.1	20.2	63.1	4.3	13.4	32.0
South Dakota	8.5	43	2.1	10.5	4.9	24.5	4.5	22.5	20.0
Tennessee	26.4	43	0.0	0.0	32.2	51.9	3.4	5.5	62.0
Texas	23.7	14	0.0	0.0	136.5	80.2	10.1	5.9	170.3
Utah	9.8	22	0.0	0.0	15.9	36.0	18.5	41.9	44.2
Vermont	7.1	24	15.2	52.2	5.4	18.6	1.4	4.8	29.1
Virginia	47.6	52	0.0	0.0	43.0	47.2	0.5	0.5	91.1
Washington	60.1	38	60.5	38.1	31.3	19.7	6.8	4.3	158.7
West Virginia	9.6	48	0.0	0.0	7.9	39.9	2.3	11.6	19.8
Wisconsin	3.7	11	0.0	0.0	26.1	75.4	4.8	13.9	34.6
Wyoming	36.3	85	0.0	0.0	3.5	8.2	3.0	7.0	42.8
Total	**2,193.2**	**44.6**	**762.0**	**15.5**	**1,660.7**	**33.8**	**303.9**	**6.2**	**4,919.8**
Average	**43.0**	**43.7**	**14.9**	**12.0**	**32.6**	**35.7**	**6.0**	**8.5**	**96.5**
Median	**21.8**	**41.5**	**1.3**	**3.2**	**20.2**	**31.4**	**4.3**	**5.9**	**48.2**

Abbreviations: FY, fiscal year; SABG, Substance Abuse Prevention and Treatment Block Grant; SSA, single state agency

Figure 23. Sources of Funding for SSAs, 2011–2012



Abbreviation: SAPT BG, Substance Abuse Prevention and Treatment Block Grant; SSA, single state agency

Medicaid Spending for Substance Use Disorder Services

Twenty-three SSAs reported having no Medicaid funding. The Medicaid share of SSA budgets reflects situations where the state made a legislative or administrative decision to have the SSA manage certain SUD treatment services and their related funds to provide SUD care for a specific segment of the Medicaid population, such as pregnant women or adolescents. In these situations, the state is using the expertise of the SSA to oversee SUD services.

The above figures illustrate the need to use caution in interpreting SSA budgets, because there are material underestimates of total state spending for SUD services. State Medicaid agency reimbursements for SUD services are probably the largest omission. A recent study for the Department of Health and Human Services undertook a rigorous analysis of state-by-state SUD treatment spending on Medicaid.[8] The study estimated spending on SUD treatment of $3.95 billion in 2011, which was more than five times greater than the $760 million in Medicaid funds that SSAs manage (see Table 17). The authors concluded that all states pay for some SUD treatment through Medicaid, even if it is only hospital inpatient care for overdoses and alcohol poisoning. That report estimated that states paid an average of 39 percent of Medicaid, and the federal government paid 61 percent.

Bouchery and colleagues also found that there are large differences across states in spending per capita for adolescents and adults, although accuracy was limited by the lack of data for Medicaid managed care plans, which report limited data. The authors concluded that these differences are due to the types of individuals the Medicaid programs covered and the types of SUD services included in plans—both of which are well-known variations of Medicaid plans across states. It

[8] Bouchery, E., Harwood, R., Malsberger, R., Caffery, E., Nysenbaum, J., & Hourihan, K. (2012). *Medicaid substance abuse treatment spending: Findings report*. Retrieved from Assistant Secretary for Planning and Evaluation website: http://aspe.hhs.gov/daltcp/reports/2012/MSATspend.pdf

is expected that differences in what is covered will become less accentuated as the Mental Health Parity and Addiction Equity Act (MMHPAEA) affects Medicaid plans. However, large differences likely will exist between states that expand Medicaid eligibility and those that do not.

It should be noted that all states pay for some SUD services through Medicaid, rather than treatments. For example, detoxification can be a life-saving service, but is generally not considered a treatment for the underlying SUD.

Table 17. State Medicaid Expenditures on SUD Treatment, 2011

State	Medicaid SUD Treatment, $ in millions	Medicaid Spending per Capita, $
Alabama	10.60	2.70
Alaska	9.10	16.20
Arizona	161.10	30.20
Arkansas	5.80	2.40
California	419.50	13.70
Colorado	73.10	17.50
Connecticut	92.50	31.00
Delaware	13.60	18.20
District of Columbia	16.40	31.20
Florida	50.20	3.20
Georgia	22.10	2.80
Hawaii	9.20	8.50
Idaho	3.40	2.70
Illinois	113.70	10.70
Indiana	32.30	6.10
Iowa	10.80	4.30
Kansas	19.40	8.40
Kentucky	39.90	11.10
Louisiana	11.40	3.10
Maine	55.10	48.60
Maryland	86.80	18.10
Massachusetts	107.90	19.30
Michigan	82.40	9.90
Minnesota	61.30	13.90
Mississippi	21.90	9.20
Missouri	73.90	14.90
Montana	7.60	9.20
Nebraska	16.10	10.80
Nevada	11.10	5.10
New Hampshire	7.40	6.60
New Jersey	85.80	11.70
New Mexico	36.00	21.60
New York	1,331.50	81.10
North Carolina	53.00	6.80
North Dakota	4.30	7.80
Ohio	203.50	21.20
Oklahoma	11.00	3.60
Oregon	60.20	18.50
Pennsylvania	127.80	12.00
Rhode Island	27.90	31.20
South Carolina	20.40	5.40
South Dakota	6.30	9.40
Tennessee	17.50	3.30
Texas	29.50	1.50
Utah	7.90	3.60

Table17. State Medicaid Expenditures on SUD Treatment, 2011 (continued)

State	Medicaid SUD Treatment, $ in millions	Medicaid Spending per Capita, $
Vermont	21.80	40.40
Virginia	21.70	3.30
Washington	166.90	29.70
West Virginia	26.90	17.20
Wisconsin	43.90	9.30
Wyoming	1.90	4.10
Total	**3,952.00**	**15.50**
Average (mean)	**77.48**	**14.36**
Median	**26.90**	**9.90**

Abbreviation: SUD, substance use disorder

Trends in Single State Agency Expenditures and Funding Sources

It is possible to examine long-term trends in SSA expenditures by joining data from state 2013 SABG reports with data from the state profile system operated by NASADAD for fiscal years 1985 through 1999, known as the State Resources and Services Related to Alcohol and Other Drug Problems.[9] Data were obtained from SSAs about their budgets, sources of funding, and expenditures on primary prevention and treatment.

SSA expenditures nearly quadrupled between 1985 and 2012, starting at $1.36 billion and ultimately reaching $4.92 billion (see Table 18 and Figure 24). Across this period, growth averaged 4.8 percent per year. State funds were just over 50 percent of the total in 1985, and they still constituted the single largest funding source in 2012, at about 45 percent. State support averaged 4.2 percent growth per year. The major driver of growth was federal BG support. The BG grew by a factor of six and a half and at a rate of 7.2 percent per year, from about a quarter of a billion dollars to $1.66 billion in 2012. Other funding sources—including other federal supports, local sources, and Medicaid—decreased in share from 35 percent of SSA funding to just over 20 percent, with annual growth that averaged 3.0 percent. Unfortunately, the NASADAD State Resources and Services Related to Alcohol and Other Drug Problems reports did not categorize Medicaid funding.

Table 18. Trends in SSA Expenditures and Funding Sources, 1985–2012

Funding Source	1985	1989	1994	1999	2012
	$ in Billions				
State Funds	0.71	1.13	1.44	1.64	2.19
SABG	0.24	0.47	1.06	1.36	1.66
Other	0.47	0.86	1.31	1.46	1.07
	Annual Growth Rate, %				
	1985–1989	1989–1994	1994–1999	1999–2012	1985–2012
State Funds	11.6	4.8	2.6	2.2	4.2
SABG	16.8	16.4	4.9	1.5	7.2
Other	15.1	8.4	2.2	–2.4	3.0
Total Budget	13.5	9.8	3.1	0.8	4.8

Abbreviation: SABG, Substance Abuse Prevention and Treatment Training Block Grant; SSA, single state agency

[9] National Association of State Alcohol/Drug Abuse Directors. *State resources and services related to alcohol and other drug problems*, editions 1986 through 2001. Washington, DC: Author.

Figure 24. Trends in SSA Expenditures and Sources of Funding, 1985–2012

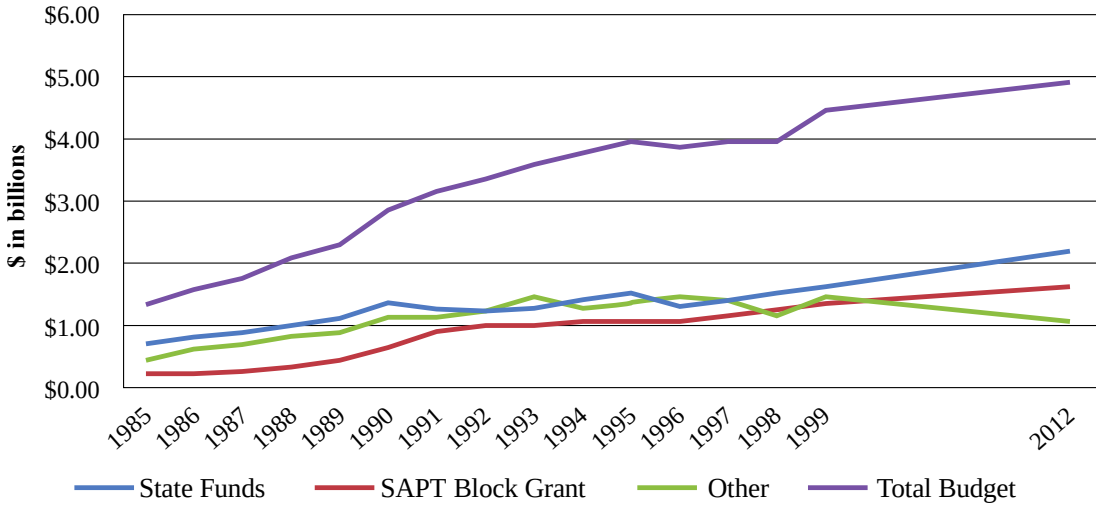
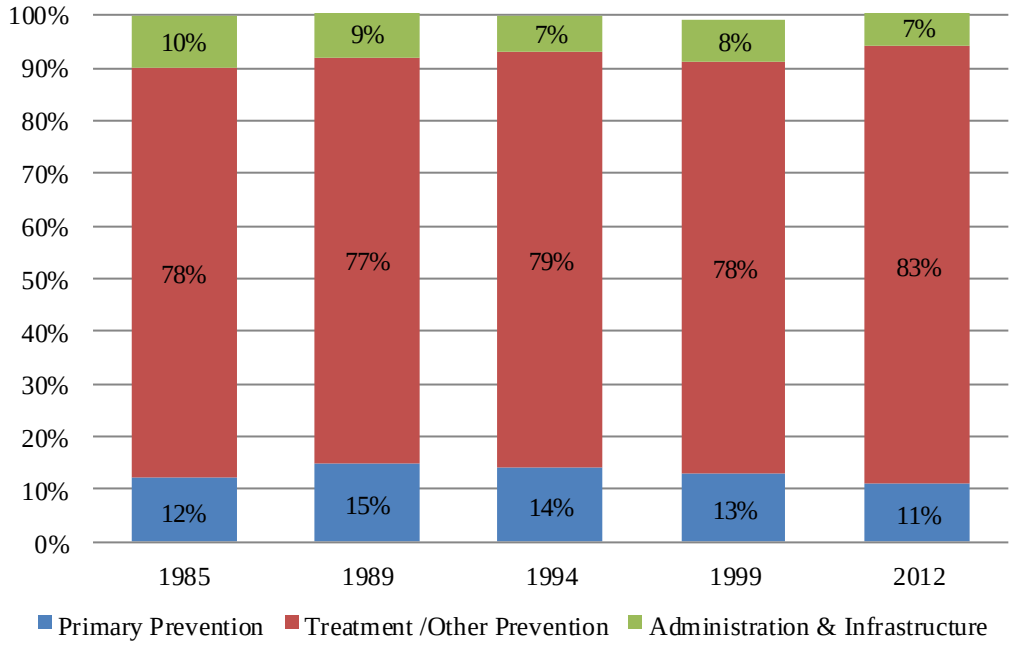


Figure 24 and Table 18 reveal that funding growth has waxed and waned over the 27-year period. Double-digit growth was sustained from 1985 until about 1991, after which growth rates steadily declined. In fact, SSA budgets grew by 0.8 percent per year from 1999 through 2012. State funds and the SABG continued very modest growth (about 2 percent per year), but other funding sources (other federal and local funds, Medicaid) actually declined by 2.4 percent per year. The time period of 1985 to 1991 included what has been called the "cocaine epidemic," which saw SSA budgets catapult to $3.2 billion in 1991.

Another key facet of SSA operations is how they allocate resources between primary prevention and treatment. Figure 25 illustrates the trends. In general, SUD treatment commanded almost 80 percent of resources from 1985 through 1999 and increased modestly to 83 percent in 2012. State spending on administration and infrastructure steadily declined over the 27 years, from 10 percent of total SSA spending to 7 percent in 2012. Viewed superficially, this might be considered a positive trend in that administration's share has gone down. However, this item also includes investments in the workforce, and it is unknown what share these investments have constituted over this time period. Future research could examine the effect of contracting out to insurance and managed care companies on this line item. Insurance and managed care use about 20 percent of funds that they manage for administration, compared with the 7 to 8 percent SSAs have used to manage their grantees. For example, under Medicaid insurance plans administration costs are capped at 20 percent.

Figure 25. Trends in SSA Share Spent on SUD Prevention and Treatment, 1985–2012



Note: Sums may not total to 100 percent because of rounding.

Abbreviation: SSA, single state agency; SUD, substance use disorder

Probably the most significant trend is the rapid growth in funding and the SSA share for prevention. This amount was $160 million (12 percent share) in 1985, and it more than doubled to $340 million (15 percent share) in 1989—a growth rate of 19 percent. The share for treatment spending only grew by 13 percent. By 1992, prevention spending had reached $490 million; however, SSA prevention expenditures have only grown negligibly since that year. These expenditures reached a high of $580 million in 1999 and are currently $540 million. They have progressively declined as a share of SSA budgets to 11 percent in 2012.

6. Characteristics of Consumers Served by the State Mental Health Agency and Single State Agency Systems

This section provides an overview of the characteristics of consumers served by the SMHAs and SSAs. Data on mental health consumers are presented by age, sex, race and ethnicity, service setting, presence of serious mental illness or serious emotional disturbance, employment status, and living situation.

6.1. Consumers Served by State Mental Health Agencies

In 2012, the 50 states, the District of Columbia, and U.S. territories, Freely Associates States and one tribe were served 7,161,659 consumers (2.3 percent of the U.S. population). The total number of consumers served by each state ranged from 9,093 in Delaware to 717,075 in New York. Fifty-two percent of consumers were female (with a utilization rate[10] of 21.1 per 1,000 population), and 48 percent were male (with a utilization rate of 19.6 per 1,000 population). Of all states reporting data, consumers served in Massachusetts[11] had the lowest utilization rate (441 per 100,000), and consumers served in Maine had the highest rate (5,327 per 100,000).

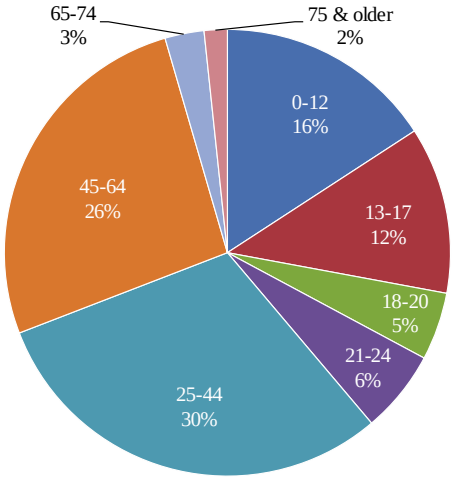
Consumers Served, by Age

In the SMHA systems, 2,169,575 adults aged 25 through 44 years received mental health services and made up the highest percentage (30 percent) of consumers served. A total of 350,837 adults aged 18 through 20 years and 322,896 adults aged 65 years or older received mental health services; these two groups each represented only 5 percent of the SMHAs caseload. Figure 26 presents the percentage distribution of consumers served by age group.

[10] *Utilization rate* refers to the number of individuals of a particular age, sex, or race and ethnicity divided by that group's population in a state.

[11] It should be noted that the total number of clients served in Massachusetts does not include individuals who received only Medicaid-funded services, and this significantly affects the utilization rate in that state.

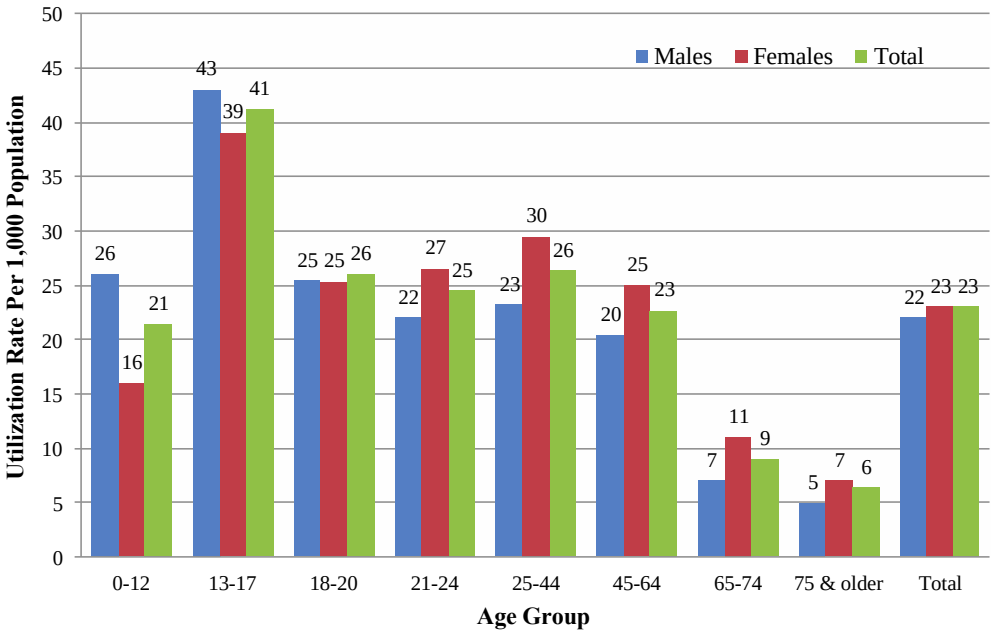
Figure 26. Percentage Distribution of Consumers Served, by Age in Years, 2012



Utilization Rates of Consumers Served, by Age and Sex

The total utilization rate was 23 individuals served per 1,000. Adolescents aged 13 through 17 years represented only 5 percent of the total population served; however, this group used services at a much higher rate (41 per 1,000) than any other age group. Males younger than 18 years used services at a higher rate than females; however, females aged 21 years and older used services at a higher rate than their male counterparts. As depicted in Figure 27, adults aged 75 years or older had the lowest utilization rate.

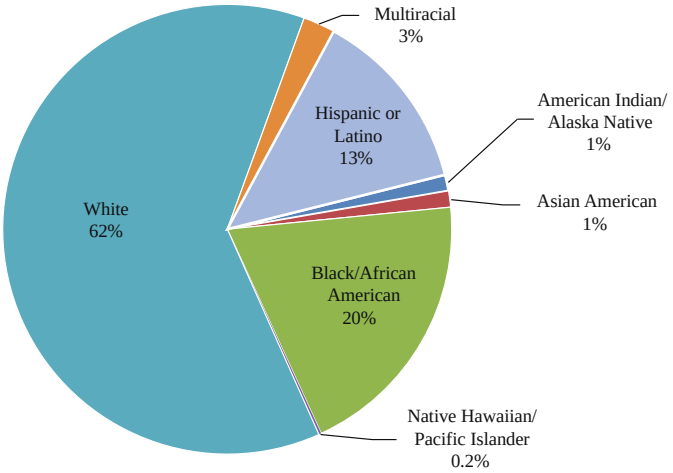
Figure 27. Utilization Rates of Individuals Served, by Age in Years and Sex, 2012



Consumers Served, by Race and Ethnicity

Sixty-two percent of consumers served by the SMHAs were White, and African-Americans represented 20 percent of consumers. Native Hawaiians and Pacific Islanders made up the smallest percentage (0.2) of all consumers served. Figure 28 provides the race and ethnicity distribution of all consumers served.

Figure 28. Percentage of Consumers Served in SMHAs, by Race and Ethnicity, 2012

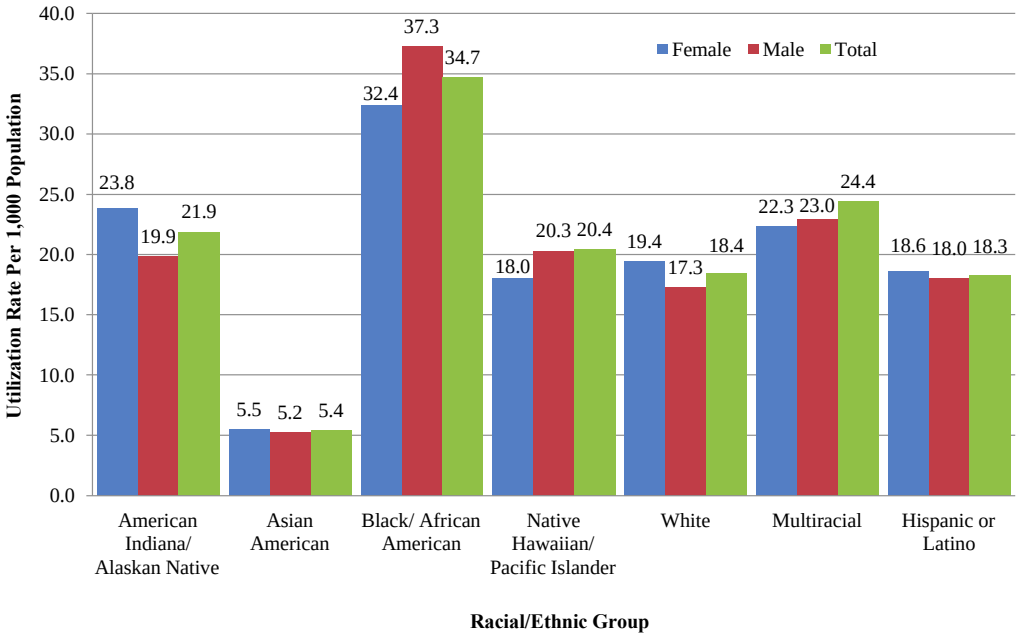


Abbreviation: SMHA, state mental health agency

Utilization Rates of Consumers Served, by Race and Ethnicity and by Sex

Asian-American consumers averaged the lowest utilization rate (5.4 per 1,000) of all racial groups, whereas African-American consumers had the highest average utilization rate (34.7 per 1,000 population). As depicted in Figure 29, males who were African-American (37.3), Native Hawaiian and Pacific Islander (20.3), and multiracial (23.0) had higher utilization rates than their female counterparts.

Figure 29. Utilization Rates of Consumers Served, by Race and Ethnicity and by Sex, 2012



Consumers Served, by Service Setting

In 2012, the vast majority of mental health consumers (96 percent of 6.8 million) received community mental health services in 59 SMHAs, with a utilization rate of 21.7 per 1,000 population. Six percent of all consumers served received services in other psychiatric inpatient settings, with a utilization rate of 1.2 per 1,000. Only 2 percent of all clients served received services in state psychiatric hospitals, with a utilization rate of 0.5; 1 percent received services in residential treatment centers, with a utilization rate of 0.1 per 1,000.

Adults With Serious Mental Illness and Children With Serious Emotional Disturbance

SAMHSA defines serious mental illness (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 DSM-III-R that has resulted in functional

> impairment which substantially interferes with or limits one or more major life activities.[12]

The federal definition of SMI has been adopted in 28 states, the District of Columbia, and by 6 U.S. territories and Freely Associated States. However, 22 states and Puerto Rico have their own definition of SMI. In 2012, 69 percent of all consumers served by the SMHAs had SMI.

SAMHSA defines serious emotional disturbance (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 DSM-III-R that results in functional impairment which substantially interferes with or limits that child's role or functioning in family, school, or community activities.[13]

Twenty-nine states, the District of Columbia, and 7 U.S. territories and Freely Associates States have adopted the federal definition of SED, and 21 states have their own definition. In 2012, 73 percent of all children served by the SMHAs had SED.

In 2012, the majority of all children (73 percent) and adults (69 percent) served by the SMHAs had SMI and SED, respectively. In 10 states, 100 percent of all adults and children served had SMI or SED. These SMHAs have strict service eligibility requirements, where state funds may be used for consumers with SMI or SED only.

Employment Status of Consumers Served

Seventeen percent of adult consumers served in community settings had full- or part-time competitive employment (58 SMHAs reporting). Fifty percent of adult consumers were not in the labor force (i.e., not actively seeking employment), whereas 33 percent were unemployed. As shown in Figure 30, consumers diagnosed with schizophrenia and related disorders had the lowest employment rate (6 percent).

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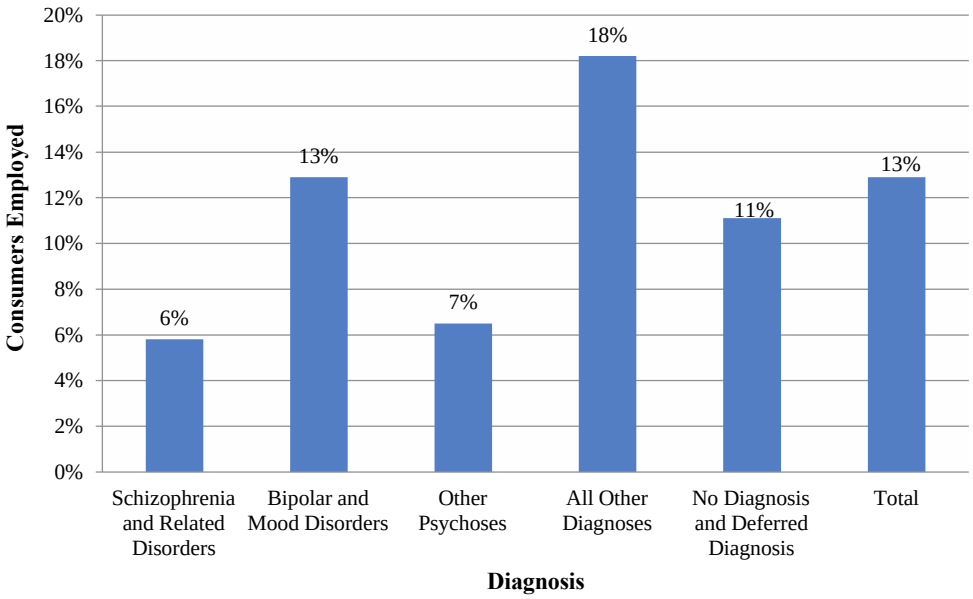
[12] Definition of Adults with a Serious Mental Illness and Definition of Children with a Serious Emotional Disturbance. 58 Fed. Reg. 29422 (May 20, 1993); Block Grants Laws and Regulations, http://www.samhsa.gov/grants/block-grants/laws-regulations

[13] Ibid.

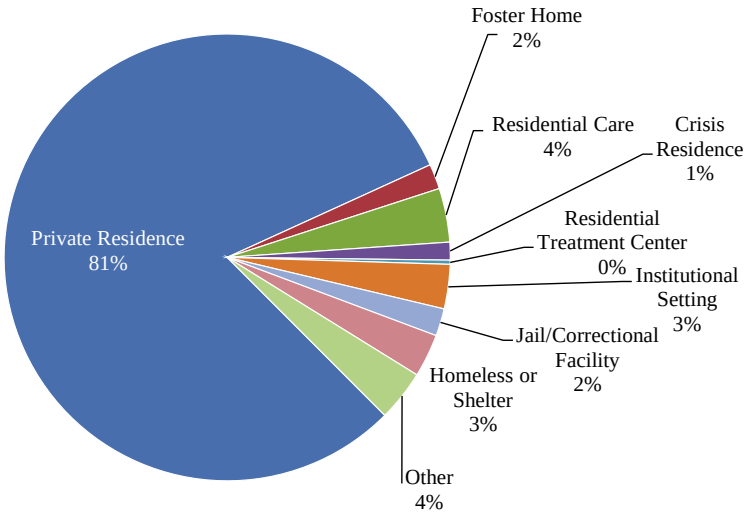
Figure 30. Percentage of Consumers Employed, by Diagnoses, 2012



Residential Setting of Consumers Served by SMHAs

In 2012, the majority (81 percent) of consumers served by SMHAs lived in private residences. The remaining 19 percent of consumers lived in a variety of settings, including residential care facilities, institutional settings, jail or correctional facilities, residential treatment centers, and foster homes. As depicted in Figure 31, about 3 percent of consumers were homeless or living in shelters.

Figure 31. Percentage of Consumers, by Residential Setting, 2012



6.2. Consumers Provided With Substance Use Disorder Services by Single State Agencies

The SSA-supported SUD treatment system served 2.5 million individuals during State Fiscal Year (SFY) 2011-2012. It is noteworthy that about 1.6 million (64 percent) of these individuals were new admissions in 2011 to 2012, while 710,000 thousand (28 percent) initiated their treatment in a prior year. The total also includes 160,000 individuals who used support or recovery services—such as those provided through the Access to Recovery (ATR) initiative—but never accessed formal treatment services. However, these individuals are in the minority, because most individuals who receive support or recovery services also receive treatment.

The distribution by state can be found in Table 19. California served the most people from SFY 2011-2012 (243,000), followed distantly by Illinois at (179,000). The three states serving the fewest number of individuals were North Dakota (5,000), Hawaii (4,900), and New Mexico (3,200). Nationally, about 1 percent of individuals aged 12 years and older received SSA-supported treatment. The percentage served by state ranged from 0.2 percent to 4.3 percent (Table 19).

Data on treatment admissions are also provided in Table 19. There were about 1.9 million treatment admissions during SFY 2011–2012. The number of admissions was higher than the number of individuals first initiating treatment in the same year, because 10 to 15 percent of those who began treatment dropped out and then re-entered treatment. When individuals change from one type of treatment to another, it is counted as a transfer rather than a new admission.

There were 1.23 million admissions to outpatient treatment; of these total admissions, 900,000 admissions were to standard outpatient care compared with 200,000 admissions to intensive outpatient care. There were about 100,000 admissions to opioid replacement treatment, which was predominantly methadone; however, buprenorphine is being used more frequently than in the past. Residential treatment made up 650,000 (one-third) of admissions, and this was split almost equally between detoxification and care oriented toward rehabilitation. Slightly more admissions were from self-referrals (36 percent) than from criminal justice (34 percent) in the most recent year. Referrals from other sources made up 28 percent (e.g., health care, social service or other substance use disorder providers).

Consumers Admitted to Publicly Supported Treatment for Substance Use Disorders

Various types of information about individuals admitted to SSA-supported treatment can be acquired by abstracting the intake assessment from the clinical records in the Treatment Episode Data Set (TEDS). The TEDS is comprised of data collected by state data systems and compiled by SAMHSA.[14] This data set includes the primary and additional substances misused by the client. Knowledge of the substances being misused has important implications for the nature and course of care given to the patient. For example, there are effective medications to treat misuse

[14] It should be noted that TEDS data can vary among states. In some states, only SSA-supported admission data are reported. Some states report all admissions from any providers that receive SSA funding, and some report all admissions to any licensed facilities, including those that receive no public funding. Further, many methadone clinics, for example, are all privately funded and may be underrepresented in TEDS.

of alcohol, heroin, or other opiates, and various therapeutic approaches may be better suited for certain substances.

The primary substances listed for admissions in the 2010 TEDS online public use file were alcohol (41 percent) and illicit drugs of different types (59 percent). In total, 60 percent of admissions misused alcohol (as their primary or secondary substance) versus 76 percent that misused some other type of drug (as their primary or secondary substance). Only 23 percent of admissions misused alcohol versus 39 percent that only misused drugs; 37 percent had problems with both alcohol and drugs.

Table 19. Number of Individuals Receiving SUD Treatment or Support Services, by Nation and State, SFY 2011–2012

State	Individuals Provided Treatment or Other Recovery Support Services					Admissions in 2011–2012			
	Total, Any Service	Treatment		Other Recovery	Total, as Share of Population Age 12+, %	Total	Residential	Outpatient	Opioid Replacement
		Admitted in 2011–2012	Admitted Prior Year						
U.S.	**2,464,318**	**1,593,434**	**710,394**	**160,490**	1.0	**1,878,596**	**650,392**	**1,228,204**	**94,765**
Alabama	23,216	18,692	4,524	0	0.6	23,216	6,656	16,560	956
Alaska	7,626	6,367	1,259	0	1.4	7,127	3,465	3,662	48
Arizona	152,759	77,646	75,113	0	2.9	80,796	6,798	73,998	5,133
Arkansas	10,219	4,702	815	4,702	0.4	9,975	5,890	4,085	356
California	243,341	143,193	100,148	0	0.8	171,157	55,944	115,213	16,210
Colorado	80,496	39,980	40,516	0	1.9	69,862	56,048	13,814	1,176
Connecticut	59,268	27,058	13,231	18,979	2.0	40,270	15,777	24,493	4,569
Delaware	9,744	4,884	4,159	701	1.3	7,641	2,065	5,576	779
District of Columbia	16,020	11,424	2,251	2,345	3.0	7,464	3,334	4,130	1,457
Florida	53,573	53,573	NA	0	0.3	75,905	30,126	45,779	3,269
Georgia	53,580	35,887	17,693	0	0.7	44,141	11,252	32,889	99
Hawaii	4,850	3,769	685	396	0.4	4,572	947	3,625	9
Idaho	16,606	12,131	4,475	0	1.3	8,763	750	8,013	0
Illinois	179,371	82,079	79,295	17,997	1.7	70,602	26,467	44,135	8,672
Indiana	44,173	22,642	21,531	0	0.8	23,921	1,493	22,428	443
Iowa	57,744	47,103	10,641	0	2.3	18,611	3,749	14,862	93
Kansas	25,582	17,630	6,817	1,135	1.1	17,162	5,667	11,495	0
Kentucky	18,153	16,440	1,713	0	0.5	23,289	6,641	16,648	64
Louisiana	25,164	18,043	6,302	819	0.7	27,190	12,673	14,517	0
Maine	18,275	12,786	275	5,214	1.6	12,939	2,578	10,361	1,997
Maryland	71,753	52,645	19,108	0	1.5	52,014	16,616	35,398	3,788
Massachusetts	68,413	52,591	15,716	106	1.2	102,528	61,579	40,949	7,271
Michigan	81,614	65,188	12,322	4,104	1.0	64,064	21,193	42,871	2,606
Minnesota	30,301	24,122	6,179	0	0.7	32,619	15,092	17,527	1,149
Mississippi	9,413	9,413	NA	0	0.4	10,451	3,528	6,923	0
Missouri	56,093	33,420	10,849	11,824	1.1	54,198	17,169	37,029	639
Montana	7,811	6,228	1,583	0	0.9	4,901	1,225	3,676	0
Nebraska	20,617	15,544	5,073	0	1.4	27,258	13,197	14,061	937
Nevada	13,150	10,522	2,628	0	0.6	8,609	2,143	6,466	110
New Hampshire	8,264	5,955	1,798	511	0.7	6,718	1,992	4,726	0
New Jersey	78,666	44,855	21,623	2,188	1.1	59,960	21,453	38,507	6,375
New Mexico	3,249	3,059	190	0	0.2	6,175	489	5,686	386
New York	137,536	99,869	37,667	0	0.8	117,402	47,495	69,907	6,794
North Carolina	90,218	48,194	16,176	25,848	1.2	74,048	21,037	53,011	660

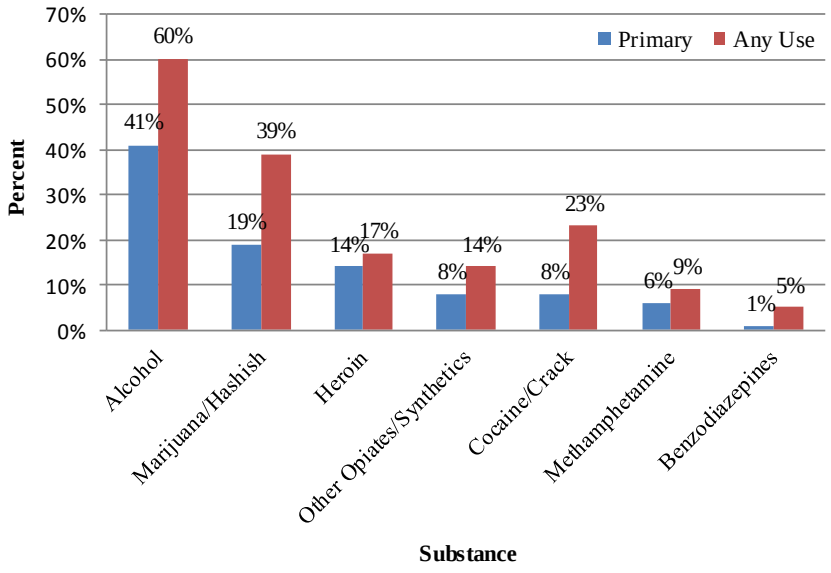
Table 19. Number of Individuals Receiving SUD Treatment or Support Services, by Nation and State, SFY 2011–2012 (continued)

State	Individuals Provided Treatment or Other Recovery Support Services					Admissions in 2011–2012			
	Total, Any Service	Treatment		Other Recovery	Total, as Share of Population Age 12+, %	Total	Residential	Outpatient	Opioid Replacement
		Admitted in 2011–2012	Admitted Prior Year						
North Dakota	4,974	3,981	993	0	0.9	3,914	799	3,115	0
Ohio	98,927	67,024	9,558	22,345	1.0	69,319	8,529	60,790	4,634
Oklahoma	26,820	19,288	7,532	0	0.9	14,277	5,148	9,129	0
Oregon	98,464	67,463	29,693	1,308	3.0	70,848	8,970	61,878	5,637
Pennsylvania	76,546	50,852	25,694	NA	0.7	67,126	25,390	41,736	1,351
Rhode Island	8,659	4,863	3,796	0	1.0	6,895	2,743	4,152	860
South Carolina	39,897	25,812	11,394	2,691	1.0	27,519	3,387	24,132	0
South Dakota	28,595	14,192	14,403	0	4.3	21,477	7,858	13,619	227
Tennessee	17,509	13,109	1,715	2,685	0.3	18,037	10,849	7,188	0
Texas	52,223	41,821	10,402	0	0.3	45,649	22,014	23,635	1,424
Utah	19,383	17,264	2,119	0	0.9	17,982	6,338	11,644	619
Vermont	17,937	6,952	1,996	8,989	3.3	9,564	3,619	5,945	195
Virginia	38,857	26,120	12,737	0	0.6	41,997	7,511	34,486	1,779
Washington	51,640	37,418	14,222	0	0.9	58,239	24,444	33,795	1,945
West Virginia	17,926	13,465	4,021	440	1.1	8,141	864	7,277	0
Wisconsin	79,264	48,698	5,403	25,163	1.7	29,926	9,339	20,587	49
Wyoming	9,839	7,478	2,361	0	2.2	2,138	62	2,076	0

Abbreviations: NA, data not available; SFY, state fiscal year; SUD, substance use disorder

Marijuana was the primary drug reported for 19 percent of admissions, followed by heroin (14 percent), other opiates (8 percent), cocaine or crack (8 percent), methamphetamines (6 percent), and benzodiazepines (1 percent). For 1 percent of admissions, there was no primary drug reported (see Figure 32).

Figure 32. Primary and Other Substances Misused at Admission to Publicly Supported SUD Treatment, 2010



Abbreviation: SUD, substance use disorder

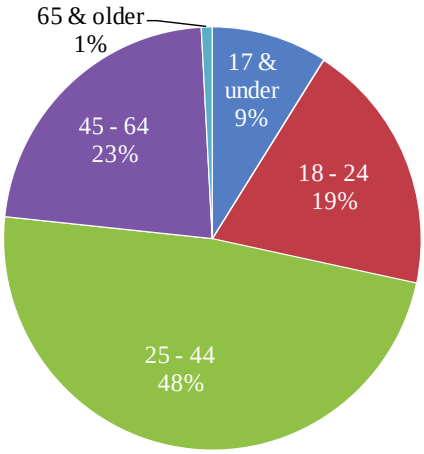
Consumers Entering Into Substance Use Disorder Treatment, by Age and Sex

As depicted in Figure 33, based on data from TEDS 2010, a large majority (71 percent) of admissions to SSA-supported treatment were for individuals between the ages of 25 and 64 years. Admissions of adults aged 18 through 24 years constituted another 19 percent. Admissions of individuals aged 17 years and younger represented only 9 percent; 1 percent of admissions were adults aged 65 years and older.

Some perspective can be gained when these values are compared with the proportion of people with SUD who needed treatment but were not receiving it, based on data from the NSDUH survey. Individuals aged 65 years and older and adults aged 18 through 24 years with SUD were underrepresented in treatment, as they constituted 4.2 percent and 26 percent, respectively, of those who needed treatment. By contrast, adults aged 25 through 44 represented 48 percent of those in treatment, but only about 40 percent of those who needed treatment. Adolescents younger than 18 years and adults aged 45 through 64 years made up about 7 percent and 22 percent, respectively, of individuals with SUD who needed treatment, which was marginally less than their shares of the treatment population (9 percent and 23 percent, respectively).

Shares of males and females enrolling in SUD treatment were similar to their shares in the population with SUD. Males made up 65 percent of treatment admissions, compared with 62 percent of those estimated to have SUD in the NSDUH survey for 2011.

Figure 33. Age Distribution of Admissions to SSA-Supported Treatment, 2010



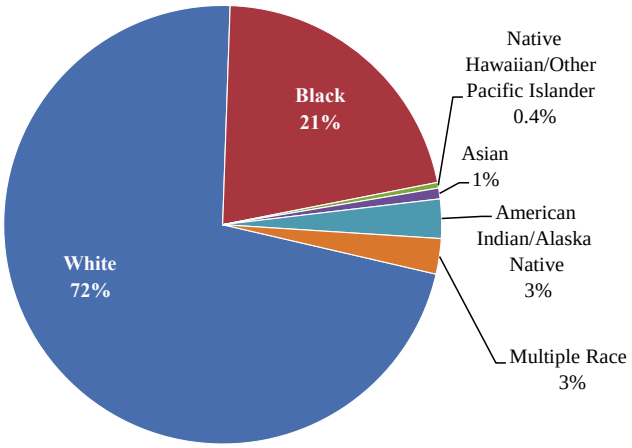
Abbreviation: SSA, single state agency

Consumers Admitted to Substance Use Disorder Treatment, by Race and Ethnicity

Figure 34 contains the racial distribution of admissions to SSA-supported SUD treatment from SFY 2011–2012. Individuals who were Hispanic or Latino represented 13 percent of SSA-supported admissions, whereas they constituted 16.6 percent of the SUD population in the NSDUH survey. Individuals who were White made up 71.9 percent of admissions, followed by admissions of individuals who were African-American (21.4 percent), American Indian and

Alaska Native (2.9 percent), multiple race (2.6 percent), and Asian (0.8 percent). NSDUH estimated that individuals who were non-Hispanic White constituted 68 percent of the SUD population, followed by those who were non-Hispanic Black (10.3 percent), Asian (2 percent), non-Hispanic multiple races (1.6 percent), and non-Hispanic Native Americans and Alaska Natives (1.1 percent).

Figure 34. Racial Distribution of Individuals Admitted to SSA-Supported SUD Treatment, SFY 2011–2012



Abbreviations: SFY, state fiscal year; SSA, single state agency; SUD, substance use disorder

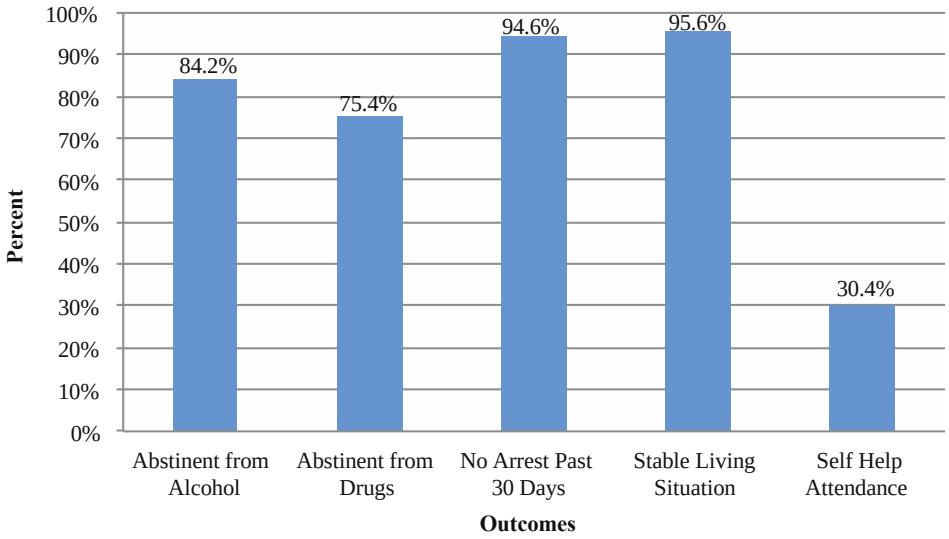
Outcomes of Treatment

States and SAMHSA have worked together in recent years to identify measures of how well treatment works. That collaboration has resulted in a national system that tracks and publishes the results through the SABG Annual Reports. In this section, a few key results are presented from the extensive and comprehensive system.

Results are presented for standard outpatient treatment and service providers that receive support from SSAs. In the modern vision of the treatment system, this is expected to be the final formal phase of a treatment episode that has prepared a patient to pursue recovery.

The most important outcomes are considered to be abstinence from (or at least reduced use of) alcohol and/or illicit drugs. Sixty percent of individuals discharged from outpatient care used alcohol at the time of entry into treatment, but 84 were judged to be abstinent from alcohol during the month following discharge (see Figure 35). Seventy-eight percent of individuals discharged from outpatient care were using drugs at intake, but 75 percent were abstinent from drugs during the month following discharge.

Figure 35. Primary Outcomes at Discharge From Standard Outpatient Treatment, SFY 2011–2012



Abbreviation: SFY, state fiscal year

Two other important measures were high at admission but improved following treatment. Ninety percent of individuals were free of arrests at admission; this number rose to 95 percent during the month before discharge. Similarly, 87 percent reported being in a stable living situation at admission, but 96 percent reported this stability at discharge.

The final outcome measure is attendance at self-help groups during the last 30 days of treatment. Thirty percent of individuals participated in these groups. This is not a direct outcome, but an indicator of prospects for sustained recovery. Numerous research studies have shown that sustained engagement in self-help groups at or following discharge is a strong predictor of long-term maintenance of recovery and abstinence. A minority of clients explore self-help groups on their own or at the suggestion of providers while waiting for admission. Self-help groups are generally the most important at the conclusion of treatment, when the patient needs support to achieve and sustain recovery.

Prevention: Population Served and Services Provided

The 2,800 prevention providers serve tens of millions of individuals each year. SAMHSA broadly differentiates between individual-based and population-based prevention strategies. *Individual-based programs or strategies* are provided to identifiable individuals who require SUD prevention services. The services may occur in a planned sequence that is intended to inform, educate, develop skills, and alter risk behaviors, and it may involve small groups (e.g., parent education groups). *Population-based strategies* include initiatives aimed at influencing communities or large groups of people through changing laws or policies or educating via public service campaigns or events such as a health fair or distribution of leaflets.

SSAs reported that 10.5 million people received individual-based SUD prevention services in SFY 2011–2012. Although it is possible that some individuals engaged in more than one service

(e.g., a student who had a health class and went to after-school, drug-free activities), SAMHSA believes that the amount of overlap is small.

In contrast, SSA-supported population-based prevention strategies reached an estimated 189 million individuals. These strategies include public service campaigns with mass media messages that may reach people multiple times. Environmental strategies encompass the entire community and include activities such as building community coalitions, restricting alcohol advertisements, training alcohol servers, and restricting the hours or density of alcohol served. As a result, the community may be affected by multiple strategies.

The total number of individuals served by population-based strategies often includes multiple counts of the same person. For example, a number of states reported the number of individuals served in excess of their state population (see Table 20). In these states, *individuals served* may be defined as "person exposures," where it is hypothesized that a given person benefited from multiple substance use disorder prevention services, messages, and strategies.

A caveat must be noted to the state-by-state data on prevention. The tendency is to expect that "more is better"; unfortunately, there is little basis on which to assess and judge the differences across states in the patterns and levels of individual versus population services. These data on the number of individuals reached by a prevention strategy are an important but limited metric of the reach of strategies. Information about intensity or type of prevention strategies and the success of the strategies in reducing SUDs is not available.

Table 20. Number of Individuals Served by SSA-Sponsored Substance Use Disorder Prevention Strategies in SFY 2011–2012, by State

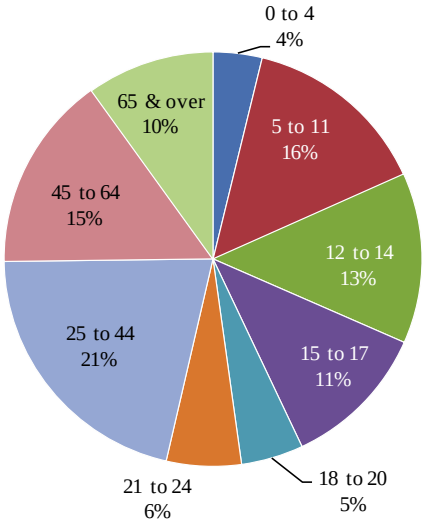
State	Number of Individuals	
	Individual Prevention Strategy	Population Prevention Strategy
Total U.S.	**10,810,102**	**189,346,392**
Alabama	16,096	1,833,954
Alaska	106,476	440,357
Arizona	16,598	11,226,726
Arkansas	21,323	169,338
California	491,570	4,304,924
Colorado	60,456	1,800,445
Connecticut	1,665,024	9,983,887
Delaware	5,537	268,073
District of Columbia	1,000	3,790
Florida	177,927	141,591
Georgia	230,516	36,833
Hawaii	34,113	38,794
Idaho	16,830	469,855
Illinois	84,585	124,342
Indiana	19,412	19,412
Iowa	136,286	398,669
Kansas	5,953	78,797
Kentucky	1,002,186	40,866,867
Louisiana	77,078	206,965
Maine	3,443	1,195,079
Maryland	10,049	146,822
Massachusetts	0	56,428,996
Michigan	133,690	128,048
Minnesota	10,984	1,833,000
Mississippi	50,792	343,122
Missouri	267,584	4,610,414
Montana	7,605	367,900
Nebraska	461,441	104,589
Nevada	8,511	805,579
New Hampshire	152,361	1,262,977
New Jersey	66,530	167,219
New Mexico	5,867	1,702,141
New York	153,500	4,276,587
North Carolina	106,580	71,942
North Dakota	1,342	10,047,577
Ohio	628,336	2,205,783
Oklahoma	244,799	90,765
Oregon	169,583	1,700
Pennsylvania	168,261	332,378
Rhode Island	13,241	3,000
South Carolina	8,384	5,230,977
South Dakota	2,817,471	2,974,091
Tennessee	16,638	303,124
Texas	226,242	8,198,737
Utah	186,308	18,030
Vermont	2,826	132,215
Virginia	24,724	707,143
Washington	42,759	81,781
West Virginia	11,839	667,614
Wisconsin	632,750	2,692,401
Wyoming	6,696	9,801,042

Abbreviation: SSA, single state agency

Individual and Population Prevention Service Recipients, by Age

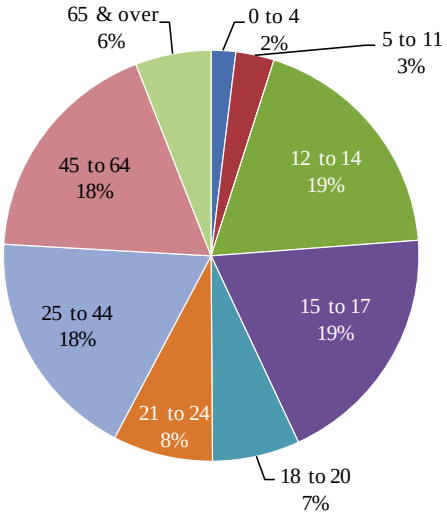
Substance use disorder prevention services provided by SSAs are reaching all ages. For individuals where age was reported, more than 46 percent of those who received individual services were older than 25 years (Figure 36). Population prevention services disproportionately reach children, adolescents, and young adults, although many people older than 24 years are also served (Figure 37).

Figure 36. Age Distribution of Individual Prevention Service Recipients, SFY 2011–2012



Abbreviation: SFY, state fiscal year

Figure 37. Age Distribution of Population Prevention Service Recipients, SFY 2011–2012

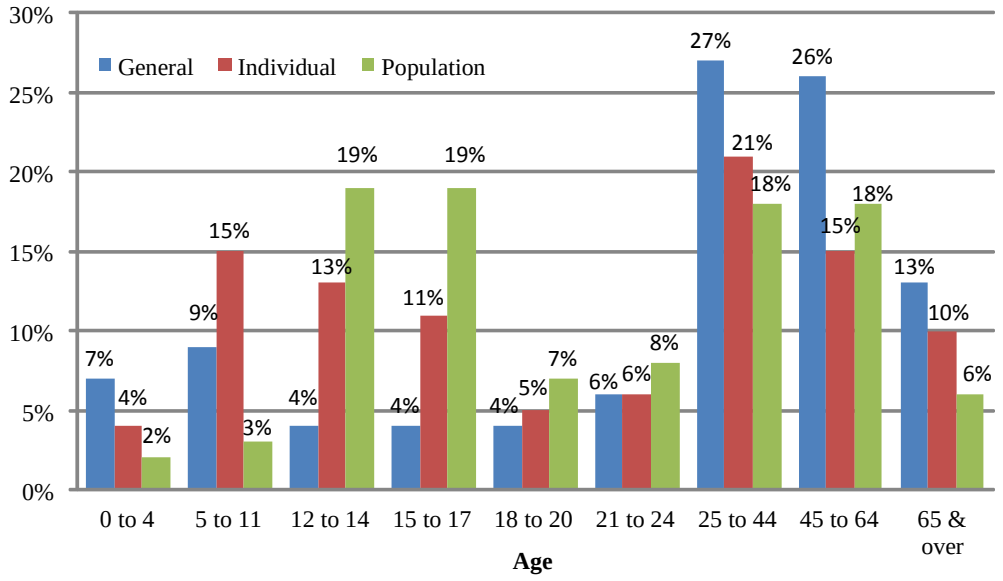


Abbreviation: SFY, state fiscal year

Figure 38 shows the distribution of individuals from various age groups in the general population and those who received individual and population SUD prevention services. Data on the general population were obtained from the Census Bureau's website (http://www.census.gov/). Alcohol and drug misuse is typically initiated by adolescents aged 12 through 17, and they receive a disproportionately large share of primary prevention services. Individuals aged 12 through 14 make up only 4 percent of the U.S. population, but they constitute 13 percent of those reached by individual prevention and 19 percent of those reached by population prevention efforts. Very similar ratios apply to those aged 15 through 17 years. Adults aged 25 through 44 and 45 through 64 years represent 27 percent and 26 percent of the population, respectively. However, they receive a disproportionately lower share of individual prevention services (21 percent and 15 percent, respectively) and a lower share of population prevention services (18 percent for each group).

About 52 percent of all individuals reached by prevention services were female.

Figure 38. Age Distribution of Individual and Population Prevention Recipients Versus General Population, 2012



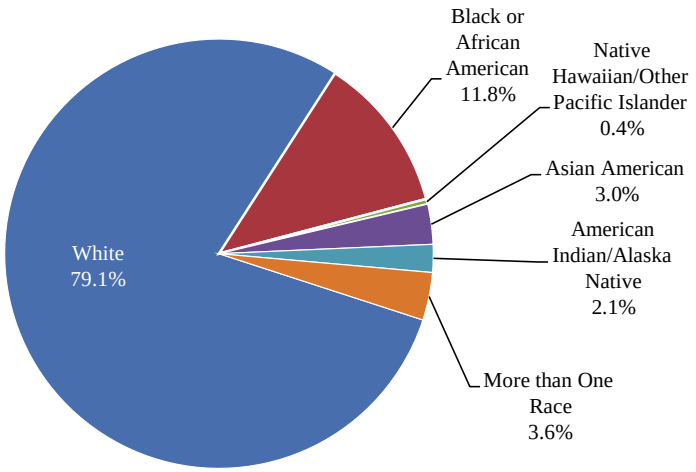
Individual and Population Prevention Service Recipients, by Race and Ethnicity

About 79 percent of individuals receiving individual prevention services were identified as White, compared with about 85 percent of people served by population prevention programs (see Figures 39 and 40). In contrast, Census Bureau data show that individuals who are White make up 74 percent of the general population.

The distributions of other racial groups can also be compared with the share of the general population. Individuals identified as Hispanic and Latino received 10.5 percent of individual prevention services and 12.6 percent of population prevention-based services. They comprise 16.1 percent of the total population. Individuals identified as African-American made up 11.8 percent of the individual prevention recipients and 8.1 percent of population prevention

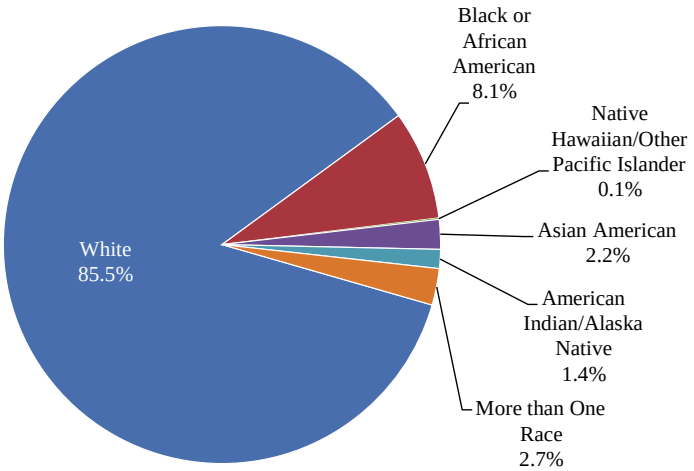
recipients, and they constitute 12.5 percent of the general population. Data from SSAs show that people who identify as being of more than one race made up 3.6 percent and 2.7 percent of individual and population prevention recipients, respectively. Individuals who identify as being of more than one race constitute 2.5 percent of the general population. Finally, individuals identified as American Indian and Alaska Native made up 2.1 percent and 1.4 percent of the individual and population prevention service recipients, respectively, compared with the 0.8 percent share in the general population.

Figure 39. Racial Distribution of Individual Prevention Services Recipients, SFY 2011–2012



Abbreviation: SFY, state fiscal year

Figure 40. Racial Distribution of Population Prevention Services Recipients, SFY 2011–2012



Abbreviation: SFY, state fiscal year

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7. Organization, Types, and Numbers of Mental Health and Substance Use Disorder Providers

Mental health services that are funded and operated by SMHAs are provided in a variety of settings, such as CMHCs, nursing homes and other intermediate care provider facilities, state psychiatric hospitals, private psychiatric hospitals, and general hospitals with separate psychiatric units (see Table 21). There are 7,457 providers across the country, and community providers are by far the most numerous.

Table 21. Number of Mental Health Providers Operated or Funded by SMHAs, 2013

Mental Health Provider	State Operated	State Funded	Total
State psychiatric hospitals	181	15	196
Community mental health providers	153	6,177	6,330
Private psychiatric hospitals	NA	212	212
General hospitals with separate psychiatric units	3	485	488
Nursing homes and other intermediate care providers	14	217	231
Total mental health providers	351	7,106	7,457

Abbreviations: NA, not applicable; SMHA, state mental health agency

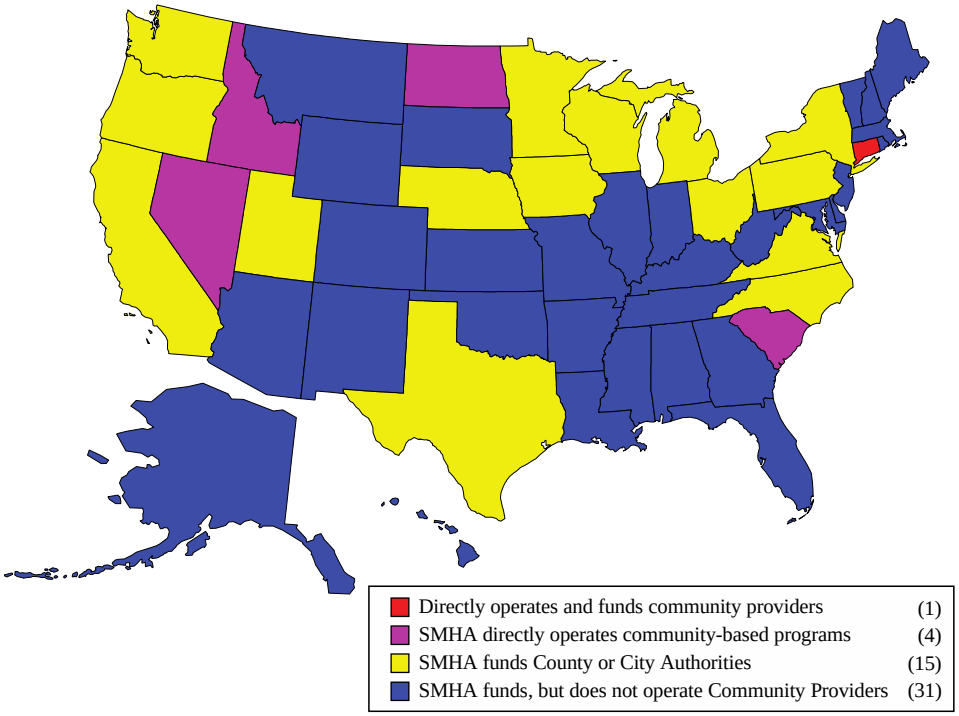
7.1. Organization of Community Mental Health Services

Community mental health systems provide a comprehensive array of mental health services and supports that are designed to help individuals with mental illness recover and live productive lives in their own communities. In 2012, 96 percent of individuals served by the state and territorial SMHAs received community mental health services. The providers of these services included CMHCs, psychosocial rehabilitation centers, various consumer-operated services, ACT teams, outpatient clinics, and day programs.

Mechanisms Used to Deliver Community-Based Mental Health Services

SMHAs use several mechanisms to pay for or deliver community-based mental health services, and many states use a combination of mechanisms. Thirty-one SMHAs directly funded, but did not operate, local community-based agencies. Fifteen SMHAs funded county or city mental health authorities that, in turn, funded providers or directly provided mental health services; and 4 SMHAs directly operated community-based programs. Figure 41 presents the primary mechanism used in each state to fund community mental health services.

Figure 41. Primary Mechanisms Used to Fund Community-Based Mental Health Services, 2013



Abbreviation: SMHA, state mental health agency

SMHAs funded or operated 6,330 community mental health providers in 52 states; the vast majority (6,177) of these providers were funded but not operated by the SMHAs. In 24 of the states, county and city authorities administered mental health services; in 7 states, this situation applied only to parts of the state. Of the states with county or city mental health service administration, 23 used local government contributions to pay for services and 15 states required these contributions.

Role of Community Mental Health Programs in Controlling Admissions to State Psychiatric Hospitals

States were nearly evenly divided on whether community mental health programs controlled admissions to state psychiatric hospitals: community programs in 25 states have no role in controlling admissions, and programs in 24 states have a role. In many of the latter states, their roles are to perform preadmission screenings related to eligibility or illness severity and often to ensure that individuals are served in the least restrictive environment. For example, in South Carolina, CMHCs must be consulted before an admission can be considered by an SMHA-operated state hospital. In Indiana, all civil commitments are initiated in the community by the CMHCs that serve as gatekeepers for admissions and discharges from the hospitals. Each gatekeeper is required to maintain contact with the patient on regular intervals during the patient's stay at the hospital and to work with the hospital and patient on discharge planning.

Of the states where community programs have no role in controlling admission to state psychiatric hospitals, 22 used other methods to control admissions. For example, in Hawaii, admission to the Hawaii State Hospital is only through forensic channels. There is no voluntary admission to the facility because of the volume of admissions from the court system. In Nebraska, access to the state psychiatric hospital is controlled through each of the six Regional Behavioral Health Authorities. Each region has a fixed number of beds, and they designate—based on the referral from community-based hospitals—which patients require that level of care. The criteria are that the patient is ordered to care by the mental health board and cannot be safely treated in the community-based hospital. Other admissions to the state psychiatric hospitals are ordered by the courts, and patients may not voluntarily access this service. Washington State uses a bed-allocation formula for state psychiatric hospitals that shifts fiscal responsibility to the regional support networks if they exceed their allocated beds.

Of the states where the community programs have a role in controlling admissions to state psychiatric hospitals, 13 also use other mechanisms. For example, in Idaho, additional mechanisms used to control admissions to state psychiatric hospitals include the use of ACT teams, outpatient dispositions, collaborations with private psychiatric hospitals, and contracted private psychiatric beds for acute care. State hospitals make the final determination as to whether the referred individual meets medical necessity for inpatient level of care. In Wisconsin, state psychiatric hospitals admit only individuals under involuntary civil detention or commitment or forensic detention or commitment. Prior to transporting an individual for detention at either of the state hospitals (Mendota Mental Health Institute or Winnebago Mental Health Institute), the County Department of Community Programs in the county where the individual was taken into custody must provide approval of the need for detention. As such, detentions to the state hospitals cannot occur unless the county provides approval.

Initiatives to Restructure Community-Based Mental Health Service

Twenty-four states are restructuring the delivery of community-based mental health services. For example, in Connecticut, the traditional case management for adults was replaced by rehabilitation-specific, recovery-oriented community support programs. In the District of Columbia, the SMHA, in coordination with the state Medicaid agency, is developing a Health Home State Plan Amendment with the anticipation that the majority of community mental health providers will become health homes; thus, the majority of the SMHA's consumers with SMI will be served through a health home model. This will lead to better coordination for all consumers' medical and mental health needs.

Types of Community Mental Health Services Provided

SMHAs offer an array of community mental health services, including outpatient testing and treatment (n=39); extensive and intensive outpatient treatment (n=39); crisis services, which include mobile crisis teams (n=39); residential support services (n=38); case management (n=38); supported employment (n=38); ACT (n=37); co-occurring mental health and substance use disorder services (n=36); residential room and board (n=35); school-based mental health services (n=35); wraparound (n=35); collateral treatment (n=31); and peer or consumer-operated services (n=32).

7.2. State Psychiatric Hospitals

Every state operates facilities that provide psychiatric inpatient services. These services provide care and treatment to individuals with SMI who are at risk to themselves or others. In 2012, 151,069 individuals were patients in state psychiatric hospitals, or 2.1 percent of all individuals served by the state and territorial SMHAs.

In 2013, states funded and/or operated 196 state psychiatric hospitals. The SMHA directly operated 181 and funded an additional 15 of these facilities. The number of state psychiatric hospitals in each state ranged from one state hospital in the District of Columbia and 13 states (Alaska, Arizona, Arkansas, Delaware, Hawaii, Montana, New Hampshire, New Mexico, North Dakota, South Dakota, Utah, Vermont, and Wyoming) to 24 state hospitals in New York.

How States Use State Psychiatric Hospitals

States vary in the way they use their psychiatric hospitals by target population. As Table 22 shows, the most common target populations are adult, older adult, and forensic. Far fewer states use their hospitals to care for children and adolescents. There is much less variability in the use of hospitals for acute care (less than 30 days), intermediate care (30 through 90 days), and long-term care (more than 90 days); intermediate care is the most common, followed closely by long-term and then short-term care.

Table 22. Number of States Providing Specific Inpatient Services, by Age, 2013

Target Population	Acute Care (less than 30 days)	Intermediate Care (30–90 days)	Long-Term Care (more than 90 days)
Children	15	13	11
Adolescents	20	20	16
Adults	42	44	42
Older Adults	36	39	39
Forensic	34	41	41

At the beginning of 2012, there were 40,305 patients residing in state psychiatric hospitals across the country. States varied in the number of total patients in these facilities, ranging from 50 in Vermont to 6,016 in California. On average, states had 13.6 patients per 100,000 population, ranging from 3.7 patients per 100,000 population in Arizona to 46 patients per 100,000 population in the District of Columbia (see Table 23).

Use of Public General and Local Hospitals

Seventeen states require that public general and local hospitals be used as an initial admission site for psychiatric inpatient treatment before an individual uses state psychiatric hospital facilities. For example, in the District of Columbia, acute involuntary admissions are authorized by the SMHA and routed to one of four general hospitals. On the 15th day of hospitalization, the person is transferred to the state psychiatric hospital. In Oregon, individuals are admitted to acute care hospitals to rule out any physical health issues that may be causing their presenting symptoms. Once a physical health cause is ruled out, the individual receives a mental health assessment. If it is determined they the person is in need of long-term care, a mental health professional may request admission to Oregon State Hospital. In Washington, individuals must spend at least 14 days in a community hospital prior to admission to a state psychiatric hospital.

Table 23. Number of State Psychiatric Hospitals, Residents, and Admissions, 2012

State	Number of State Hospitals	Number of Residents (start of 2012)	Residents per 100,000 Population	State Hospital Admissions (2012)
Alabama	4	865	18	2,492
Alaska	1	70	10	1,630
Arizona	1	235	4	75
Arkansas	1	207	7	574
California	5	6,016	16	3,388
Colorado	2	465	9	1,776
Connecticut	4	747	21	1,080
Delaware	1	149	16	599
District of Columbia	1	290	46	403
Florida	7	3,172	16	2,876
Georgia	6	1,076	11	7,034
Hawaii	1	178	13	277
Idaho	2	128	8	854
Illinois	7	1,516	12	9,169
Indiana	6	805	12	497
Iowa	4	126	4	1,129
Kansas	3	705	25	4,267
Kentucky	3	465	11	9,093
Louisiana	2	685	15	2,023
Maine	2	193	15	514
Maryland	5	972	17	1,051
Massachusetts	2	542	8	967
Michigan	5	507	5	1,612
Minnesota	10	209	4	2,005
Mississippi	4	674	23	3,514
Missouri	9	1,094	18	709
Montana	1	149	15	732
Nebraska	3	296	16	191
Nevada	3	252	9	3,956
New Hampshire	1	127	10	2,369
New Jersey	4	1,748	20	2,527
New Mexico	1	171	8	963
New York	24	4,691	24	7,540
North Carolina	3	682	7	3,339
North Dakota	1	144	21	624
Ohio	6	1,028	9	6,747
Oklahoma	2	310	8	1,958
Oregon	2	657	17	821
Pennsylvania	6	1,608	13	1,127
Rhode Island[a]	1	157	15	1,157
South Carolina	4	589	13	1,791
South Dakota	1	221	27	1,922
Tennessee	4	544	8	10,185
Texas	11	2,497	10	14,452
Utah	1	290	10	388
Vermont	1	50	8	38
Virginia	10	1,310	16	4,330
Washington	3	1,142	17	2,120
West Virginia	2	271	15	1,155
Wisconsin	2	681	12	4,843
Wyoming	1	115	20	223
Total	**196**	**41,821**	**709**	**135,106**
Median	**3**	**507**	**13**	**1,630**
Maximum	**24**	**6,016**	**46**	**14,452**
Minimum	**1**	**50**	**4**	**38**

[a] Rhode Island has state-operated psychiatric inpatient beds that are part of a general hospital.

Reorganization of State Psychiatric Hospitals

SMHAs in 19 states are reorganizing their state psychiatric hospitals, including closing one or more hospital (n=3), increasing psychiatric beds (n=5), consolidating two or more hospitals into one facility (n=2), decreasing total psychiatric beds (n=6), transferring patients from hospitals to community inpatient facilities (n=4), reducing the size of wards (n=3), closing wards (n=3), opening a new hospital (n=2), and replacing an older hospital with a newer facility (n=5). Other reorganization activities include partnering with private providers to open a co-located crisis stabilization unit in Tennessee and purchasing private psychiatric beds for civilly committed patients to convert civil beds to forensic beds in a state hospital in Texas.

Between FY 2011 and FY 2013, 14 state psychiatric hospitals were either closed or merged in nine states. Georgia and Oregon are planning to close state psychiatric hospitals, and Delaware is planning to decrease inpatient beds between FY 2013 and FY 2014.

Psychiatric Inpatient Bed Shortages

Only 12 states have a model for determining the number of psychiatric inpatient beds they need. Nevertheless, 27 of the states reported shortages of psychiatric beds, including shortages of acute (n=10) and long-term (n=13) state psychiatric hospital beds, acute (n=19) and long-term (n=7) private and/or general hospital psychiatric beds, and forensic beds (n=17). Twenty-six of the states are experiencing a shortage of psychiatric beds, including four that have reduced state psychiatric bed capacity since FY 2012. Nine states reduced their psychiatric hospital bed capacity; general hospital specialty psychiatric units reduced their available beds in 3 states; and private psychiatric hospitals reduced their bed capacity in 2 states.

The shortages of psychiatric beds have led to increased waiting lists for state psychiatric hospital beds in 17 states, increased waiting lists for other psychiatric beds in 15 states, overcrowding in state hospitals in 6 states, and increased resistance to closing additional state hospital beds in 10 states. Other consequences of inpatient bed shortages include increased time in emergency departments, additional pressure on the community-based treatment system, and diversion to local community hospitals or jails because of lack of other alternatives.

SMHAs are using a variety of strategies to address the shortages of psychiatric inpatient beds. Forty-seven states are developing and/or supporting alternative forms of mental health treatment to reduce the need for hospitalization. For example, in Alabama, the SMHA promotes the expansion of crisis services among providers and the adoption of evidenced-based services such as ACT and Peer Recovery Services. Some providers additionally employ or share clinical staff with local jails, courts, and hospitals to provide and coordinate alternative treatment through diversionary practices. Services are provided with a focus on mobility across a variety of community settings, which include homes, and in partnership with other community organizations such as schools and health clinics. Providers also incorporate the use of telemedicine and wraparound services to expand service capacity. In Colorado, the SMHA is developing crisis services to rely less on hospitalization. In Missouri, the SMHA is developing hospital diversion programs and programs to reduce 30-day recidivism rates. In Oregon, the SMHA is working with acute care hospitals to transition individuals back to community-based services.

7.3. Forensic Mental Health Services

Forensic mental health services are services such as psychiatric evaluation and treatment that are provided to individuals who have a mental illness and are involved with the criminal justice system. These services are provided in a secure unit to defendants, inmates, those not found guilty by reason of insanity, and those found guilty but mentally ill. The individual's recovery and progress toward rehabilitation after receiving these mental health services affect the person's legal situation.

Responsibility fo Forensic Mental Health Services

The SMHA has some responsibility for evaluating the mental health status of individuals involved with the court system in 46 states; of these, 33 SMHAs have the sole responsibility, and 13 share the responsibility with another agency. In 34 states, the SMHA has some responsibility for providing mental health services to individuals in prisons and/or jails; of these, 29 SMHAs share this responsibility with another agency, and only the SMHAs in Arkansas, Louisiana, New York, and Utah have sole responsibility. The SMHA has some responsibility for providing services to sex offenders in 28 states; of these, 20 SMHAs share this responsibility with another agency and 8 have sole responsibility.

Forensic Psychiatric Hospitalization

Forty-three states provide services to forensic patients at their state psychiatric hospitals. Of these, 29 provide these services at the acute, intermediate, and long-term levels of care; 9 at the intermediate and long-term levels; 2 at the acute and intermediate levels; 1 at the acute and long-term levels; 1 at the short-term level only; and 1 at the long-term level only. Seventeen states reported that they had a shortage of forensic psychiatric inpatient beds.

Thirty-six states use general funds to pay for forensic inpatient services. A small number of states also use other funding sources on a limited basis to pay for these services, such as the state's Medicaid match (n=6), the federal share of Medicaid (n=5), Medicare (n=8), Veteran's Affairs (n=2), local government (n=4), self-pay or first party (n=7), and private insurance or third party (n=8). Twenty-one states use general funds to pay for services for sex offenders. A small number of states use other funding sources, such the state's Medicaid match (n=3), the federal share of Medicaid (n=2), Medicare (n=3), self-pay or first party (n=5), and private insurance or third party (n=6) to pay for these services.

7.4. Public Substance Use Disorder Prevention and Treatment Systems

States have developed substantial networks of primary prevention and treatment and other prevention providers over the years. There were almost 2,800 primary prevention providers funded with SABG funds through SSAs. In addition, there were about 8,000 providers of specialty SUD treatment that used funding from the state, local, or federal government to provide care for people who were underinsured or had low incomes.

A national roster of 2,788 primary prevention organizations that are funded with SAPT dollars is submitted by SSAs in required BG Reports (see Table 25). Funded providers are required to

compile and report data about the numbers and characteristics of individuals served and the general nature of preventive services received. These statistics are tabulated and reported elsewhere in this document. Still, little work has been done at this time to analyze the characteristics of the national system of prevention providers, such as the types of organizations (e.g., boys or girls clubs, community coalitions), the types of primary prevention strategies they use, or the types of services they deliver. A review of the state rosters indicates that the vast majority of primary prevention providers are nonprofit nongovernmental organizations, and the few government units are local health departments or school districts.

The 7,982 publicly supported SUD treatment and service providers have been studied over the years through the annual National Survey of Substance Abuse Treatment Services (N-SSATS). The N-SSATS is an inventory of "specialty" SUD service provision facilities. "Specialty" SUD providers are facilities that have qualified treatment practitioners on staff, meaning that these individuals have a SUD-specific license, certificate, or credential. Additionally, the facility is extremely likely to be licensed or certified by the state SUD facility credentialing agency. Private practitioners (e.g., doctors, counselors, clinical social workers) are not in N-SSATS unless they are affiliated with a facility.

Analyses of these data reveal several important patterns about SUDs. For example, in 2011 there were 13,720 specialty SUD treatment and service providers; of these, about 8,000 or 58 percent receive public funding (exclusive of Medicaid or Medicare). Integration of SUD with mental health care has been a growing theme, and 37 percent of SUD specialty facilities offer both SUD and mental health care. However, 60 percent of providers offer only SUD care, and the final 3 percent are health clinics or community hospitals. There is much variation across states in the degree to which SUD facilities offer only SUD or M/SUD care.

A range of types of treatment can be accessed for rehabilitation from SUD disorders. The field increasingly is designed around a continuum of care, ranging from very high acuity care to acute care hospital inpatient services (very high intensity) to nonhospital residential care, followed by intensive outpatient and then regular outpatient care. Very few hospitals are in SSA-supported treatment systems, primarily because the SABG does not permit funding of hospital inpatient care—a prohibition in federal funding that goes back to the inception of federal grant support of drug treatment in the early 1970s. In fact, only 3 percent (n=237) of the publicly supported providers have SUD hospital inpatient care units.

Progressively larger shares of providers are associated with lower intensity services, with 30 percent offering some type of nonhospital residential care, 45 percent offering intensive outpatient care, and 75 percent offering regular outpatient care. Opioid outpatient treatment with methadone or buprenorphine is the final level of care, at only 7 percent or about 550 providers. Opioid treatment is the most effective treatment for dependence on heroin and opioid pain medications. Data on the size and configuration of the respective state public treatment systems are provided in Table 24.

Table 24. SSA-Supported Providers of Primary Prevention and Treatment, by State, 2011

Area	SAPT Funded Prevention Providers, n	Public Treatment Providers, n	Types of Treatment Offered by Public SUD Treatment Providers, %					
			SUD Only	SUD and Mental Health	Residential	Intensive Outpatient	Regular Outpatient	Opioid Outpatient
Total U.S.	**2,788**	**7,982**	**60**	**37**	**30**	**45**	**75**	**7**
Alabama	23	96	67	31	28	67	59	2
Alaska	24	61	41	52	38	46	75	3
Arizona	13	103	46	51	28	51	75	16
Arkansas	20	42	55	43	52	50	76	2
California	311	973	69	27	39	37	63	4
Colorado	54	240	47	49	18	49	88	4
Connecticut	72	128	59	40	30	40	65	22
Delaware	3	25	68	32	32	40	68	16
District of Columbia	6	25	48	48	44	56	68	4
Florida	91	321	54	43	39	27	69	4
Georgia	115	119	43	57	34	41	71	5
Hawaii	13	106	88	12	7	33	97	2
Idaho	62	66	56	42	15	85	94	2
Illinois	241	335	57	38	29	59	82	10
Indiana	12	165	29	70	13	57	92	3
Iowa	25	99	77	21	25	54	83	2
Kansas	14	124	64	32	20	48	94	1
Kentucky	17	157	31	67	25	27	78	3
Louisiana	53	97	81	18	36	53	71	2
Maine	35	78	33	58	24	33	78	4
Maryland	24	179	80	18	33	50	68	16
Massachusetts	31	203	66	30	49	15	48	19
Michigan	154	286	50	49	24	47	86	6
Minnesota	27	167	69	28	46	54	70	4
Mississippi	28	67	46	54	42	24	69	0
Missouri	118	224	64	33	25	62	96	2
Montana	12	49	59	39	24	63	88	0
Nebraska	60	100	47	51	39	34	75	1
Nevada	28	54	67	30	26	46	80	11
New Hampshire	11	34	71	24	41	24	71	9
New Jersey	37	214	66	33	21	64	80	13
New Mexico	24	112	29	65	19	57	83	3
New York	113	550	89	9	39	23	57	15
North Carolina	36	192	47	51	30	44	72	6
North Dakota	50	25	44	48	60	52	80	0
Ohio	168	274	55	44	28	50	83	5
Oklahoma	19	110	55	41	25	38	85	1
Oregon	42	148	56	42	24	69	84	7
Pennsylvania	54	329	71	29	24	49	78	11
Rhode Island	6	40	65	30	33	43	78	30
South Carolina	33	63	86	11	17	51	89	3
South Dakota	22	44	59	36	41	68	82	0
Tennessee	60	146	36	62	36	44	76	0
Texas	86	265	78	20	31	49	77	6
Utah	39	71	49	51	31	55	85	3
Vermont	5	31	42	52	16	39	84	16
Virginia	30	134	28	70	22	38	82	6
Washington	130	250	65	34	18	71	84	5
West Virginia	18	69	28	70	35	29	71	1
Wisconsin	94	141	41	58	28	34	79	2
Wyoming	25	51	29	65	27	67	73	0

Abbreviations: SAPT, Substance Abuse Prevention and Treatment Block Grants; SSA, single state agency; SUD, substance use disorder

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8. Major Policies of State Mental Health Agencies and Single State Agencies

8.1. Eligibility Requirements for State Mental Health Agency Services

Each state determines its own eligibility criteria for individuals to receive SMHA-operated or SMHA-funded services. Within a state, these criteria can vary by funding source. There is an income cap below which individuals are eligible for SMHA services in 16 states. There is an illness severity requirement for SMHA services in 26 states. Collateral, non-mental health services are provided to family members and significant others of individuals receiving SMHA services who themselves may not have a mental health diagnosis in 41 states. The SMHA has a waiting list for individuals in need of mental health services in 15 states, including 10 with a waiting list for inpatient services, 6 for residential services, 2 for case management, 4 for EBPs, and 6 for forensic services.

Some states have eligibility criteria that restrict who can receive mental health services from SMHA-operated or SMHA-funded providers. In 25 states, all adults with a mental illness are eligible for mental health services from a mental health provider that is operated or funded by an SMHA, when the services are funded by state general or special funds; in 22 states, only adults with SMI are eligible. Similarly, in 28 states, all children with a mental illness are eligible for services from mental health providers that are operated or funded by an SMHA when the services are funded by state general or special funds; in 19 states, only children with SED are eligible.

Restrictions on who is eligible for services from SMHA-operated or SMHA-funded providers also apply to Medicaid and other funding sources in some states. All adults are eligible for services funded by Medicaid in 28 states, whereas only adults with SMI are eligible in 18 states. All children with a mental illness are eligible for services funded by Medicaid in 29 states, whereas only children with SED are eligible in 17 states.

All adults with any mental illness are eligible for services funded through other funding sources in 21 states, whereas only adults with SMI are eligible in 11 states. All children with a mental illness are eligible for services funded through other funding sources in 19 states, whereas only children with SED are eligible in 13 states.

8.2. Health-Mental Health Integration Initiatives

At the present time, the Affordable Care Act is in various stages of implementation across the country. Many states are actively engaged in addressing mental health integration with primary health care.

- Forty-seven SMHAs have initiatives in place to improve the integration of mental health with primary health care.

- Forty-five SMHAs are supporting the colocation of primary care services with the mental health programs the SMHA operates or funds.

- Forty-five SMHAs are supporting locating mental health services within primary care settings.

Health Screening in Mental Health Programs

An important element in physical health and mental health integration initiatives is the active engagement of screening for physical health conditions. With the health care delivery system moving toward an integrated approach to care, some states are requiring health screens in their CMHCs.

In 2013, 43 states were screening or assessing mental health consumers for physical health issues in community mental health programs. However, physical health assessments were not conducted by all community mental health providers or for all clients (see Table 25).

Table 25. Screening for Physical Health Needs in SMHA Systems, 2013

Provider	State-Funded or -Operated Community Mental Health Providers	
	All Patients	Some Patients
All mental health service providers	14	11
Some mental health service providers	10	16

Abbreviation: SMHA, state mental health agency

Twelve states require physical health screenings in all CMHCs funded or operated by SMHAs. Funding for these screenings comes from the following sources: state general funds (16 states), Medicaid (21 states), Medicare (6 states), and other sources (6 states). Twelve states require physical health screenings in some SMHA-funded or -operated community mental health programs. Funding for these screenings comes from the following sources: state general funds (18 states), Medicaid (20 states), Medicare (7 states), and other funds such as the MHBG, private insurance, and local funds (13 states).

Substance Use Disorder Screening in State Mental Health Agencies

Specific to substance use disorder screening efforts and activities in SMHAs, 50 states are screening for co-occurring mental health and SUDs. States noted that with the integration of their mental health and substance use disorder departments, this is now a requirement. States also noted that the implementation of SBIRT is paving the way for statewide practices and standards.

8.3. Substance Use Disorder and Primary Care Services Integration

Integration of SUD prevention and treatment services with primary care services is one of SAMHSA's key themes and a federal strategy to improve and expand SUD care. States have primary responsibility for the operation and reformation of primary care health service delivery systems, and they manage and provide primary funding for public SUD systems as well as

Medicaid systems. SSAs described a variety of plans in the SABG application for FY 2012 through 2013.

In total, 48 states (94 percent) reported planning initiatives that will advance SUD and primary care services integration. Eighteen states (35 percent) designed SUD and primary care integration as a primary state priority. Another 10 states (20 percent) indicated that integration was a secondary strategy supporting another state priority.

Twenty-five states (49 percent) wrote in their SABG application about planning for health homes. Twenty-two states (43 percent) included plans for screening or SBIRT services. Twenty-five states specified engagement in collaborative efforts with Medicaid, and 39 SSAs described collaboration with primary care providers in their states.

SSAs described a variety of additional tactics to promote SUD and primary care integration. Sixteen states detailed workforce initiatives such as SBIRT training and education to primary care providers. In addition, 24 states reported working on HIT issues related to SUD and primary care service integration, such as linking SUD and primary care EHR systems.

A handful of states noted their work integrating SUD care and primary care for special populations, including rural residents (seven states), women (six states), adolescents (four states), Native American tribes (two states), older adults (one state), and individuals who are homeless (one state).

Nearly all SSAs are doing some work to integrate SUD and primary care services, and they described these activities in their 2012 through 2013 SABG applications. It is important to note that the applications do not necessarily reflect all work being done by states. Some states may be using state funds rather than SABG funds to do this work. Another possibility is that a state's SUD and primary care service integration efforts might be spearheaded by a different agency; thus they were not included in their SABG application. However, this does not mean that the states are not making advances in this domain through another funding source.

8.4. Prevention of Mental Illness

Forty-five SMHAs collaborate with other systems and/or stakeholder groups on initiatives to prevent risk factors for mental health problems and to foster resilience. Some SMHAs are partnering with the planning councils, child welfare programs and services, disability councils, local school boards, the military, juvenile justice and public health agencies, System of Care services and supports, primary care services, peer support, and legislatures.

The SMHAs provided evidence-based interventions to prevent the onset of mental health problems and to foster resilience in 27 states. These states noted that they offered the following EBPs and/or promising practices: adolescent leadership programs, Mental Health First Aid, Circle of Security (parenting program in California), case management services and supports, ACT, Multisystemic Therapy, Family Functional Therapy, Triple P (parenting program), nurse family partnership, Parent-Child Interaction Therapy, and suicide prevention programs such as crisis hotlines, continuity of care following discharge from emergency departments and inpatient

psychiatric hospitalization, and training of mental health professionals in evidence-based treatments to reduce suicidal behaviors among the mentally ill.

Early Intervention

Early intervention programs—designed to screen and enroll individuals into treatment at the first sign of symptoms of mental illness—can reduce the severity and duration of some mental illnesses. The SMHAs had early intervention programs for children with mental illness either statewide (17 states) or in parts of the state (19 states).

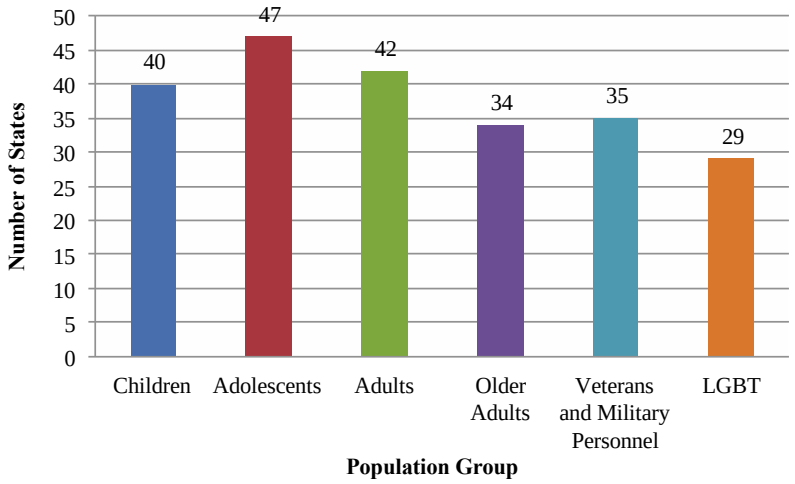
The SMHAs had early intervention programs or initiatives for adults with mental illness in parts of 15 states. Early intervention programs in which SMHAs are engaged include first responders' training from law enforcement, SBIRT, other state-based early identifications for individuals with schizophrenia, consumer-run help lines, and partnerships with universities and faith-based organizations.

Twenty-nine states have partnerships to increase the early identification and treatment of depression. These states identified the following as examples of these partnerships: co-location of CMHCs within primary care, screening tools (inclusive of perinatal and postnatal), school mental health programs, Mental Health First Aid, and performance measurement collection for depression.

Suicide Prevention

Most SMHAs operated, funded, or participated in suicide prevention programs for children and adolescents, adults, older adults, veterans and military personnel, and individuals who are lesbian, gay, bisexual or transgender (LGBT). Figure 42 depicts the number of states that have a suicide prevention program in place for specific targeted populations. These states indicated that they either operate or fund these suicide prevention programs.

Figure 42. Number of States Funding or Operating Suicide Prevention for Specific Groups, 2013



Forty-three SMHAs supported crisis hotlines to ensure that individuals at risk for suicide—including those who had made a suicide attempt—could readily access high-quality crisis support

services. Thirty-five SMHAs were also involved in training mental health professionals in evidence-based treatments that reduce rates of suicidal behaviors among individuals with a mental illness. Twenty-six SMHAs have initiated policies and practices in collaboration with the state health agency to improve continuity of care for some individuals. These individuals are at heightened risk for suicide after discharge from emergency departments for suicide attempts and inpatient psychiatric hospitalization. Twenty SMHAs have developed and implemented strategies to reduce access to lethal means of suicide. Twenty-seven SMHAs operate, fund, or participate in programs that provide post-suicide support for the surviving families of suicide victims.

8.5. Recovery Support

SAMHSA's Strategic Initiative #4, *Recovery Support*, is focused on "partnering with people in recovery from M/SUD and family members to guide the behavioral health system and promote individual-level, program-level, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers."[15]

State Mental Health Agencies and Recovery Supports

Many SMHAs are actively engaged in promoting health- and recovery-oriented service systems for individuals in recovery from M/SUD. As shown in Table 26, a majority of states are promoting health and recovery through different services and supports.

Table 26. SMHA Promotion of Health- and Recovery-Oriented Service Systems, 2013

Activity	Number of States
Promoting recovery-oriented service systems	51
Promoting health, wellness, and resiliency	50
Engaging individuals in recovery and their families in self-directed care, shared decisionmaking, and person-centered planning	49
Promoting self-care and alternatives to traditional care	46

Abbreviation: SMHA, state mental health agency

Almost all SMHAs ensure that permanent housing and supportive services are available to consumers. SMHAs in 48 states are improving access to mainstream benefits (those not specific to individuals with mental illnesses), such as housing assistance programs and supportive behavioral health services. Forty-nine states are building leadership, promoting collaborations, and supporting the use of EBPs related to permanent supportive housing for individuals and families who are homeless or at risk of homelessness and have mental and/or substance use disorders. Forty-seven states are working on initiatives to increase the knowledge of the behavioral health field about homelessness.

Nearly all SMHAs are working to increase gainful employment and educational opportunities for individuals in recovery. Forty-five SMHAs are working to increase the proportion of individuals who are gainfully employed and/or participating in self-directed educational endeavors, and 46 SMHAs are working to improve consumers' employment and educational outcomes. Almost all

[15] Substance Abuse and Mental Health Services Administration. (2011). *SAMHSA strategic initiatives fact sheet*. Page 7. Retrieved from http://store.samhsa.gov/product/SAMHSA-Strategic-Initiatives-Fact-Sheet/SMA11-4666

SMHAs promote peer support and social inclusion. SMHAs are working to increase the number and quality of consumer and peer recovery support specialists (n=48), promote social inclusion (n=44), and increase the number and quality of recovery support service provider organizations operated by consumers and run by peers (n=46).

Single State Agencies and Recovery Supports

A large majority of states are employing recovery-oriented services, and nearly all states have given consideration to Recovery-Oriented System of Care (ROSC) transformation or embarked on the initial stages of reforms. However, only a small group of states is in the midst of comprehensive reform.

SSAs are engaged in reforming their systems of care, and 96 percent of SSAs participating in an ROSC survey have implemented one or more recovery-oriented services, such as peer support services, employment services, case management, faith-based support, and recovery housing.

Nearly as many SSAs have considered—or are considering—implementing a systems change effort on ROSC; of these SSAs, nearly one-third were first addressing systems barriers, and half were already taking action such as seeking technical assistance. Other SSAs are engaged in activities such as changing state policies to be aligned with ROSC values and reforming billing processes to be inclusive of recovery-oriented services. These initiatives might suggest that states are far along in their undertaking of systems reform; on closer examination, most acknowledge they are just in the developmental phase or in the early process of reforming their systems of care.

More than half of states have completed—or are in the process of performing—ROSC-related readiness assessments, needs assessments, specification of some of their ROSC conceptual elements, strategic planning, and implementation.

About one-third of SSAs noted that they need technical assistance for ROSC advancement; 10 states requested training; and 11 states indicated a need for financial resources to advance ROSC transformation and health reform.

Nearly all states have reported high rates of "consideration of implementation of a systems change effort." However, in examining the SSAs closely, only six states are fully engaged in comprehensive ROSC reform, and an additional seven states have made significant effort toward systems change. In addition, the current context of health reform makes continued education, training, and technical assistance on ROSC and health reform essential to promoting progress toward systems change.

8.6. Trauma

Individuals with mental illness often have experienced histories of trauma that may trigger mental health crises or exacerbate their illnesses. Most SMHAs (83 percent of 52 reporting) require or work with mental health providers to screen for histories of trauma in individuals served by the public mental health system. Twenty-seven SMHAs provide or make referrals for

specialized trauma services such as Trauma-Focused Cognitive Behavioral Therapy, and 29 SMHAs fund or operate special trauma treatments for individuals with a history of trauma.

8.7. Public Awareness Initiatives

Forty-five states have initiatives to reduce stigma and discrimination related to mental illness, and 35 states have public information initiatives to promote a better understanding of the role of mental health in overall health. Twenty-two states are undertaking anti-stigma information initiatives or have issued statements that attempt to dispel the notion that individuals with a mental illness are more violent than the general population.

8.8. Consumer-Operated Services

Consumer-operated services are "peer-run service programs that are owned, administratively controlled, and operated by mental health consumers and emphasize self-help as their operational definition."[16] Forty-three SMHAs provide resources to support consumer-operated services; of these, 33 states provided $168.7 million to support 369 consumer-operated programs.

SMHAs funded a variety of consumer-operated services. As depicted in Table 27, the most commonly funded services were peer and mutual support, advocacy, drop-in centers, wellness and prevention services, leadership skills training, and promotion of positive public attitudes.

Table 27. Types of Consumer-Operated Services Funded by SMHAs, 2013

Services	Number of States
Peer and mutual support	43
Advocacy	37
Drop-in centers	35
Wellness and prevention services	35
Leadership skills training	30
Promoting positive public attitudes	26
Technical assistance	22
Social services	21
Policy development	17
Vocational rehabilitation and employment	16
Transitional and supported housing	13
Residential crisis facility	11
Case management	11
Client-staffed businesses	11
Non-residential crisis intervention	11
Research activities	5

Abbreviation: SMHA, state mental health agency

[16] Substance Abuse and Mental Health Services Administration. (2011). *Building your program: Consumer-operated services* (HHS Pub. No. SMA-11-4633). Page 1. Retrieved from http://store.samhsa.gov/shin/content//SMA11-4633CD-DVD/BuildingYourProgram-COSP.pdf

8.9. Involuntary Mental Health Treatment

Almost all health care requires a patient's agreement (consent) to receive treatment. Mental health is the largest area of medicine where state laws permit the provision of treatments to individuals against their will (i.e., without their consent). Every state has public health and safety laws that permit the involuntary assessment and treatment of individuals with mental illnesses if they are at risk of harming themselves or others. However, the state statutes that guide involuntary treatment vary widely.

The provision of involuntary treatment typically requires review and approval by a court, but involuntary treatment can also include short-term emergency inpatient stays (or holds) for a psychiatric evaluation prior to a court hearing. Every state allows for *involuntary civil status commitment*, meaning that individuals are deemed by a court to be dangerous to themselves or others, and *forensic commitment*, which is involuntary criminal commitment for individuals who have a mental illness and are charged with a crime. Traditionally, all involuntary treatment was conducted in an inpatient psychiatric facility; over the past decade, most states (85 percent of 47 states reporting) have added an outpatient civil commitment law (also known as Assisted Outpatient Treatment). This law mandates that individuals receive mental health treatment while living in their own community.

Every SMHA operates some psychiatric inpatient beds that are used to treat individuals with a mental illness (usually individuals who are in a crisis) who need the high-intensity level of treatment that is provided through inpatient levels of care. Each SMHA has a public safety responsibility; they use some of their psychiatric inpatient capacity to treat individuals who have been determined by a court to need inpatient psychiatric treatment because they pose a danger to themselves or others.

Involuntary Evaluations and Holds

Prior to a formal commitment hearing, states allow individuals to be involuntarily taken by law enforcement or a physician to a psychiatric hospital for an emergency evaluation and, sometimes, emergency treatment. State statutes vary regarding how long an individual can be held for observation or emergency evaluation under a hold before requiring a formal court hearing to continue involuntary treatment:

- Twenty-three states allow for holds of up to 72 hours
- Eight states allow for holds of up to 24 hours
- Twenty-one states allow for holds of other time periods

Involuntary treatment is often instigated by law enforcement, local courts, physicians, and even families in some states. Information about all involuntary treatment often is not shared with the SMHA; it may be maintained by local courts or individual public and private mental health providers. Table 28 shows that although almost all reporting SMHAs have information about involuntary commitments of forensic clients to their state hospitals, just under half of SMHAs have information about forensic commitments to other state-funded inpatient settings (a private psychiatric hospital or general hospital psychiatric bed). For all legal statuses, less than one-third

of SMHAs receive information about involuntary treatments at private psychiatric inpatient providers when the SMHA is not paying for that care.

Table 28. Percentage of SMHAs Able to Access Information About Involuntary Treatment, by Legal Status and Setting, 2013 (41 States Reporting)

Legal Status	State Psychiatric Hospitals	Other State-Funded Psychiatric Inpatient	Private Psychiatric Inpatient Care
Involuntary holds and evaluations	70	49	21
Involuntary civil status (excluding sex offenders)	96	62	27
Involuntary forensic (criminal status)	98	50	18
Sex offender status	52	29	6
Other legal status	63	24	100

Abbreviation: SMHA, state mental health agency

A total of 87,256 individuals had an involuntary emergency hold in 2012 (24 states reporting), and the majority of holds were not to state hospitals; rather, they were at other psychiatric inpatient settings (69,420 holds with only 11 states reporting). Although more states were able to report on psychiatric holds in their state hospitals, fewer patients were sent to state hospitals for a psychiatric hold (17,836 individuals in 24 states). For the states that were able to report on emergency holds in both state psychiatric hospitals and other psychiatric inpatient settings, the use of state hospitals ranged from 0.05 percent (2 holds out of 4,112) in one state to 99.8 percent of holds in another state.

Legal Status of Patients in State Psychiatric Hospitals

State psychiatric hospitals serve as a public safety-net system that provides intensive services to individuals who often are deemed dangerous to themselves or others. In 2012, 85 percent of patients admitted to state psychiatric hospitals were involuntary status (either involuntary–civil, involuntary–forensic, or sex-offender status), and only 12 percent were voluntary. More than half of all admissions had a voluntary legal status in only 2 states; more than half of admissions had an involuntary status in 26 states; and more than half of admissions had a forensic status in 7 states (see Table 29).

Table 29. Legal Status of Patients in State Psychiatric Hospitals, 2012

	Legal Status of Admissions to State Psychiatric Hospitals During the Year			Legal Status of Residents in State Psychiatric Hospitals at End of Year		
Legal Status	Admissions, %	Number of States With >50% With Status	Number of States Reporting	Residents, %	Number of States With >50% With Status	Number of States Reporting
Voluntary	12.1	2	37	10.9	1	36
Involuntary (civil)	49.9	26	43	40.2	19	41
Forensic	23.2	7	40	30.8	13	38
Other	12.2	5	19	7.8	1	19

Note: Percentages do not total to 100 because of varying numbers of states reporting.

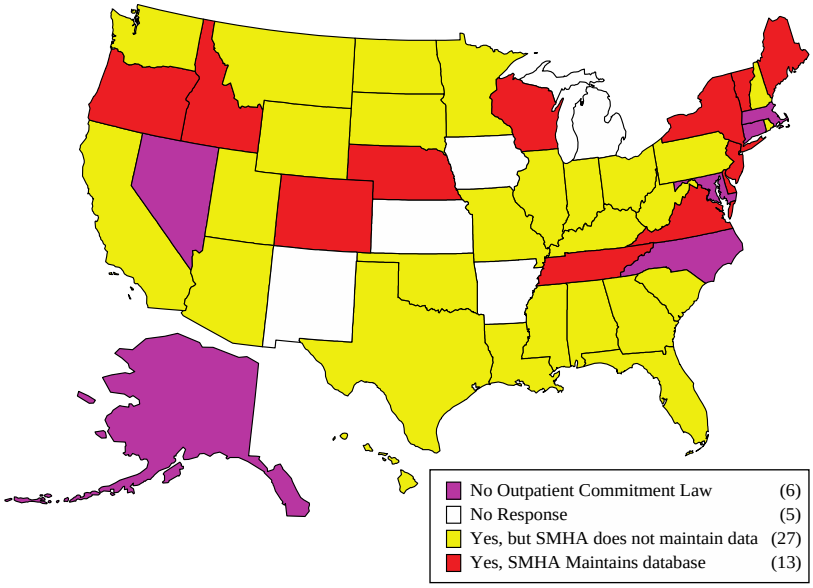
Resident patients who remained in the hospital at the end of the year had a similar pattern, with an average of only 11 percent having a voluntary status. In 19 states, more than half of the

residents had an involuntary–civil legal status. In 13 states, more than half of the residents had a forensic legal status.

Outpatient Commitment and Assisted Outpatient Treatment

The state's mental health law allows the use of outpatient commitment in 85 percent of the states (40 SMHAs). Although most states have an outpatient commitment law, the SMHA is usually not responsible for maintaining a database or information about who is under an outpatient commitment status. In FY 2013, only 13 SMHAs were responsible for maintaining a database of individuals under outpatient commitment status, and the SMHA shared this responsibility with county or local providers in seven states (see Figure 43). The police or court system was responsible for maintaining the database of individuals with outpatient commitment status in eight states.

Figure 43. States With Outpatient Commitment Law and SMHA Role in Maintaining List of Individuals With Commitments, 2013



Abbreviation: SMHA, state mental health agency

In FY 2012, 27,173 individuals in 15 states had an outpatient commitment status (ranging from 9 individuals in South Carolina to 9,934 individuals in Wisconsin). During FY 2012, 10,431 individuals were added to outpatient commitment in 13 states (ranging from 7 individuals in Missouri to 4,324 in Wisconsin).

Only four SMHAs received dedicated funding to support services to individuals under outpatient commitment. The amount of dedicated funds for individuals under the outpatient commitment status ranged from $120,000 for a pilot project in Tennessee to $18 million in Wisconsin.

Glossary

ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ARRA	American Recovery and Reinvestment Act
ASO	administrative services organization
ATR	Access to Recovery
BG	block grant
CAN	Coordinated Access Network
CFRI	Center for Financing Reform and Innovations
CI	confidence interval
CMHC	community mental health center
CMHS	Center for Mental Health Services
CMO	care management organization
CMS	Centers for Medicare & Medicaid Services
EBP	evidence-based practices
EHR	electronic health record
ESPDT	early and periodic screening, diagnosis, and treatment
FPL	federal poverty level
FQHC	Federally Qualified Health Center
FTE	full-time equivalent
FY	fiscal year
HCBS	home and community-based services
HHS	U.S. Department of Health and Human Services
HIE	health information exchange
HIT	health information technology
HIV	human immunodeficiency virus
LGBT	lesbian, gay, bisexual, and transgender
M/SUD	mental or substance use disorder
MHBG	Mental Health Block Grant
MHPAEA	Mental Health Parity and Addiction Equity Act
NA	not applicable
NASADAD	National Association of State Alcohol/Drug Abuse Directors
NRI	National Association of State Mental Health Directors Research Institute
NSDUH	National Survey on Drug Use and Health
N-SSATS	National Survey of Substance Abuse Treatment Services
PACE	Programs for All-Inclusive Care of the Elderly
PHR	personal health record
ROSC	Recovery-Oriented Systems of Care
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SBIRT	screening, brief intervention, and referral to treatment
SED	serious emotional disturbance
SFY	state fiscal year

SMHA	state mental health agency
SMI	serious mental illness
SPS	SMHA Profiling System
SSA	single state agencies for substance use disorder services
SUD	substance use disorder
TEDS	Treatment Episode Data System
URS	Uniform Reporting System
WebBGAS	Web Block Grant Application System

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Appendix A: Profiles of State Mental Health Agencies

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Alabama Mental Health 2013

Department of Mental Health
http://www.mh.alabama.gov

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (21.7 per 1,000 population)	104,279
Community Mental Health Utilization Rate (per 1,000 population)	21.2
State Psychiatric Hospital Residents at the Start of the Year (18.0 per 100,000 population)	865
Percentage of Hospital Residents with a Forensic Status at the End of the Year	33%
State Population	4,802,740

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	27	27
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$366.9 million
Revenue from Medicaid	$161.6 million
Expenditures for Community Mental Health Services (62% of Total SMHA)	$225.8 million
Expenditures for State Psychiatric Hospital Inpatient Care (36% of Total SMHA)	$132.7 million
Per Capita State Mental Health Expenditures	$76.27

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	Shared with another agency
Court Evaluation of Mental Health Status	Responsibility of 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 SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

Serious mental illness or serious emotional disturbance criteria are used to determine Department of Mental Health (DMH) contract eligibility. For all services, a consumer would have to meet the guidelines and admission criteria as outlined in the DMH Administrative Code for Mental Illness Program Standards. If a consumer has Medicaid and an appropriate diagnosis, services are provided. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	45,866	(7.8–21.7)
Estimated Eligible to Use Health Insurance Exchange	18,843	(4.1–14.0)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has already approved a Medicaid plan amendment that includes providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Four State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 290 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, adolescent, and forensic patients. Between FY 2011 and FY 2013, two State hospitals were closed or merged; however, the State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 4 State psychiatric hospitals and 19 community mental health centers (CMHCs). State psychiatric hospitals are implementing 1 EHR component and CMHCs are implementing 13. All State hospital and some CMHC EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between community providers and State hospitals.

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Alaska Mental Health 2013

Division of Behavioral Health, Department of Health and Social Services
http://dhss.alaska.gov/dbh/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (29.0 per 1,000 population)	20,979
Community Mental Health Utilization Rate (per 1,000 population)	25.2
State Psychiatric Hospital Residents at the Start of the Year (9.7 per 100,000 population)	70
Percentage of Hospital Residents with a Forensic Status at the End of the Year	17%
State Population	722,718

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	80	80
Private Psychiatric Hospitals	NA	1	1
General Hospitals with Separate Psychiatric Units	0	2	2
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$238.2 million
Revenue from Medicaid	$175.9 million
Expenditures for Community Mental Health Services (84% of Total SMHA)	$200.2 million
Expenditures for State Psychiatric Hospital Inpatient Care (14% of Total SMHA)	$32.2 million
Per Capita State Mental Health Expenditures	$335.36

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Although adults with a serious mental illness and children with a serious emotional disturbance are the State's designated target populations, any person experiencing a mental health crisis may seek and receive services in one of the State-funded mental health centers. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	1,959	(2.5–13.4)
Estimated Eligible to Use Health Insurance Exchange	3,991	(3.0–13.0)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State has not finalized a decision to expand eligibility for Medicaid or establish a State-based or partnership marketplace under the Affordable Care Act (ACA). The State has not finalized a decision to expand Medicaid coverage under the ACA. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA supports the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA neither screens nor assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. There is 1 State psychiatric hospital that is accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 80 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, adolescent, and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and is not planning on closing or merging hospitals or hospital inpatient beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 40 community mental health centers and 1 State psychiatric hospital. All State hospital and community mental health EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data through a health information exchange.

Arizona Mental Health 2013

Division of Behavioral Health Services, Department of Mental Health Services
http://www.azdhs.gov/bhs/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (28.9 per 1,000 population)	20,979
Community Mental Health Utilization Rate (per 1,000 population)	22.2
State Psychiatric Hospital Residents at the Start of the Year (3.6 per 100,000 population)	70
Percentage of Hospital Residents with a Forensic Status at the End of the Year	51%
State Population	6,482,505

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	486	486
Private Psychiatric Hospitals	NA	50	50
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities administer mental health services statewide.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$1.4 billion
Revenue from Medicaid	$1.2 billion
Expenditures for Community Mental Health Services (94% of Total SMHA)	$1.3 billion
Expenditures for State Psychiatric Hospital Inpatient Care (5% of Total SMHA)	$70.2 million
Per Capita State Mental Health Expenditures	$209.29

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Adults without a serious mental illness are limited to crisis services or Community Mental Health Services Block Grant-funded services, pending qualifications. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1115 waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	26,097	(2.9–12.0)
Estimated Eligible to Use Health Insurance Exchange	23,201	(2.6–11.8)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is educating or training health navigators on providing information about eligibility for insurance coverage to consumers with mental health and/or substance abuse issues. The SMHA is working on including SMHA providers within expanded Medicaid plans and helping mental health providers become certified Medicaid providers. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. There is one State psychiatric hospital that is accredited by the Joint Commission. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and has no plans to close or merge hospitals between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in one State psychiatric hospital. The State hospital is implementing 11 EHR components, and community mental health centers are implementing 14. The State hospital and community EHRs are not certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between

community providers and the State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Arkansas Mental Health 2013

Division of Behavioral Health Services, Department of Human Services
http://humanservices.arkansas.gov/dbhs/Pages/default.aspx

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (24.6 per 1,000 population)	72,351
Community Mental Health Utilization Rate (per 1,000 population)	24.4
State Psychiatric Hospital Residents at the Start of the Year (7.0 per 100,000 population)	207
Percentage of Hospital Residents with a Forensic Status at the End of the Year	Not reported
State Population	2,937,979

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
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2010	Dollars
Total SMHA-Controlled Revenue	$122.5 million
Revenue from Medicaid	$37.0 million
Expenditures for Community Mental Health Services (60% of Total SMHA)	$73.7 million
Expenditures for State Psychiatric Hospital Inpatient Care (36% of Total SMHA)	$43.8 million
Per Capita State Mental Health Expenditures	$42.02

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	Responsibility of SMHA
Sex Offender Services	Shared with another agency

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

There is an income cap for individuals to be eligible for SMHA-funded and/or SMHA-operated services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	15,956	(4.1–11.5)
Estimated Eligible to Use Health Insurance Exchange	14,558	(3.3–13.6)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse and working with family and consumer groups to provide information about eligibility. The SMHA is working with the health insurance marketplace for the State to provide information and working with the State's Medicaid agency to educate consumers. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. There is one State psychiatric hospital that is accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 220 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, adolescent, and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013, and has no plans to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

The SMHA has not provided information on the status of electronic health record implementation in State psychiatric hospitals or community mental health centers.

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California Mental Health 2013

Mental Health and Substance Use Disorder Services, Department of Health Care Services
http://www.dhcs.ca.gov/Pages/default.aspx

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (16.5 per 1,000 population)	622,116
Community Mental Health Utilization Rate (per 1,000 population)	16.2
State Psychiatric Hospital Residents at the Start of the Year (16.0 per 100,000 population)	6,016
Percentage of Hospital Residents with a Forensic Status at the End of the Year	Not reported
State Population	37,691,912

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	7[a]	0	7[a]
Community Mental Health Providers	0	56	56
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

[a] Operated by the Department of State Hospitals. NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. County or city authorities administer mental health services statewide. Some counties merge together to form multicounty authorities. There is a local contribution to pay for the services, and these local contributions are required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$6.4 billion
Revenue from Medicaid	$2.5 billion
Expenditures for Community Mental Health Services (79% of Total SMHA)	$5.1 billion
Expenditures for State Psychiatric Hospital Inpatient Care (20% of Total SMHA)	$1.3 billion
Per Capita State Mental Health Expenditures	$169.65

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Part of SMHA
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

In Medicaid/Medi-Cal, any beneficiary that meets the medical necessity criteria for Medi-Cal specialty mental health services may receive those services consistent with their need and for them and the goals in their treatment plan. There is no enrollment into the Medi-Cal specialty mental health services program. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Mental health services are delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	80,563	(2.2–4.6)
Estimated Eligible to Use Health Insurance Exchange	117,950	(2.5–6.2)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is not responsible for operating State psychiatric hospitals. State psychiatric hospitals are the responsibility of the Department of State Hospitals.

Electronic Health Records
Electronic health records (EHRs) are implemented in 43 community mental health centers (CMHCs). CMHCs are implementing five EHR components. Some community mental health EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Colorado Mental Health 2013

Office of Behavioral Health, Department of Human Services
http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251578892077

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (18.8 per 1,000 population)	96,000
Community Mental Health Utilization Rate (per 1,000 population)	18.4
State Psychiatric Hospital Residents at the Start of the Year (9.1 per 100,000 population)	465
Percentage of Hospital Residents with a Forensic Status at the End of the Year	Not reported
State Population	5,116,796

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	17	17
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$489.5 million
Revenue from Medicaid	$335.8 million
Expenditures for Community Mental Health Services (78% of Total SMHA)	$380.8 million
Expenditures for State Psychiatric Hospital Inpatient Care (22% of Total SMHA)	$108.7 million
Per Capita State Mental Health Expenditures	$95.01

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

The SMHA provides services to all adults and children with any mental illness. Individuals below 300 percent of the Federal poverty line are eligible for SMHA-funded or SMHA-operated services.

Medicaid

Mental health services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	3,181	(0.6–2.5)
Estimated Eligible to Use Health Insurance Exchange	21,127[a]	(2.5–16.3)

[a] This estimate is deemed unreliable as it satisfies the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, working with family and consumer groups to provide information about eligibility, and working with the Insurance Commissioner's office to educate consumers about eligibility for the new coverage programs. The SMHA is working with the State's Medicaid agency to educate consumers and educating or training health navigators on how to provide information about eligibility for insurance coverage to consumers with mental health and/or substance abuse issues. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative plans, working on including SMHA providers within expanded Medicaid plans, helping mental health providers become certified Medicaid providers within expanded Medicaid plans, and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. Two State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 532 State-operated psychiatric hospital beds.

The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records
Electronic health records (EHRs) are implemented in 17 community mental health centers (CMHCs), and the State hospitals have an outdated, partial EHR but are requesting funding to develop a new, certified EHR system. State hospitals are implementing 8 EHR components, and CMHCs are implementing 11. Some community mental health EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Connecticut Adults Mental Health 2013

Department of Mental Health and Addiction Services
http://www.ct.gov/dmhas

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (25.2 per 1,000 population)	90,346
Community Mental Health Utilization Rate (per 1,000 population)	24.7
State Psychiatric Hospital Residents at the Start of the Year (20.9 per 100,000 population)	747
Percentage of Hospital Residents with a Forensic Status at the End of the Year	32%
State Population	3,580,709

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	9	94	103
Private Psychiatric Hospitals	NA	1	1
General Hospitals with Separate Psychiatric Units	0	13	13
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The SMHA equally funds local provider agencies and directly operated community-based programs. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures, FY 2012	Dollars
Total SMHA-Controlled Revenue	$788.4 million
Revenue from Medicaid	$12.4 million
Expenditures for Community Mental Health Services (68% of Total SMHA)	$518.8 million
Expenditures for State Psychiatric Hospital Inpatient Care (25% of Total SMHA)	$194.4 million
Per Capita State Mental Health Expenditures	$213.43

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	No responsibility
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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 SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

Services are typically made available to clients with a serious and persistent mental illness who experience some disability from their condition. There is in an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Nursing home diversion and acquired brain injury services are administered through a Medicaid 1915(c) Home and Community-Based Services waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	NA[a]	NA[a]
Estimated Eligible to Use Health Insurance Exchange	1,270	(0.2–3.1)

[a] Insufficient sample size. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working with family and consumer groups to provide information about eligibility and with the Insurance Commissioner's office to educate consumers about eligibility for the new coverage programs. The SMHA is working with the health insurance marketplace for the State to provide information and working with the State's Medicaid agency to educate consumers. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, helping mental health providers become certified Medicaid providers, and assisting private practitioners and individual mental health consumers and other clinicians to be certified to bill Medicaid for mental health services. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. The SMHA coordinates care between State psychiatric hospitals and community programs through weekly utilization management meetings between the Department of Mental Health and Addiction Services' utilization management teams and hospital utilization management. Three psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 545 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. Between FY 2011 and FY 2013, one State hospital was closed or merged. The State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records
State hospitals are implementing four electronic health record (EHR) components, and community mental health centers are implementing three. Some State hospital and community mental health EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between community providers and State hospitals.

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Connecticut Children's Mental Health 2013

Department of Children and Families
http://www.ct.gov/dcf/site/default.asp

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (25.2 per 1,000 population)	90,346
Community Mental Health Utilization Rate (per 1,000 population)	24.7
State Psychiatric Hospital Residents at the Start of the Year (20.9 per 100,000 population)	747
Percentage of Hospital Residents with a Forensic Status at the End of the Year	0%
State Population	3,580,709

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	Several hundred	Several hundred
Private Psychiatric Hospitals	NA	1	1
General Hospitals with Separate Psychiatric Units	0	13	13
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Responsibility of SMHA

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services
Children with any mental illness are eligible for SMHA-funded and/or SMHA-operated services.

Medicaid
Both mental health and substance abuse services are being delivered via managed care.

Mental Health Integration with Physical Health Care
The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. No State psychiatric hospitals are accredited by the Joint Commissioner and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 85 State-operated psychiatric hospital beds.

Electronic Health Records
Electronic health records (EHRs) are implemented in the majority of community mental health centers (CMHCs); however, the children's State hospital has not yet implemented EHRs. CMHCs are implementing 12 EHR components.

Delaware Mental Health 2013

Division of Substance Abuse and Mental Health, Department of Health and Social Services
http://www.state.de.us/dhss/dsamh/dmhhome.htm

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (10.0 per 1,000 population)	9,093
Community Mental Health Utilization Rate (per 1,000 population)	10.7
State Psychiatric Hospital Residents at the Start of the Year (16.4 per 100,000 population)	149
Percentage of Hospital Residents with a Forensic Status at the End of the Year	19%
State Population	907,135

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	10	14
Private Psychiatric Hospitals	NA	3	3
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$93.6 million
Revenue from Medicaid	$17.4 million
Expenditures for Community Mental Health Services (55% of Total SMHA)	$50.2 million
Expenditures for State Psychiatric Hospital Inpatient Care (42% of Total SMHA)	$38.8 million
Per Capita State Mental Health Expenditures	$100.02

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	No responsibility
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

The SMHA does not have any restrictions on who can receive SMHA-funded or -operated services. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1115 waiver; however, some services are carved out of the managed care organizations' purview and are paid through a combination of fee-for-services and State general revenues (for inpatient services).

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	2,942[a]	(5.1–24.6)
Estimated Eligible to Use Health Insurance Exchange	1,129	(1.1–8.7)

[a] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working with the State's Medicaid agency to educate consumers and educate or train health navigators on how to provide information about eligibility for insurance coverage to consumers with mental health and/or substance abuse issues. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is not applying for a Medicaid plan amendment that would include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating the State psychiatric hospital. The State hospital is considered part of the community system of care, and care managers broker services necessary for community tenure. One State psychiatric hospital is accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 130 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult patients. Between FY 2011 and FY 2013, no State hospitals were closed or merged. The State has no plans to close any State hospitals between FY 2014 and FY 2015 but is planning to close 25 hospital beds during this period.

Electronic Health Records
The SMHA is developing an EHR system in community mental health centers (CMHCs) and State psychiatric hospitals. All State hospital and CMHC EHRs will be certified to meet the Meaningful Use requirements.

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District of Columbia Mental Health 2013

Department of Mental Health
http://dmh.dc.gov/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (38.9 per 1,000 population)	24,052
Community Mental Health Utilization Rate (per 1,000 population)	37.3
State Psychiatric Hospital Residents at the Start of the Year (46.9 per 100,000 population)	290
Percentage of Hospital Residents with a Forensic Status at the End of the Year	65%
State Population	617,996

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	34	35
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$192.3 million
Revenue from Medicaid	$15.5 million
Expenditures for Community Mental Health Services (41% of Total SMHA)	$79.0 million
Expenditures for State Psychiatric Hospital Inpatient Care (43% of Total SMHA)	$82.6 million
Per Capita State Mental Health Expenditures	$305.37

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Different State department
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

SMHA-funded or -operated services are available to adults with less than 200 percent area median income (AMI) and children/families with less than 300 percent AMI. There is an income cap for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. The District does not operate a 1915(b) waiver per se; rather, the authority is incorporated into the State Plan and allows the District to enroll certain beneficiaries on a mandatory basis.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	NA[a]	NA[a]
Estimated Eligible to Use Health Insurance Exchange	1,157[b]	(3.1–18.2)

[a] Insufficient sample size. [b] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The District is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing a providing mental health and/or substance abuse providers training on how to work with consumers about eligibility for the new coverage programs. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans; working on including SMHA providers within expanded Medicaid plans; helping mental health providers become certified Medicaid providers; and helping private practitioners, individual mental health consumers, and other clinicians get certified to bill Medicaid for mental health services. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care. The SMHA neither screens nor assesses mental health consumers for physical health issues in community mental health programs; however, the SMHA, in coordination with the State's Medicaid agency, is developing a Health Homes State Plan Amendment. The expectation is that the majority of community mental health providers will become health homes; thus, the majority of SMHA consumers with a serious mental illness will be served through a health home model. The health home services will include an assessment of consumers' physical health issues and

close coordination with consumers' health providers. This approach will lead to better coordination of all of the consumers' medical and mental health needs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. The District has one State psychiatric hospital that is accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 110 State-operated psychiatric hospital beds.

No State hospitals were closed or merged between FY 2011 and FY 2013, and the District is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in five community mental health centers (CMHCs) and one State psychiatric hospital. The State hospital and CMHCs are implementing eight EHR components. The State hospital EHR is not certified to meet the Meaningful Use requirement; however, some CMHC EHR systems are. Agreements allow the sharing of EHR client data between community providers and the State hospital.

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Florida Mental Health 2013

Mental Hygiene Administration, Department of Health and Mental Hygiene
http://www.myflfamilies.com/service-programs/substance-abuse

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (16.7 per 1,000 population)	319,190
Community Mental Health Utilization Rate (per 1,000 population)	15.3
State Psychiatric Hospital Residents at the Start of the Year (16.6 per 100,000 population)	3,172
Percentage of Hospital Residents with a Forensic Status at the End of the Year	58%
State Population	19,057,542

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	260	260
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities administer mental health services only in selected parts of the State. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for the services, but these local contributions are not required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$730.1 million
Revenue from Medicaid	$116.7 million
Expenditures for Community Mental Health Services (53% of Total SMHA)	$377.9 million
Expenditures for State Psychiatric Hospital Inpatient Care (45% of Total SMHA)	$319.4 million
Per Capita State Mental Health Expenditures	$37.28

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

The State's Substance Abuse and Mental Health services are available to individuals within target population groups, such as persons with marital and family issues. There is an income cap and illness severity requirement in order for individuals to be eligible for SMHA services.

Medicaid

Mental health services are being delivered via managed care. Behavioral health services are administered through Medicaid 1115 and 1915(b) waivers.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	94,626	(4.3–8.5)
Estimated Eligible to Use Health Insurance Exchange	59,219	(2.4–5.4)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has not indicated if it is applying for a Medicaid plan amendment that would include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. Two State psychiatric hospitals are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 110 State-operated psychiatric hospital beds.

Between FY 2011 and FY 2013, two State hospitals were closed or merged; however, the State has no plans to close or merge State hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records
Community mental health centers (CMHCs) are implementing nine electronic health record (EHR) components. Some CMHCs' EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between providers.

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Georgia Mental Health 2013

Department of Behavioral Health
http://dbhdd.georgia.gov

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (17.1 per 1,000 population)	167,568
Community Mental Health Utilization Rate (rate per 1,000 population)	17.1
State Psychiatric Hospital Residents at the Start of the Year (11.0 per 100,000 population)	1,076
Percentage of Hospital Residents with a Forensic Status at the End of the Year	63%
State Population	9,815,210

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	198	198
Private Psychiatric Hospitals	NA	4	4
General Hospitals with Separate Psychiatric Units	0	3	3
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities administer mental health services only in selected parts of the State. There is a local contribution to pay for the services, but these local contributions are not required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$552.4 million
Revenue from Medicaid	$3.7 million
Expenditures for Community Mental Health Services (63% of Total SMHA)	$347.3 million
Expenditures for State Psychiatric Hospital Inpatient Care (37% of Total SMHA)	$205.1 million
Per Capita State Mental Health Expenditures	$56.08

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No Response
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Response

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

SMHA services have targeted admission criteria focusing services to specific individual needs. There is an income cap and an illness severity requirement in order for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(c) Home and Community Based waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	27,927	(1.4–7.4)
Estimated Eligible to Use Health Insurance Exchange	11,640	(0.4–5.8)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA neither screens nor assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Six psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services.

State psychiatric hospital beds are used for civil status adult and forensic patients. Between FY 2011 and FY 2013, one State hospital was closed or merged. The State is planning to close one State hospital between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in five State psychiatric hospitals; however, the SMHA does not know details of the scope of EHRs the various community providers may have implemented because it differs from provider to provider. State hospitals are implementing

nine EHR components. All State hospital EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between State hospitals within the State.

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Hawaii Mental Health 2013

Behavioral Health Administration, Department of Health
http://health.hawaii.gov/about/links-to-doh-program-information/behavioral-health-services-administration/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (9.4 per 1,000 population)	12,981
Community Mental Health Utilization Rate (per 1,000 population)	9.3
State Psychiatric Hospital Residents at the Start of the Year (12.9 per 100,000 population)	178
Percentage of Hospital Residents with a Forensic Status at the End of the Year	85%
State Population	1,374,810

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	18	85	103
Private Psychiatric Hospitals	NA	1	1
General Hospitals with Separate Psychiatric Units	0	4	4
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly find, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$156.0 million
Revenue from Medicaid	$19.5 million
Expenditures for Community Mental Health Services (60% of Total SMHA)	$106.4 million
Expenditures for State Psychiatric Hospital Inpatient Care (33% of Total SMHA)	$58.0 million
Per Capita State Mental Health Expenditures	$131.16

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Adults must have a serious mental illness and children must have a serious emotional disturbance in order to be eligible for SMHA services. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1115 waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	1,462	(1.4–11.7)
Estimated Eligible to Use Health Insurance Exchange	2,737[a]	(2.4–20.8)

[a] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in the mental health programs. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. One State psychiatric hospital is accredited by the Joint Commission.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and is not planning on closing or merging hospitals between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 24 community mental health centers (CMHCs) and 1 State psychiatric hospital. The State hospital and CMHCs are implementing six EHR components. The State psychiatric hospital EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Idaho Mental Health 2013

Division of Behavioral Health, Department of Health and Welfare
http://www.mentalhealth.idaho.gov

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (7.0 per 1,000 population)	11,089
Community Mental Health Utilization Rate (1,000 population)	5.3
State Psychiatric Hospital Residents at the Start of the Year (8.1 per 100,000 population)	128
Percentage of Hospital Residents with a Forensic Status at the End of the Year	15%
State Population	1,584,985

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	7	0	7
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based programs is to directly operate community-based programs. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$51.8 million
Revenue from Medicaid	$5.0 million
Expenditures for Community Mental Health Services (44% of Total SMHA)	$22.7 million
Expenditures for State Psychiatric Hospital Inpatient Care (51% of Total SMHA)	$26.5 million
Per Capita State Mental Health Expenditures	$32.54

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

SMHA-funded mental health services are provided to those individuals who meet eligibility criteria and who either have no other resources or may have Medicaid but whose symptoms are too challenging for private providers to treat successfully. Priority service populations are those in crisis and those who are court ordered for treatment.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	9,478	(5.6–16.0)
Estimated Eligible to Use Health Insurance Exchange	11,127	(5.5–19.9)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to establish a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has an already approved a Medicaid plan amendment that includes providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA does not have initiatives to improve the integration of mental health services with primary health care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Collaborative efforts are made to coordinate hospital admissions and discharges. Hospital staff meetings are held regularly with regional clinical staff to discuss patient progress and plans for discharge back to the community. There is one State psychiatric hospital that is accredited by the Joint Commission and one that is certified by the Centers for Medicare & Medicaid Services.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013. The State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in seven regional community mental health centers (CMHCs) and two State psychiatric hospitals. State hospitals and CMHCs are implementing 12 EHR components. All State hospital and community EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between community providers and State hospitals as well as among State hospitals within the State.

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Illinois Mental Health 2013

Division of Mental Health, Department of Human Services
http://www.dhs.state.il.us/page.aspx?item=29728

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (10.6 per 1,000 population)	136,047
Community Mental Health Utilization Rate (per 1,000 population)	10.6
State Psychiatric Hospital Residents at the Start of the Year (8.7 per 100,000 population)	1,124
Percentage of Hospital Residents with a Forensic Status at the End of the Year	44%
State Population	12,869,257

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	156	156
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities administer mental health services only in selected parts of the State. There is a local contribution to pay for the services, but these local contributions are not required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$961.9 million
Revenue from Medicaid	$432.3 million
Expenditures for Community Mental Health Services (70% of Total SMHA)	$672.6 million
Expenditures for State Psychiatric Hospital Inpatient Care (28% of Total SMHA)	$267.0 million
Per Capita State Mental Health Expenditures	$74.88

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	No responsibility
Sex Offender Services	Responsibility of SMHA

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

Service benefit packages with limited services have been developed for individuals who are not Medicaid eligible and for adults who do not a have a serious mental illness (SMI) and children who do not have a serious emotional disturbance (SED). Payments for these service packages vary by household income and family size, and persons not meeting the criteria for SMI or SED (based on illness/severity) are in a group that receives a less-intensive service benefit package. There is an income cap for individuals to be eligible for SMHA payment for services.

Medicaid

Both mental health and substance abuse services are delivered via managed care.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	26,886	(2.7–5.9)
Estimated Eligible to Use Health Insurance Exchange	38,415	(3.6–7.8)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. Some agencies funded by the SMHA screen or assess mental health consumers seen in community mental health programs for physical health issues.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Seven State psychiatric hospitals are accredited by the Joint Commission, and six are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 353 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult patients. Between FY 2011 and FY 2013, two State hospitals were closed or merged. The State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Although some community mental health centers in the State have moved forward to establish and use an electronic health record (EHR) system of their own, the Department of Mental Health does not currently fund or oversee the operation of these independent systems. Because of budget restrictions, State hospitals do not have EHRs currently.

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Indiana Mental Health 2013

Division of Mental Health and Addiction, Family and Social Services Administration
http://www.in.gov/fssa

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (17.8 per 1,000 population)	116,189
Community Mental Health Utilization Rate (per 1,000 population)	17.7
State Psychiatric Hospital Residents at the Start of the Year (12.4 per 100,000 population)	805
Percentage of Hospital Residents with a Forensic Status at the End of the Year	30%
State Population	6,516,922

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	25	25
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$461.2 million
Revenue from Medicaid	$274.6 million
Expenditures for Community Mental Health Services (65% of Total SMHA)	$301.4 million
Expenditures for State Psychiatric Hospital Inpatient Care (33% of Total SMHA)	$153.6 million
Per Capita State Mental Health Expenditures	$70.58

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

Eligibility criteria for mental health services include the deferral definition of serious mental illness and serious emotional disturbance, plus Medicaid or other public benefit (food stamps, Temporary Assistance for Needy Families, or income below 200 percent of the Federal poverty level). There is an income cap and illness severity requirement in order for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care for some consumers. Behavioral health services are administered through Medicaid 1115 and Medicaid 1915(c) Home and Community-Based Services waivers. Most mental health and substance abuse services are fee-for-service.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	53,345	(9.4–18.9)
Estimated Eligible to Use Health Insurance Exchange	24,253	(3.3–11.5)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State has not made a decision regarding expanded eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working with the State Medicaid agency to provide integrated services for individuals with chronic mental health conditions. The State is not applying for a Medicaid plan amendment that would include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Community mental health centers (CMHCs) are responsible for managing who is admitted and discharged from the State hospitals for all groups except persons with forensic commitment status and persons with primary intellectual disabilities. Six State psychiatric hospitals are accredited by the Joint Commission, and five are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 716 State-operated psychiatric hospital beds.

The State neither closed nor merged State hospitals between FY 2011 and FY 2013. The State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 24 community mental health centers and 6 State psychiatric hospitals. State hospitals are implementing eight EHR components, and CMHCs are implementing nine. All State hospital and community EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data among State hospitals within the State.

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Iowa Mental Health 2013

Division of Mental Health and Disability Services, Department of Human Services
http://www.dhs.state.ia.us/mhdd

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (33.3 per 1,000 population)	101,937
Community Mental Health Utilization Rate (per 1,000 population)	16.9
State Psychiatric Hospital Residents at the Start of the Year (4.1 per 100,000 population)	126
Percentage of Hospital Residents with a Forensic Status at the End of the Year	Not reported
State Population	3,062,309

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	30	30
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	24	24
Nursing Homes and Other ICF-MI and SNF Providers	0	3	3

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. County authorities administer mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$441.9 million
Revenue from Medicaid	$286.9 million
Expenditures for Community Mental Health Services (91% of Total SMHA)	$400.2 million
Expenditures for State Psychiatric Hospital Inpatient Care (8% of Total SMHA)	$36.8 million
Per Capita State Mental Health Expenditures	$143.81

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	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
Substance Abuse Agency	Different State department
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

The SMHA did not describe restrictions on who can receive SMHA-funded and/or -operated mental health services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through Medicaid 1115 and 1915(b) waivers.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	9,537	(4.1–17.4)
Estimated Eligible to Use Health Insurance Exchange	6,548	(2.5–13.2)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, helping mental health providers become certified Medicaid providers, and helping private practitioners and individual mental health consumers and other clinicians get certified to bill Medicaid for mental health services. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has applied for but not yet received approval for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental

health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. The State hospital staff work with community-based providers and case managers to ensure continuity of care between the State hospitals and community. Two State psychiatric hospitals are accredited by the Joint Commission, and four are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 174 State-operated psychiatric hospital beds.

Electronic Health Records

Although some community mental health centers in the State have moved forward to establish and use an electronic health record (EHR) system of their own, the Department of Mental Health does not currently fund or oversee the operation of these independent systems. Because of budget restrictions, State hospitals do not have EHRs currently.

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Kansas Mental Health 2013

Behavioral Health Services Division, Commission on Community Services and Programs, Department of Aging and Disability Services
http://www.kansasbehavioralhealthservices.org/bhs1.0/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (44.2 per 1,000 population)	126,861
Community Mental Health Utilization Rate (per 1,000 population)	44.2
State Psychiatric Hospital Residents at the Start of the Year (24.6 per 100,000 population)	705
Percentage of Hospital Residents with a Forensic Status at the End of the Year	47%
State Population	2,871,238

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
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$385.0 million
Revenue from Medicaid	$269.3 million
Expenditures for Community Mental Health Services (75% of Total SMHA)	$290.4 million
Expenditures for State Psychiatric Hospital Inpatient Care (24% of Total SMHA)	$93.3 million
Per Capita State Mental Health Expenditures	$134.49

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	Responsibility of SMHA
Sex Offender Services	Responsibility of SMHA

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

There are no eligibility restrictions for SMHA-funded and/or SMHA-operated services. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1115 waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	6,075	(1.5–9.6)
Estimated Eligible to Use Health Insurance Exchange	5,787	(1.7–9.3)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has an approved Medicaid plan amendment that includes providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Three State psychiatric hospitals are accredited by the Joint Commission.

State psychiatric hospital beds are used for civil status adults and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013; however, the State is planning to merge two State hospitals between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 24 community mental health centers (CMHCs) and 3 State psychiatric hospitals. State hospitals are implementing seven EHR components, and CMHCs are implementing two. All State hospital EHRs and some community EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing

of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Kentucky Mental Health 2013

Department of Behavioral Health, Development, and Intellectual Disabilities
http://dbhdid.ky.gov/kdbhdid/default.aspx

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (37.2 per 1,000 population)	162,450
Community Mental Health Utilization Rate (per 1,000 population)	36.6
State Psychiatric Hospital Residents at the Start of the Year (10.6 per 100,000 population)	465
Percentage of Hospital Residents with a Forensic Status at the End of the Year	16%
State Population	4,369,356

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	14	14
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	1	1
Nursing Homes and Other ICF-MI and SNF Providers	2	0	2

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$239.8 million
Revenue from Medicaid	$85.2 million
Expenditures for Community Mental Health Services (48% of Total SMHA)	$115.6 million
Expenditures for State Psychiatric Hospital Inpatient Care (48% of Total SMHA)	$114.1 million
Per Capita State Mental Health Expenditures	$55.07

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

The SMHA provides services to individuals with any mental illness; however, a State general fund program (Impact) and a Medicaid-funded program (Impact Plus) are focused only on children with a serious emotional disturbance. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Mental health services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	22,033	(3.9–11.8)
Estimated Eligible to Use Health Insurance Exchange	11,033	(2.1–10.0)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based partnership marketplace under the Affordable Care Act. The SMHA is working with the health insurance marketplace for the State to provide information. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Two State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 691 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 14 community mental health centers. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Louisiana Mental Health 2013

Office of Behavioral Health, Department of Health and Hospitals
http://www.dhh.state.la.us/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (10.5 per 1,000 population)	47,943
Community Mental Health Utilization Rate (per 1,000 population)	10.1
State Psychiatric Hospital Residents at the Start of the Year (15.0 per 100,000 population)	685
Percentage of Hospital Residents with a Forensic Status at the End of the Year	58%
State Population	4,574,836

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	111	111
Private Psychiatric Hospitals	NA	79	79
General Hospitals with Separate Psychiatric Units	0	101	101
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$300.1 million
Revenue from Medicaid	$76.0 million
Expenditures for Community Mental Health Services (45% of Total SMHA)	$135.7 million
Expenditures for State Psychiatric Hospital Inpatient Care (42% of Total SMHA)	$124.7 million
Per Capita State Mental Health Expenditures	$65.51

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No response
Alzheimer's Disease	No response
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	Responsibility of SMHA
Sex Offender Services	Responsibility of SMHA

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Medical necessity is the primary factor for service eligibility for those treatments funded through Medicaid and State general funds. For those individuals who have income exceeding 200 percent of the Federal poverty level, fees are assessed based on a sliding scale. This percentage is based on the household and number of dependents. There is an income cap and an illness severity requirement in order for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	19,445	(2.8–9.2)
Estimated Eligible to Use Health Insurance Exchange	11,451	(1.8–7.0)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. All State hospitals are required to develop an aftercare plan and schedule behavioral health appointments for individuals in the community prior to discharge. This is also coordinated through Magellan, the State's Statewide Management Organization (SMO), which is responsible for ensuring individuals receive the services needed to maintain community tenure. Staff within the SMO coordinate with community-based providers regarding the provision of services at a rate and frequency intended to meet the individual's needs. Additionally, prior to discharge, the Office of Behavioral Health staff coordinates with clinicians working within the State hospitals on activities related to discharge planning. This approach allows for reviewing pending discharges along with needed community supports to ensure a smooth transition into the community. Two State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers

for Medicare & Medicaid Services (CMS). CMS has certified 298 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult patients. The State has no plans to close or merge State hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 120 community mental health centers (CMHCs). The CMHCs are implementing 14 EHR components; however, these EHRs are not certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Maine Mental Health 2013

Substance Abuse and Mental Health Services, Department of Health and Human Services
http://www.maine.gov/dhhs/samhs/mentalhealth/index.shtml

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (53.3 per 1,000 population)	70,758
Community Mental Health Utilization Rate (per 1,000 population)	53.3
State Psychiatric Hospital Residents at the Start of the Year (14.5 per 100,000 population)	193
Percentage of Hospital Residents with a Forensic Status at the End of the Year	58%
State Population	1,328,188

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	7-9	7-9
Nursing Homes and Other ICF-MI and SNF Providers	0	3	3

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$449.2 million
Revenue from Medicaid	$400.2 million
Expenditures for Community Mental Health Services (87% of Total SMHA)	$389.2 million
Expenditures for State Psychiatric Hospital Inpatient Care (11% of Total SMHA)	$48.8 million
Per Capita State Mental Health Expenditures	$338.24

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Adults or children with any mental illness may receive services funded and/or operated by the SMHA. For some children's services, such as residential treatment, children must have impairments in functional requirements and meet clear necessary standards to be admitted to this high level of care.

Medicaid

Neither mental health nor substance abuse services are delivered via managed care. Currently, APS Healthcare acts as an administrative services organization for designated mental health and substance abuse services. Currently, no waivers are in place related to managing behavioral health services.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	3,592[a]	(3.1–18.3)
Estimated Eligible to Use Health Insurance Exchange	1,928	(1.0–7.9)

[a] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, and working with family and consumer groups to provide information about eligibility. The SMHA is working with the health insurance marketplace for the State to provide information, working with the State's Medicaid agency to educate consumers, and educating or training health navigators on how to provide information about eligibility for insurance coverage to consumers with mental health and/or substance abuse issues. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA neither screens nor assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. Two State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 150 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and has no plans to do so between FY 2014 and 2015.

Electronic Health Records
Electronic health records (EHRs) are implemented in the two State psychiatric hospitals as well as in community mental health centers (CMHCs). State hospitals are implementing seven EHR components, and CMHCs are implementing six. All State hospital EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data among State psychiatric hospitals and through a health information exchange.

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Maryland Mental Health 2013

Mental Hygiene Administration, Department of Health and Mental Hygiene
http://www.dhmh.state.md.us

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (25.1 per 1,000 population)	146,217
Community Mental Health Utilization Rate (per 1,000 population)	24.8
State Psychiatric Hospital Residents at the Start of the Year (16.7 per 100,000 population)	972
Percentage of Hospital Residents with a Forensic Status at the End of the Year	65%
State Population	5,828,289

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	7[a]	0	7[a]
Community Mental Health Providers	0	400	400
Private Psychiatric Hospitals	NA	3	3
General Hospitals with Separate Psychiatric Units	0	28	28
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

[a] Maryland's SMHA operates two residential treatment centers for children that are reported as hospitals. NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities administer mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for the services, but these local contributions are not required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$1.1 billion
Revenue from Medicaid	$3.5 billion
Expenditures for Community Mental Health Services (76% of Total SMHA)	$821.4 million
Expenditures for State Psychiatric Hospital Inpatient Care (21% of Total SMHA)	$229.4 million
Per Capita State Mental Health Expenditures	$184.62

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Eligibility for SMHA services is based on income, recent hospitalization, homelessness, and Social Security disability income due to mental health issues and whether the person meets medical necessity for the service. There is an income cap for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through Medicaid 1115 and Medicaid 1915(c) Home and Community-Based Services waivers.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	13,282[a]	(2.3–19.9)
Estimated Eligible to Use Health Insurance Exchange	8,585	(1.4–8.1)

[a] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers who will work with consumers, working with family and consumer groups to provide information about eligibility, and working with the Insurance Commissioner's office to educate consumers about eligibility for the new coverage programs. The SMHA is working with the health insurance marketplace for the State to provide information, working with the State's Medicaid agency to educate consumers, educating or training health navigators on how to provide information about eligibility for insurance coverage to consumers with mental health

and/or substance abuse issues, and working with enrollment brokers. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, helping mental health consumers and clinicians get certified to bill Medicaid for mental health services. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has applied for but not yet received approval for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Five State psychiatric hospitals and children's residential treatment centers are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 1,035 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, adolescent, and forensic patients. Between FY 2011 and FY 2013, State hospitals did not close or merge and the State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 1 State psychiatric hospital and 11 community mental health centers (CMHCs). State psychiatric hospitals are implementing 11 EHR components, and CMHCs are implementing 3. State psychiatric hospital EHRs are not certified to meet the Meaningful Use requirements. There are no agreements that allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Massachusetts Mental Health 2013

Department of Mental Health
http://www.mass.gov/dmh/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (4.4 per 1,000 population)	29,053
Community Mental Health Utilization Rate (per 1,000 population)	4.3
State Psychiatric Hospital Residents at the Start of the Year (8.2 per 100,000 population)	542
Percentage of Hospital Residents with a Forensic Status at the End of the Year	22%
State Population	6,587,536

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	5	103	108
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	2	1	3
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$843.3 million
Revenue from Medicaid	$113.0 million
Expenditures for Community Mental Health Services (85% of Total SMHA)	$611.4 million
Expenditures for State Psychiatric Hospital Inpatient Care (13% of Total SMHA)	$90.4 million
Per Capita State Mental Health Expenditures	$108.62

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

For adults to receive SMHA-funded and/or -operated mental health services, an individual must meet qualified *Diagnostic and Statistical Manual of Mental Disorders* criteria for serious mental illness and functioning must be substantially impaired by the disorder in one or more major life activities with an expected duration of a year or more. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through Medicaid 1115 and Medicaid 1915(b) waivers.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	NA[a]	NA[a]
Estimated Eligible to Use Health Insurance Exchange	10,885[b]	(2.2–28.3)

[a] Insufficient sample size. [b] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State was the first in the nation to implement a State-based marketplace, the Health Connector, and is working to develop new requirements as an Affordable Care Act (ACA)-compliant marketplace, including any needed changes to the essential health benefits package. Massachusetts has the highest rate of insured individuals in the nation (97 percent) and is reviewing ACA eligibility guidelines to identify opportunities to simplify the existing Medicaid eligibility structure. The SMHA is working with the State's Medicaid agency to educate consumers. The SMHA is also working with the State's Medicaid agency on what mental health benefits will be included in alternative benefits plans and working on including SMHA providers within alternative Medicaid benefits plans. The SMHA is developing plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. The State has 2 psychiatric hospitals, 2 Department of Public Health hospitals with psychiatric units, and 3 inpatient units at community mental health centers (CMHCs) that are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS), in addition to 30 contracted beds at a private facility. CMS has certified 681 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013.

Electronic Health Records
Electronic health records (EHRs) are implemented in five CMHCs and two State psychiatric hospitals. State hospitals are implementing six EHR components and CMHCs are implementing five. The State hospital and community mental health EHRs are not certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between community providers and State hospitals.

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Michigan Mental Health 2013

Behavioral Health and Developmental Disabilities Administration, Department of Community Health

http://www.michigan.gov/mdch/0,1607,7-132-2941---,00.html

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (23.6 per 1,000 population)	233,139
Community Mental Health Utilization Rate (per 1,000 population)	23.6
State Psychiatric Hospital Residents at the Start of the Year (5.1 per 100,000 population)	507
Percentage of Hospital Residents with a Forensic Status at the End of the Year	43%
State Population	9,876,187

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	46	0	46
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$1.2 billion
Revenue from Medicaid	$880.1 million
Expenditures for Community Mental Health Services (80% of Total SMHA)	$949.1 million
Expenditures for State Psychiatric Hospital Inpatient Care (19% of Total SMHA)	$231.1 million
Per Capita State Mental Health Expenditures	$120.10

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Part of SMHA
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA
Health Department	Part of SMHA

Eligibility Criteria for State Mental Health Services

To be eligible for SMHA-funded or SMHA-operated services, adults and children must meet serious mental illness and serious emotional disturbance criteria, respectively. In addition, individuals must meet medical necessity criteria. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	38,503	(5.2–10.2)
Estimated Eligible to Use Health Insurance Exchange	28,597	(4.4–8.0)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, working with family and consumer groups to provide information about eligibility, and working with the Insurance Commissioner's office to educate consumers about eligibility for the new coverage programs. The SMHA is working with the health insurance marketplace for the State to provide information, working with the State's Medicaid agency to educate consumers, educating or training health navigators on how to provide information about eligibility for insurance coverage to consumers with mental health and/or substance abuse issues, and working with enrollment brokers. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans and is working on including consumers and clinicians to be certified to bill Medicaid for mental health services. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. Five State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 1,017 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, and adolescent patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and has no plans to do so between FY 2014 and 2015.

Electronic Health Records
The SMHA is currently working with a vendor to implement an electronic health record system that will be certified to meet the Meaningful Use requirements in the five State psychiatric hospitals by July 2014.

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Minnesota Mental Health 2013

Adult Mental Health Division, Department of Human Services
http://mn.gov/dhs

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (41.4 per 1,000 population)	221,509
Community Mental Health Utilization Rate (per 1,000 population)	41.4
State Psychiatric Hospital Residents at the Start of the Year (3.9 per 100,000 population)	209
Percentage of Hospital Residents with a Forensic Status at the End of the Year	2%
State Population	5,344,861

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	600	600
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	16	16
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is through Medicaid, either as fee-for-service or through a contractual arrangement with a managed care organization. In addition, community-based services are enhanced through a State appropriation, administered by the SMHA, to local county mental health authorities that, in turn, fund local provider agencies or provide mental health services directly statewide. The SMHA also awards a State appropriation for housing supportive services for adults with mental illness, crisis grants for mobile crisis response, and mental health court grants. Some counties merge together to form multicounty mental health authorities. In some case, there is a local contribution to pay for the services, and these local contributions are required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$904.1 million
Revenue from Medicaid	$569.1 million
Expenditures for Community Mental Health Services (87% of Total SMHA)	$786.1 million
Expenditures for State Psychiatric Hospital Inpatient Care (12% of Total SMHA)	$112.0 million
Per Capita State Mental Health Expenditures	$168.15

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	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
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

Eligibility criteria for SMHA-funded and/or SMHA-operated mental health services depend on diagnostic and functional assessments. Some services have a level of care requirement. Housing with supports services funded by the SMHA have specific eligibility requirements related to mental health diagnosis and housing stability. Mobile crisis response services do not have restrictions on eligibility.

Medicaid

Both mental health and substance abuse services are being delivered via managed care or fee-for-service arrangements. Behavioral health services are administered through Medicaid 1115 and Medicaid 1915(b) waivers.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	18,851[a]	(5.5–26.1)
Estimated Eligible to Use Health Insurance Exchange	12,930	(2.9–14.3)

[a] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, working with family and consumer groups to provide information about eligibility, and working with the Insurance Commissioner's office to educate consumers about eligibility for the new coverage programs. The SMHA is working with the health insurance marketplace for the State to provide information and working with the State's

Medicaid Agency to educate consumers. The SMHA is working with the State Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, helping mental health providers become certified Medicaid providers, and helping private practitioners and individual mental health consumers and other clinicians get certified to bill Medicaid for mental health services. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Eight State-operated psychiatric hospitals are accredited by the Joint Commission. The State has 222 State-operated psychiatric beds that are certified by the Centers for Medicare & Medicaid Services. This number does not include the additional psychiatric hospital beds available through community hospitals.

State psychiatric hospital beds are used for civil status adult, child, adolescent, and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013. The State has no plans to close or merge hospitals or close hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in eight State psychiatric hospitals. State hospitals are implementing nine EHR components, and community mental health centers are implementing six. Some State hospital and community EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Mississippi Mental Health 2013

Department of Mental Health
http://www.dmh.ms.gov/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (36.0 per 1,000 population)	107,277
Community Mental Health Utilization Rate (per 1,000 population)	34.7
State Psychiatric Hospital Residents at the Start of the Year (22.6 per 100,000 population)	674
Percentage of Hospital Residents with a Forensic Status at the End of the Year	1%
State Population	2,978,512

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	15	15
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	2	0	2

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is through grants, not directly through the operation of local community-based agencies. County or city authorities administer mental health services in all parts of the State. Some counties merge together to form multicounty mental health authorities. Local contributions help pay for services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures, FY 2012	Dollars
Total SMHA-Controlled Revenue	$316.6 million
Revenue from Medicaid	$146.4 million
Expenditures for Community Mental Health Services (57% of Total SMHA)	$179.2 million
Expenditures for State Psychiatric Hospital Inpatient Care (42% of Total SMHA)	$133.8 million
Per Capita State Mental Health Expenditures	$106.61

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	Shared with another agency
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

The SMHA requires that individuals who receive SMHA-funded and/or -operated mental health services must have a treatable mental illness as defined in the most recent *Diagnostic and Statistical Manual of Mental Disorders*.

Medicaid

Mental health services are being delivered through two mechanisms—fee-for-service and managed care. However, the State is using managed care-like practices with State dollars. The State has implemented the Mississippi Coordinated Access Network under the 1932 State Plan Authority by the Mississippi Division of Medicaid. Legislation allows up to 45 percent to be enrolled in managed care in certain mandated categories.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	22,760	(5.3–13.7)
Estimated Eligible to Use Health Insurance Exchange	10,168	(3.0–9.6)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. To coordinate care between the State hospitals and the community, community mental health centers (CMHCs) must conduct a pre-evaluation screening before an individual can be committed to a State psychiatric hospital. CMHCs use intensive case managers to participate in discharge planning and transition back to the community. Three psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 254 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, and adolescent patients. No State psychiatric hospitals were closed or merged between FY 2011 and FY 2013. The State has

reduced the number of beds at its State behavioral health programs but is not planning to close any beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in six CMHCs and six State psychiatric hospitals. State hospitals are implementing 12 EHR components, and CMHCs are implementing 13. All State hospital and community EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between community providers and State hospitals and between State hospitals and general hospitals.

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Missouri Mental Health 2013

Department of Mental Health
www.dmh.missouri.gov

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (12.4 per 1,000 population)	74,344
Community Mental Health Utilization Rate (per 1,000 population)	12.2
State Psychiatric Hospital Residents at the Start of the Year (18.2 per 100,000 population)	1,094
Percentage of Hospital Residents with a Forensic Status at the End of the Year	44%
State Population	6,010,688

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	29	29
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities administer mental health services only in selected parts of the State. There is a local contribution to pay for the services, but these local contributions are not required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$739.1 million
Revenue from Medicaid	$349.3 million
Expenditures for Community Mental Health Services (55% of Total SMHA)	$305.8 million
Expenditures for State Psychiatric Hospital Inpatient Care (41% of Total SMHA)	$226.2 million
Per Capita State Mental Health Expenditures	$92.21

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

The target population for mental health services includes individuals in acute care, those with serious mental illness and serious emotional disturbance, and individuals in the forensic system. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are delivered statewide, either through the Missouri HealthNet fee-for-service program or the Missouri HealthNet managed care program. The program through which the mental health and substance abuse services are delivered depends on the participant's eligibility category and place of residence.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	18,547	(2.6–9.9)
Estimated Eligible to Use Health Insurance Exchange	20,136	(3.1–12.5)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has already approved a Medicaid plan amendment that includes providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Eight State psychiatric hospitals are accredited by the Joint Commission and nine are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 335 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, and adolescent patients. The State has no plans to close or merge any State hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 23 community mental health centers (CMHCs) and 3 State psychiatric hospitals. State hospitals are implementing five EHR components, and CMHCs are implementing eight. No State hospital EHRs are certified to meet the Meaningful Use requirements, whereas some community mental health EHRs are. Agreements allow the sharing of EHR client data among State hospitals within the State.

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Montana Mental Health 2013

Addictive and Mental Disorders Division, Department of Public Health and Human Services
http://www.dphhs.mt.gov

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (34.6 per 1,000 population)	34,550
Community Mental Health Utilization Rate (1,000 population)	26.9
State Psychiatric Hospital Residents at the Start of the Year (14.9 per 100,000 population)	149
Percentage of Hospital Residents with a Forensic Status at the End of the Year	25%
State Population	998,199

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	10	10
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	5	5
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities administer mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for services, and these local contributions are required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures, FY 2012	Dollars
Total SMHA-Controlled Revenue	$198.2 million
Revenue from Medicaid	$145.5 million
Expenditures for Community Mental Health Services (84% of Total SMHA)	$167.0 million
Expenditures for State Psychiatric Hospital Inpatient Care (14% of Total SMHA)	$27.2 million
Per Capita State Mental Health Expenditures	$197.89

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

There is an income cap and an illness severity requirement in order for individuals to be eligible for SMHA-funded and/or SMHA-operated services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	3,559	(2.4–11.0)
Estimated Eligible to Use Health Insurance Exchange	2,997	(2.0–7.6)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. One State psychiatric hospital is certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 174 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013, and is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in one community mental health center and one State psychiatric hospital. All treatment planning, class scheduling, and medication prescriptions are entered into the State hospital EHR. The State hospital EHR system is not certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Nebraska Mental Health 2013

Division of Behavioral Health, Department of Health and Human Services
http://dhhs.ne.gov/behavioral_health/Pages/behavioral_health_index.aspx

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (12.8 per 1,000 population)	23,535
Community Mental Health Utilization Rate (per 1,000 population)	11.3
State Psychiatric Hospital Residents at the Start of the Year (16.1 per 100,000 population)	296
Percentage of Hospital Residents with a Forensic Status at the End of the Year	18.2
State Population	1,842,641

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	53	53
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	7	7
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities, which, in turn, fund local provider agencies or directly provide mental health services statewide. Some counties merge together to form multicounty mental health authorities.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$156.8 million
Revenue from Medicaid	$20.1 million
Expenditures for Community Mental Health Services (69% of Total SMHA)	$107.9 million
Expenditures for State Psychiatric Hospital Inpatient Care (30% of Total SMHA)	$46.4 million
Per Capita State Mental Health Expenditures	$84.82

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Responsibility of SMHA

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Currently, consumers must be financially and/or clinically eligible for SMHA-funded services. The Financial Eligibility Policy and Fee Schedule outlines the financial eligibility requirements. Clinical eligibility is addressed in utilization management guidelines as determined by the managed care vendor. There is an income cap and an illness severity requirement in order for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	6,582	(4.2–14.9)
Estimated Eligible to Use Health Insurance Exchange	7,887	(4.5–16.7)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is not applying for a Medicaid plan amendment that would include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. One State psychiatric hospital is accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 60 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and has no plans to do so between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 11 community mental health centers (CMHCs) and 2 State psychiatric hospitals. State hospitals are implementing 7 EHR components, and CMHCs are implementing 11. The community and State hospital EHR systems are managed outside the SMHA. Agreements allow the sharing of EHR client data among State hospitals within the State.

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Nevada Mental Health 2013

Division of Mental Health and Developmental Services, Department of Health and Human Services

http://mhds.state.nv.us

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (10.7 per 1,000 population)	29,081
Community Mental Health Utilization Rate (per 1,000 population)	10.5
State Psychiatric Hospital Residents at the Start of the Year (9.3 per 100,000 population)	252
Percentage of Hospital Residents with a Forensic Status at the End of the Year	0%
State Population	2,723,322

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	22	0	22
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based programs is to directly operate community-based programs. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$163.2 million
Revenue from Medicaid	$21.3 million
Expenditures for Community Mental Health Services (57% of Total SMHA)	$93.0 million
Expenditures for State Psychiatric Hospital Inpatient Care (40% of Total SMHA)	$65.5 million
Per Capita State Mental Health Expenditures	$59.41

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Parts of SMHA

Eligibility Criteria for State Mental Health Services

The Division of Public and Behavioral Health primarily serves adults in urban areas and adults and children in rural areas who have little to no insurance coverage or pay on a sliding scale fee. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1115 waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	10,551[a]	(1.5–15.9)
Estimated Eligible to Use Health Insurance Exchange	13,597	(3.0–10.8)

[a] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is participating in efforts to expand eligibility for Medicaid and establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, working with family and consumer groups to provide information about eligibility, and working with the Insurance Commissioner's office to educate consumers about eligibility for the new coverage programs. The SMHA is working with the health insurance marketplace for the State to provide information and working with the State's Medicaid agency to educate providers and consumers. The SMHA is working on including SMHA providers within expanded Medicaid plans, helping mental health providers become certified Medicaid providers, and helping private practitioners and individual mental health consumers and other clinicians get certified to bill Medicaid for mental health services. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA is implementing a new service delivery model that includes primary health care providers as integral partners in the delivery of preventive health care, wellness and self-care education, and support programs for individuals receiving services. This model is focused on including prevention in the approach to treatment and case management services for mental health, substance abuse, and co-occurring disorders under a bio-psychosocial model. The SMHA

neither screens nor assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Two of the three State psychiatric hospitals are certified by the Centers for Medicare & Medicaid Services (CMS) with a total of 240 CMS-certified beds; one is accredited through the Joint Commission and one recently submitted an application to become Joint Commission accredited.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and is not planning to close or merge State hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 22 community mental health centers (CMHCs) and 3 State psychiatric hospitals. State hospitals and CMHCs are implementing seven EHR components. The State hospitals and community EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between community providers and State hospitals.

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New Hampshire Mental Health 2013

Bureau of Behavioral Health, Department of Health and Human Services
http://www.dhhs.state.nh.us

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (37.7 per 1,000 population)	49,684
Community Mental Health Utilization Rate (per 1,000 population)	37.7
State Psychiatric Hospital Residents at the Start of the Year (9.6 per 100,000 population)	127
Percentage of Hospital Residents with a Forensic Status at the End of the Year	0%
State Population	1,318,194

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	1[a]	0	1[a]
Community Mental Health Providers	0	10	10
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	5	5
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

[a] Operated by the Division of Community Based Care Services, Department of Health and Human Services
NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures, FY 2012	Dollars
Total SMHA-Controlled Revenue	$179.6 million
Revenue from Medicaid	$115.7 million
Expenditures for Community Mental Health Services (69% of Total SMHA)	$123.9 million
Expenditures for State Psychiatric Hospital Inpatient Care (30% of Total SMHA)	$53.7 million
Per Capita State Mental Health Expenditures	$136.14

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Neither mental health nor substance abuse services are delivered via managed care; however, contracts are being signed for pending implementation of managed care.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	2,436	(2.2–14.2)
Estimated Eligible to Use Health Insurance Exchange	2,748	(1.8–10.6)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, working with family and consumer groups to provide information about eligibility, and working with the Insurance Commissioner's office to educate consumers about eligibility for new coverage programs. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health program and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is not responsible for operating State psychiatric hospitals. State psychiatric hospitals are the responsibility of the Division of Community Based Care Services, Division of Health and Human Services. Care is coordinated between the State psychiatric hospital and community programs through the Bureau of Behavioral Health. One State psychiatric hospital is certified by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 164 State-operated psychiatric hospital beds. State psychiatric hospital beds are used for civil status adult, child, and adolescent patients.

Electronic Health Records

Electronic health records (EHRs) are being implemented in many of the community mental health centers. The State psychiatric hospital is currently developing an EHR system.

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New Jersey Mental Health 2013

Division of Mental Health Services, Department of Human Services
http://www.state.nj.us/humanservices/dmhs/home/index.html

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (39.4 per 1,000 population)	347,582
Community Mental Health Utilization Rate (per 1,000 population)	37.1
State Psychiatric Hospital Residents at the Start of the Year (19.8 per 100,000 population)	1,748
Percentage of Hospital Residents with a Forensic Status at the End of the Year	19%
State Population	8,821,155

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	113	113
Private Psychiatric Hospitals	NA	1	1
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	1	1

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$1.9 billion
Revenue from Medicaid	$560.7 million
Expenditures for Community Mental Health Services (69% of Total SMHA)	$1.3 billion
Expenditures for State Psychiatric Hospital Inpatient Care (29% of Total SMHA)	$549.9 million
Per Capita State Mental Health Expenditures	$210.58

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

There are no eligibility restrictions for SMHA-funded and/or SMHA-operated services. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	NA[a]	NA[a]
Estimated Eligible to Use Health Insurance Exchange	30,334	(2.2–15.0)

[a] Insufficient sample size. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, and working with family and consumer groups to provide information about eligibility. The SMHA is working with the State's Medicaid agency to educate consumers. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Four State psychiatric hospitals are accredited by the Joint Commission, and three are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 1,577 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. Between FY 2011 and FY 2013, one State hospital was closed or merged; however, the State has no plans to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 34 community mental health centers (CMHCs). CMHCs are implementing 11 EHR components. Some community mental health EHRs are certified to meet the Meaningful Use requirements.

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New Mexico Mental Health 2013

Behavioral Health Collaborative, Human Services Department
http://www.hsd.state.nm.us/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (39.0 per 1,000 population)	81,190
Community Mental Health Utilization Rate (per 1,000 population)	38.6
State Psychiatric Hospital Residents at the Start of the Year (8.2 per 100,000 population)	171
Percentage of Hospital Residents with a Forensic Status at the End of the Year	Not reported
State Population	2,082,224

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	1[a]	0	1
Community Mental Health Providers	Not reported	Not reported	Not reported
Private Psychiatric Hospitals	NA	Not reported	Not reported
General Hospitals with Separate Psychiatric Units	Not reported	Not reported	Not reported
Nursing Homes and Other ICF-MI and SNF Providers	Not reported	Not reported	Not reported

[a] Operated by the Department of Health. NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$272.1 million
Revenue from Medicaid	$220.8 million
Expenditures for Community Mental Health Services (91% of Total SMHA)	$248.1 million
Expenditures for State Psychiatric Hospital Inpatient Care (9% of Total SMHA)	$24.3 million
Per Capita State Mental Health Expenditures	$131.44

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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 SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

SMHA services funded through non-Medicaid funding sources have special restrictions, and some are targeted to adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). In general, non-Medicaid funding is focused on individuals with SMI/SED. There are no eligibility restrictions for behavioral health services funded through Medicaid.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through Medicaid 1115 and 1915(b) waivers.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	13,228	(3.7–14.7)
Estimated Eligible to Use Health Insurance Exchange	12,841	(5.0–11.8)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The SMHA has not indicated if the State is participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA did not indicate if it is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has not indicated if it is applying for a Medicaid plan amendment that would include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is not responsible for operating State psychiatric hospitals. State psychiatric hospitals are the responsibility of the New Mexico Department of Health. One State psychiatric hospital is accredited by the Joint Commission.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and has no plans to do between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 26 community mental health centers and 1 State psychiatric hospital. State hospitals are implementing eight EHR components. All State psychiatric hospital EHRs are certified to meet the Meaningful Use requirements.

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New York Mental Health 2013

Office of Mental Health
http://www.omh.ny.gov

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (36.8 per 1,000 population)	717,075
Community Mental Health Utilization Rate (per 1,000 population)	33.2
State Psychiatric Hospital Residents at the Start of the Year (24.1 per 100,000 population)	4,691
Percentage of Hospital Residents with a Forensic Status at the End of the Year	28%
State Population	19,465,197

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	24	0	24
Community Mental Health Providers	0	733	733
Private Psychiatric Hospitals	NA	8	8
General Hospitals with Separate Psychiatric Units	0	109	109
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2011	Dollars
Total SMHA-Controlled Revenue	$4.6 billion
Revenue from Medicaid	$2.6 billion
Expenditures for Community Mental Health Services (70% of Total SMHA)	$3.6 billion
Expenditures for State Psychiatric Hospital Inpatient Care (25% of Total SMHA)	$1.3 billion
Per Capita State Mental Health Expenditures	$259.55

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	Responsibility of SMHA
Sex Offender Services	Responsibility of SMHA

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

In order to be eligible for SMHA-funded and/or -operated mental health services, individuals must have a diagnosis of mental illness but need not meet serious emotional disturbance criteria for every service. There is no income cap for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care and fee-for-services. Behavioral health services are administered through Medicaid 1115 and 1915(c) Home and Community-Based Services waivers.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	16,074	(1.2–3.9)
Estimated Eligible to Use Health Insurance Exchange	42,320	(2.7–6.9)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans and working on including SMHA providers within expanded Medicaid plans. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has already approved a Medicaid plan amendment that includes providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Twenty-three State psychiatric hospitals are accredited by the Joint Commission, and 17 are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 2,882 State-operated psychiatric hospital beds.

The State uses psychiatric hospitals to provide mostly intermediate care (some long stay and a very small part of acute care) to adults with mental illness. Between FY 2011 and FY 2013, three

hospitals merged into one. The State is planning to merge hospitals and close inpatient beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 22 State psychiatric hospitals. State hospitals are implementing 10 EHR components. No State hospital EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data through a health information exchange.

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North Carolina Mental Health 2013

Division of Mental Health, Development Disabilities, and Substance Abuse Services,
Department of Health and Human Services
http://www.ncdhhs.gov/mhddsas/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (21.5 per 1,000 population)	207,297
Community Mental Health Utilization Rate (per 1,000 population)	21.0
State Psychiatric Hospital Residents at the Start of the Year (7.1 per 100,000 population)	682
Percentage of Hospital Residents with a Forensic Status at the End of the Year	1%
State Population	9,656,401

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	0	0
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	21	21
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. County or city authorities administer mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for the services, but these local contributions are not required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2010	Dollars
Total SMHA-Controlled Revenue	$1.6 billion
Revenue from Medicaid	$1.2 billion
Expenditures for Community Mental Health Services (80% of Total SMHA)	$1.3 billion
Expenditures for State Psychiatric Hospital Inpatient Care (19% of Total SMHA)	$298.1 million
Per Capita State Mental Health Expenditures	$165.75

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Responsibility of SMHA
Alzheimer's Disease	Shared with another agency
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Eligibility is based on medical necessity, level of care, and target population for State funds. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	19,199	(1.0–8.0)
Estimated Eligible to Use Health Insurance Exchange	21,257	(1.5–7.4)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has already approved a Medicaid plan amendment that includes providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is not responsible for operating State psychiatric hospitals. State psychiatric hospitals are operated by the Division of State Operated Healthcare Facilities. Funding, financial

operations, contracting, information technology, and other administrative supports are provided by the SMHA (the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services). Both agencies are under the aegis of the North Carolina Department of Human Services. Local Management Entities (LMEs)/Managed Care Organizations (MCOs)—the Division's intermediaries for publicly funded mental health, developmental disability, and substance abuse services—recommend admissions from their catchment areas to the State psychiatric hospitals that, in turn, coordinate discharge/aftercare planning between hospital staff and LMEs/MCOs and their contracted providers. Three State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 809 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, adolescent, and forensic patients. Between FY 2011 and FY 2013, one State hospital closed or merged. The State has not indicated if it will close hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 11 LMEs/MCOs and numerous contracted provider agencies and 1 State psychiatric hospital. LMEs/MCOs are implementing five EHR components. All State hospital and LMEs/MCOs EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between State hospitals within the State and between health maintenance organizations, other managed care firms, and the SMHA.

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North Dakota Mental Health 2013

Mental Health and Substance Abuse Services, Department of Human Services
http://www.nd.gov/dhs/services/mentalhealth/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (25.7 per 1,000 population)	17,596
Community Mental Health Utilization Rate (per 1,000 population)	24.2
State Psychiatric Hospital Residents at the Start of the Year (21.1 per 100,000 population)	144
Percentage of Hospital Residents with a Forensic Status at the End of the Year	Not reported
State Population	683,932

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	0	1	1
Community Mental Health Providers	0	8	8
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$58.9 million
Revenue from Medicaid	$12.9 million
Expenditures for Community Mental Health Services (78% of Total SMHA)	$46.6 million
Expenditures for State Psychiatric Hospital Inpatient Care (22% of Total SMHA)	$12.9 million
Per Capita State Mental Health Expenditures	$86.17

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Responsibility of SMHA

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

There are no eligibility restrictions for SMHA-funded and/or SMHA-operated services. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	932	(1.2–11.5)
Estimated Eligible to Use Health Insurance Exchange	1,147	(1.9–9.9)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, working with family and consumer groups to provide information about eligibility, and working with the Insurance Commissioner's office to educate consumers about eligibility for the new coverage programs. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefits plans, working on including SMHA providers within expanded Medicaid plans, helping mental health providers become certified Medicaid providers, and helping private practitioners and individual mental health consumers and other clinicians get certified to bill Medicaid for mental health services. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. One State psychiatric hospital is accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 120 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and has no plans to do so between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in eight community mental health centers (CMHCs) and one State psychiatric hospital. The 1 State hospital is implementing 11 EHR components, and CMHCs are implementing 10. The State hospital EHRs are not certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between community providers and State hospitals.

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Ohio Mental Health 2013

Department of Mental Health
http://www.mh.state.oh.us

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (31.6 per 1,000 population)	365,184
Community Mental Health Utilization Rate (per 1,000 population)	31.1
State Psychiatric Hospital Residents at the Start of the Year (8.9 per 100,000 population)	1,028
Percentage of Hospital Residents with a Forensic Status at the End of the Year	64%
State Population	11,544,951

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	3	406	409
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. County or city authorities administer mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for services, but these local contributions are not required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2010	Dollars
Total SMHA-Controlled Revenue	$1.2 billion
Revenue from Medicaid	$445.0 million
Expenditures for Community Mental Health Services (72% of Total SMHA)	$606.6 million
Expenditures for State Psychiatric Hospital Inpatient Care (25% of Total SMHA)	$209.1 million
Per Capita State Mental Health Expenditures	$73.13

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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 SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA-funded and/or SMHA-operated services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	62,810	(7.6–14.7)
Estimated Eligible to Use Health Insurance Exchange	28,210	(3.3–7.4)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has already approved a Medicaid plan amendment that includes providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. Six State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 1,077 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. One State hospital was closed or merged between FY 2011 and FY 2013. The State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records
Electronic health records (EHRs) are implemented in six State psychiatric hospitals. State hospitals are implementing 10 EHR components. EHRs used by the State psychiatric hospitals are not certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data among State hospitals within the State.

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Oklahoma Mental Health 2013

Department of Mental Health and Substance Abuse Services
http://www.odmhsas.org

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (20.9 per 1,000 population)	79,124
Community Mental Health Utilization Rate (per 1,000 population)	20.6
State Psychiatric Hospital Residents at the Start of the Year (8.2 per 100,000 population)	310
Percentage of Hospital Residents with a Forensic Status at the End of the Year	51%
State Population	3,791,508

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	4	10	14
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly, fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$213.1 million
Revenue from Medicaid	$12.8 million
Expenditures for Community Mental Health Services (70% of Total SMHA)	$149.7 million
Expenditures for State Psychiatric Hospital Inpatient Care (25% of Total SMHA)	$52.6 million
Per Capita State Mental Health Expenditures	$56.22

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

To be eligible for SMHA-funded and/or SMHA-operated services, individuals must be in need of behavioral health services ad defined by the Department and must be (a) indigent and (b) uninsured or underinsured. There is an income cap and an illness severity requirement in order for adults to be eligible for SMHA services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	14,451	(2.5–8.5)
Estimated Eligible to Use Health Insurance Exchange	10,978	(2.0–9.2)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. One State psychiatric hospital is accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). The State's forensic hospital is accredited by the Commission on Accreditation of Rehabilitation Facilities. CMS has certified 120 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, adolescent, and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 14 community mental health centers (CMHCs) and 2 State psychiatric hospitals. State hospitals and CMHCs are implementing 11 EHR components. All State hospital EHRs and some CMHC EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data through a health information exchange.

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Oregon Mental Health 2013

Addictions and Mental Health Division, Oregon Health Authority
http://www.oregon.gov/oha/amh/Pages/index.aspx

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (32.1 per 1,000 population)	120,890
Community Mental Health Utilization Rate (per 1,000 population)	28.8
State Psychiatric Hospital Residents at the Start of the Year (17.0 per 100,000 population)	657
Percentage of Hospital Residents with a Forensic Status at the End of the Year	67%
State Population	3,871,859

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	32	32
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	10	10
Nursing Homes and Other ICF-MI and SNF Providers	0	5	5

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. County or city authorities administer mental health services only in selected parts of the State. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for the services, but these local contributions are not required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$692.8 million
Revenue from Medicaid	$404.3 million
Expenditures for Community Mental Health Services (70% of Total SMHA)	$482.3 million
Expenditures for State Psychiatric Hospital Inpatient Care (29% of Total SMHA)	$202.3 million
Per Capita State Mental Health Expenditures	$177.80

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Court Evaluation of Mental Health Status	Responsibility of 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 SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Oregon Revised Statutes require community mental health programs to prioritize certain populations, such as those at risk of harming self or others or those at risk of hospitalization. Although community mental health programs are permitted to use general funds or block grant funds to serve an adult with any mental illness, with limited resources, some may only be able to serve those priority populations. Not all mental health diagnoses are covered under the Oregon Health Plan. To be reimbursed by Medicaid, the individual must have a diagnosis that is recognized as a prioritized diagnosis in Oregon's Prioritized List of Health Services. There is an income cap for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1115 waiver. Oregon also has a 1915(i) Home and Community-Based State plan amendment used to cover mental health services.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	19,744	(4.0–14.8)
Estimated Eligible to Use Health Insurance Exchange	17,213	(3.3–13.0)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse. The SMHA is working with the health insurance marketplace for the State to provide information and working with the State's Medicaid agency to educate consumers. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded

Medicaid plans, and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has already approved a Medicaid plan amendment that includes providing health homes services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. One State psychiatric hospital is accredited by the Joint Commission and two are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 90 State-operated psychiatric hospital beds.

The State neither closed nor merged State hospitals between FY 2011 and FY 2013 but is planning to merge 1 hospital between FY 2014 and FY 2015. The Oregon State Hospital currently has two campuses—one in Salem and one in Portland. The Portland campus will be merged with the Salem campus and the Junction City campus (once built).

Electronic Health Records

Electronic health records (EHRs) are implemented in 125 community mental health centers (CMHCs) and 1 State psychiatric hospital. State hospitals are implementing 11 EHRs components and CMHCs are implementing 10. All State hospital EHRs and some community mental health EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data through a health information exchange.

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Pennsylvania Mental Health 2013

Office of Mental Health and Substance Abuse Services, Department of Public Welfare
http://www.dpw.state.pa.us

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (49.7 per 1,000 population)	633,624
Community Mental Health Utilization Rate (per 1,000 population)	49.0
State Psychiatric Hospital Residents at the Start of the Year (12.6 per 100,000 population)	1,608
Percentage of Hospital Residents with a Forensic Status at the End of the Year	15%
State Population	12,742,886

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	1,400	1,400
Private Psychiatric Hospitals	NA	33	33
General Hospitals with Separate Psychiatric Units	0	94	94
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for the services, and these local contributions are required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$3.8 billion
Revenue from Medicaid	$2.9 billion
Expenditures for Community Mental Health Services (90% of Total SMHA)	$3.4 billion
Expenditures for State Psychiatric Hospital Inpatient Care (9% of Total SMHA)	$3.6 billion
Per Capita State Mental Health Expenditures	$295.08

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	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 response

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Different State department
Medicaid Agency	Part of SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

Services have medical necessity criteria or program eligibility criteria for admission. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	24,604	(2.8–8.5)
Estimated Eligible to Use Health Insurance Exchange	24,050	(2.7–7.1)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The SMHA has not indicated if the State is participating in efforts to expand eligibility for Medicaid or establishing a State-based partnership under the Affordable Care Act (ACA). The SMHA has not indicated activities it is undertaking to help consumers apply for insurance coverage that meets their needs. The SMHA is not undertaking any activities with the State's Medicaid agency related to expanded Medicaid coverage under the ACA. The SMHA has not indicated whether it is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA supports the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA neither screens nor assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. Six State psychiatric hospitals are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 1,602 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and is not planning on closing or merging hospitals or hospital inpatient beds between FY 2014 and FY 2015.

Electronic Health Records
The number of community providers using electronic health records (EHRs) is unknown to the SMHA. The Pennsylvania Department of Public Welfare has provided incentives to select providers to implement EHRs. However, community behavioral health providers, in and of themselves, do not meet the EHR incentive criteria. A psychiatrist can participate in the incentive program, however, and designate the incentive to a community mental health program for which he or she works. The SMHA hopes to work with the Department of Public Welfare's Bureau of Information Systems as part of the Department-wide EHR solution to implement EHRs in State psychiatric hospitals.

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Rhode Island Mental Health 2013

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
http://www.bhddh.ri.gov/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (30.5 per 1,000 population)	32,015
Community Mental Health Utilization Rate (per 1,000 population)	30.2
State Psychiatric Hospital Residents at the Start of the Year (14.9 per 100,000 population)	157
Percentage of Hospital Residents with a Forensic Status at the End of the Year	Not reported
State Population	1,051,302

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	8	8
Private Psychiatric Hospitals	NA	1	1
General Hospitals with Separate Psychiatric Units	1	0	1
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$111.3 million
Revenue from Medicaid	$96.9 million
Expenditures for Community Mental Health Services (65% of Total SMHA)	$72.2 million
Expenditures for State Psychiatric Hospital Inpatient Care (33% of Total SMHA)	$36.8 million
Per Capita State Mental Health Expenditures	$106.35

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	No responsibility
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

There are no eligibility restrictions for SMHA-funded and/or SMHA-operated services. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1115 waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	2,238	(2.0–13.5)
Estimated Eligible to Use Health Insurance Exchange	5,692	(5.9–20.7)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, and working with family and consumer groups to provide information about eligibility. The SMHA is working with the State's Medicaid agency to educate consumers and educating or training health navigators on how to provide information about eligibility for insurance coverage to consumers with mental health and/or substance abuse issues. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans and working on including SMHA providers within expanded Medicaid plans. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has an approved a Medicaid plan amendment that includes providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

Rhode Island does not have a stand-alone State psychiatric hospital; however, the SMHA operates psychiatric inpatient beds at a State general hospital.

Electronic Health Records

Electronic health records (EHRs) are implemented are implemented in eight community mental health centers (CMHCs). CMHCs are implementing 11 EHR components. Some community mental health EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data through a health information exchange.

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South Carolina Mental Health 2013

Department of Mental Health
http://www.state.sc.us/dmh/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (16.4 per 1,000 population)	76,546
Community Mental Health Utilization Rate (per 1,000 population)	16.2
State Psychiatric Hospital Residents at the Start of the Year (12.6 per 100,000 population)	589
Percentage of Hospital Residents with a Forensic Status at the End of the Year	21%
State Population	4,679,230

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	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	2	2	4

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based programs is to directly operate community-based programs. Country or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$267.3 million
Revenue from Medicaid	$127.6 million
Expenditures for Community Mental Health Services (59% of Total SMHA)	$158.0 million
Expenditures for State Psychiatric Hospital Inpatient Care (36% of Total SMHA)	$95.3 million
Per Capita State Mental Health Expenditures	$57.07

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Different State department
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

Although the priority of the SMHA is the treatment of adults diagnosed with serious and persistent mental illness and children with serious emotional disturbance, the SMHA provides treatment to individuals with any mental illness based on its capacity. Eligibility criteria are not influenced or restricted by any funding source.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(c) Home and Community-Based Services waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	32,598	(4.4–17.9)
Estimated Eligible to Use Health Insurance Exchange	9,401	(1.2–8.3)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Three State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 590 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, adolescent, and forensic patients. The State has neither merged nor closed State hospitals or hospital beds between FY 2011 and FY 2013 and has no plans to do so between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 17 community mental health centers (CMHCs). CMHCs are implementing eight EHR components. Agreements allow the sharing of EHR client data between community providers and State hospitals.

South Dakota Mental Health 2013

Division of Community Behavioral Health, Department of Social Services
http://dss.sd.gov/behavioralhealthservices/community/index.asp

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (18.3 per 1,000 population)	15,042
Community Mental Health Utilization Rate (per 1,000 population)	18.3
State Psychiatric Hospital Residents at the Start of the Year (26.8 per 100,000 population)	221
Percentage of Hospital Residents with a Forensic Status at the End of the Year	0%
State Population	824,082

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	1[a]	0	1
Community Mental Health Providers	0	11	11
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

[a] operated by the Department of Social Services
NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$70.2 million
Revenue from Medicaid	$25.8 million
Expenditures for Community Mental Health Services (38% of Total SMHA)	$26.7 million
Expenditures for State Psychiatric Hospital Inpatient Care (60% of Total SMHA)	$42.7 million
Per Capita State Mental Health Expenditures	$85.58

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

There is an income cap and an illness severity requirement in order for individuals to be eligible for SMHA services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	1,940	(2.3–11.0)
Estimated Eligible to Use Health Insurance Exchange	1,217	(1.3–8.3)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA does not have any initiatives to improve the integration of mental health services with primary health care. The SMHA neither screens nor assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is not responsible for operating the State psychiatric hospital; it is the responsibility of the Department of Social Services. Social workers at the State psychiatric hospitals work with community mental health centers (CMHCs) and other community agencies to coordinate care for consumers being discharged back to the community. The State psychiatric hospital is accredited

by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 196 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, adolescent, and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and has no plans to do so between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in five CMHCs and the State psychiatric hospital. The State hospital is implementing 2 EHR components, and CMHCs are implementing 14. All State hospital EHR and some CMHC EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data through a health information exchange.

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Tennessee Mental Health 2013

Department of Mental Health and Substance Abuse Services
http://www.tn.gov/mental/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (33.1 per 1,000 population)	212,200
Community Mental Health Utilization Rate (per 1,000 population)	31.6
State Psychiatric Hospital Residents at the Start of the Year (8.5 per 100,000 population)	544
Percentage of Hospital Residents with a Forensic Status at the End of the Year	21%
State Population	6,403,353

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	42	42
Private Psychiatric Hospitals	NA	1	1
General Hospitals with Separate Psychiatric Units	0	2	2
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$571.6 million
Revenue from Medicaid	$365.4 million
Expenditures for Community Mental Health Services (73% of Total SMHA)	$417.9 million
Expenditures for State Psychiatric Hospital Inpatient Care (25% of Total SMHA)	$141.3 million
Per Capita State Mental Health Expenditures	$88.85

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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 SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Different State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

Clients must meet poverty-level criteria for safety net funds. Specific programs may target adults with a serious mental illness only. There is an income cap for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	29,483	(4.0–11.3)
Estimated Eligible to Use Health Insurance Exchange	10,995	(1.1–6.8)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is awaiting implementation of the federally operated insurance marketplace and a decision by Secretary Sebelius on a "Tennessee Plan' to address Medicaid expansion. Some activities undertaken by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), and/or in collaboration with other State agencies, will be reported after decisions are made and after October 1, 2013, when the marketplace has launched in Tennessee.

TDMHSAS is in the planning process to establish activities to be undertaken to help consumers apply for insurance coverage that meets their health care needs.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Four State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 300 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State closed one State hospital between FY 2011 and FY 2013 but has no plans to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

There is no statewide electronic health records (EHR) for community mental health programs; however, some community providers may have implemented or are in the process of implementing EHRs. State hospitals are implementing five EHR components. All State hospital EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Texas Mental Health 2013

Mental Health and Substance Abuse, Department of State Health Services
http://www.dshs.state.tx.us

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (12.0 per 1,000 population)	308,032
Community Mental Health Utilization Rate (per 1,000 population)	11.9
State Psychiatric Hospital Residents at the Start of the Year (11.9 per 100,000 population)	2,497
Percentage of Hospital Residents with a Forensic Status at the End of the Year	43%
State Population	25,674,681

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	9	2	11
Community Mental Health Providers	0	38	38
Private Psychiatric Hospitals	NA	6	6
General Hospitals with Separate Psychiatric Units	0	7	7
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. County or city authorities administer mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for services, and these local contributions are required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$986.5 million
Revenue from Medicaid	$133.7 million
Expenditures for Community Mental Health Services (61% of Total SMHA)	$601.8 million
Expenditures for State Psychiatric Hospital Inpatient Care (36% of Total SMHA)	$357.2 million
Per Capita State Mental Health Expenditures	$38.05

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Individuals are not denied services based on inability to pay. Ability to pay is assessed on entry into services and reviewed annually. Assessment on ability to pay is based on 150 percent of the Federal Poverty Level as outlined in Texas Administrative Code Rule §412.110 and Rule §412.106. Texas defines those eligible for services in the SMHA by identifying a target population. Those identified as part of the target population are prioritized for services. The priority population consists of persons the department has identified as being in greatest need of mental health services. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Increasingly, mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through Medicaid Research and Demonstration (1115), Medicaid 1915(b), and Medicaid 1915(c) Home and Community-Based Services waivers.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	81,167	(2.5–5.0)
Estimated Eligible to Use Health Insurance Exchange	86,787	(2.5–5.5)

Source: SAMHSA estimates prepared by Truven Health Analytics.

As of FY 2012, the State is neither expanding Medicaid nor participating in a health insurance marketplace exchange. The SMHA is not working on plans to use Medicaid health homes to provide services to individuals with mental illness.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental

health providers in primary care. Beginning in FY 2013, the SMHA will require all contracted providers to implement the Adult Needs and Strengths Assessment for adults, and the Child and Adolescent Needs and Strengths assessment for children and youth. Providers will use these tools to primarily assess behavioral health needs, and there is a physical health component.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Nine State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 961 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, adolescent, and forensic patient. The State did not close or merge State hospitals between FY 2011 and FY 2013. The State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 38 community mental health centers (CMHCs) and 10 State psychiatric hospitals. State hospitals have implemented 11 EHR functions, and CMHCs have implemented 12 functions as of FY 2012. All State hospital and some community mental health EHRs are certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between community providers and State hospitals.

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Utah Mental Health 2013

Division of Substance Abuse and Mental Health, Department of Human Services
http://dsamh.utah.gov/

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (15.8 per 1,000 population)	44,538
Community Mental Health Utilization Rate (per 1,000 population)	15.8
State Psychiatric Hospital Residents at the Start of the Year (10.3 per 100,000 population)	290
Percentage of Hospital Residents with a Forensic Status at the End of the Year	31%
State Population	2,817,222

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
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county mental health authorities that, in turn, fund local provider agencies or directly provide mental health services. County mental health authorities administer mental health services in their geographic region with authorities responsible for every areas of the State. Some counties merge together to form multicounty mental health authorities. Each county is required by the State to provide at least a 20 percent match on all State general funds. The majority of these funds are used to meet State Medicaid match requirements.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$183.6 million
Revenue from Medicaid	$134.0 million
Expenditures for Community Mental Health Services (71% of Total SMHA)	$130.6 million
Expenditures for State Psychiatric Hospital Inpatient Care (28% of Total SMHA)	$51.8 million
Per Capita State Mental Health Expenditures	$64.39

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Persons with Mental Illness in Prison/Jail	Responsibility of SMHA
Sex Offender Services	No responsibility

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Same State department
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

The SMHA uses State general and special funds for adults with serious mental illness and children with serious emotional disturbance. The SMHA has an illness severity requirement in order for individuals to be eligible for SMHA services. The SMHA has an income cap for eligibility for services.

Medicaid

Neither mental health nor substance abuse services are being delivered via managed care. Local mental health and substance abuse authorities are capitated providers under Medicaid and are "at risk" for the populations they serve.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	11,237	(3.7–14.6)
Estimated Eligible to Use Health Insurance Exchange	9,107	(3.0–12.1)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State has not yet decided if it will participate in efforts to expand eligibility for Medicaid. Utah will have a bifurcated health insurance marketplace, meaning it will have a federally facilitated individual marketplace and State-operated small business marketplace. The SMHA is working with the State's Medicaid agency to educate consumers. The SMHA has worked with the State's Medicaid agency to provide data for a cost-benefit analysis of participating in efforts to expand Medicaid eligibility. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is not applying for a Medicaid plan amendment that would include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care
The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating the State psychiatric hospital, which is accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 329 State-operated psychiatric hospital beds.

The SMHA uses State psychiatric hospital beds to serve civil status adult, children, adolescent, and forensic patients. The State did not close the State psychiatric hospital between FY 2011 and FY 2013 and is not planning to close the hospital or reduce hospital beds between FY 2014 and FY 2015.

Electronic Health Records
Electronic health records (EHRs) are implemented in 15 community mental health centers (CMHCs) and the one State psychiatric hospital. The State hospital is implementing 14 EHR components, and CMHCs are implementing 12. The State hospital EHR is not certified to meet the Meaningful Use requirements. Some CMHCs' EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and the State hospital, between the State hospital and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange. Currently, some individuals are participating in Utah's health information exchange because, as of 2012, all Medicaid enrollees are auto-enrolled in Utah's health information exchange unless they opted out of inclusion.

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Vermont Mental Health 2013

Department of Mental Health
http://www.healthvermont.gov

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (39.1 per 1,000 population)	24,490
Community Mental Health Utilization Rate (per 1,000 population)	39.0
State Psychiatric Hospital Residents at the Start of the Year (8.0 per 100,000 population)	50
Percentage of Hospital Residents with a Forensic Status at the End of the Year	60
State Population	626,431

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	11	11
Private Psychiatric Hospitals	NA	1	1
General Hospitals with Separate Psychiatric Units	0	4	4
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$158.4 million
Revenue from Medicaid	$141.4 million
Expenditures for Community Mental Health Services (84% of Total SMHA)	$133.2 million
Expenditures for State Psychiatric Hospital Inpatient Care (36% of Total SMHA)	$18.8 million
Per Capita State Mental Health Expenditures	$252.28

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Same umbrella department
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Vermont has program eligibility criteria within community mental health centers (CMHCs) but no blanket population screen. There is an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1115 waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	1,253[a]	(5.6–20.7)
Estimated Eligible to Use Health Insurance Exchange	2,120	(4.7–16.5)

[a] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is participating in efforts to expand eligibility for Medicaid and establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, working with family and consumer groups to provide information about eligibility, and working with the Insurance Commissioner's office to educate consumers about eligibility for the new coverage programs. The SMHA is working with the health insurance marketplace for the State to provide information, working with the State's Medicaid agency to educate consumers, and educating or training health navigators on how to provide information about eligibility for insurance coverage to consumers with mental health and/or substance abuse issues. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, helping mental health providers become certified Medicaid providers, and helping private practitioners and individual mental health consumers and other clinicians get certified to bill Medicaid for mental health services. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has applied for but not yet received approval for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care
The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. The State psychiatric hospital was closed in 2011 due to damage from a tropical storm. The State is currently building a new State hospital to be completed in 2015.

Electronic Health Records
Electronic health records (EHRs) are implemented in 10 CMHCs. CMHCs are implementing eight EHR components. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Virginia Mental Health 2013

Department of Behavioral Health and Developmental Services
http://www.dbhds.virginia.gov

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (13.7 per 1,000 population)	111,666
Community Mental Health Utilization Rate (per 1,000 population)	13.6
State Psychiatric Hospital Residents at the Start of the Year (16.2 per 100,000 population)	1,310
Percentage of Hospital Residents with a Forensic Status at the End of the Year	31%
State Population	8,096,604

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	40	40
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. County or city authorities administer mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for the services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$747.9 million
Revenue from Medicaid	$259.0 million
Expenditures for Community Mental Health Services (53% of Total SMHA)	$395.5 million
Expenditures for State Psychiatric Hospital Inpatient Care (44% of Total SMHA)	$329.3 million
Per Capita State Mental Health Expenditures	$92.48

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	25,942	(3.1–15.2)
Estimated Eligible to Use Health Insurance Exchange	29,963	(3.3–14.7)

Source: SAMHSA estimates prepared by Truven Health Analytics.

Although the State is not participating in efforts to expand eligibility for Medicaid at this time, it has moved forward with the approval process to establish a health insurance exchange under the Affordable Care Act. The SMHA is not working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Ten State psychiatric hospitals are accredited by the Joint Commission, and seven are certified by the Centers for

Medicare & Medicaid Services (CMS). CMS has certified 1,229 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, adolescent, and forensic patient. The State did not close or merge State hospitals between FY 2011 and FY 2013 and is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 40 community mental health centers (CMHCs), and 3 psychiatric hospitals are serving as pilot sites and have "gone live" (EHRs in 11 State hospitals will go live in 2014). CMHCs are implementing 11 EHR components. All of the community mental health EHRs will be certified to meet the Meaningful Use requirements. All State hospital EHRs will be certified to meet the Meaningful Use requirements. Agreements allow the sharing of EHR client data between community providers and State hospitals.

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Washington Mental Health 2013

Division of Behavioral Health and Recovery, Department of Social and Health Services
http://www.wa.gov/dshs

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (19.9 per 1,000 population)	136,203
Community Mental Health Utilization Rate (per 1,000 population)	19.5
State Psychiatric Hospital Residents at the Start of the Year (16.7 per 100,000 population)	1142
Percentage of Hospital Residents with a Forensic Status at the End of the Year	44%
State Population	6,830,038

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	0	3[a]	3[a]
Community Mental Health Providers	0	158	158
Private Psychiatric Hospitals	NA	3	3
General Hospitals with Separate Psychiatric Units	0	21	21
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

[a] Washington has three State psychiatric hospitals operated by a separate division from the division responsible for community mental health services. NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for the services, and these local contributions are required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$773.9 million
Revenue from Medicaid	$539.6 million
Expenditures for Community Mental Health Services (70% of Total SMHA)	$543.3 million
Expenditures for State Psychiatric Hospital Inpatient Care (28% of Total SMHA)	$216.5 million
Per Capita State Mental Health Expenditures	$112.98

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Different State department
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA
Health Department	Different State department

Eligibility Criteria for State Mental Health Services

Services are typically limited based on Medicaid eligibility and Access to Care standards in the State's 1915(b) waiver. Services to people in crisis are not restricted by Medicaid eligibility. There is an income cap and an illness severity requirement in order for individuals to be eligible for SMHA services.

Medicaid

Mental health services are being delivered via managed care. Behavioral health services are administered through a Medicaid 1915(b) waiver.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	23,118[a]	(2.3–16.0)
Estimated Eligible to Use Health Insurance Exchange	21,240	(2.4 –10.9)

[a] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is developing public awareness efforts about new coverage opportunities targeting persons with mental illness or substance abuse, developing or providing training for mental health and/or substance abuse providers on how to work with consumers, working with family and consumer groups to provide information about eligibility, and working with the Insurance Commissioner's office to educate consumers about eligibility for the new coverage programs. The SMHA is working with the health insurance marketplace for the State to provide information, working with the State's Medicaid agency to educate consumers, educating or training health navigators on how to provide information about eligibility for insurance coverage to consumers with mental health

and/or substance abuse issues, and working with enrollment brokers. The SMHA is working with the State Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, and helping mental health providers become certified Medicaid providers. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State has applied for but not yet received approval for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community mental health programs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. State psychiatric hospitals are within the same State department (Social and Health Services) and the same administration (Behavioral Health and Service Integration) but within a distinct division from community mental health. Both systems report to the State mental health commissioner. Care is coordinated between the State psychiatric hospitals and community programs through Regional Support Networks (RSNs) that contract with the State for a certain number of State hospital beds. If they use more than a contracted number of beds, the RSN has to pay a penalty. With that incentive, each RSN has a liaison staff assigned and housed at the hospital responsible for coordinating care and discharges. They attend treatment team meetings and have access to the hospital database. Three State psychiatric hospitals are accredited by the Joint Commission and three are certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 1,161 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, adolescent, and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013. The State is not planning to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in an unknown number of community mental health centers (CMHCs) and in no State psychiatric hospitals. CMHCs are implementing seven EHR components. All community mental health EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health maintenance organizations and other managed care firms and the SMHA, or through a health information exchange.

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West Virginia Mental Health 2013

Bureau for Behavioral and Health Facilities, Department of Health and Human Resources
http://www.dhhr.wv.gov/bhhf/Pages/default.aspx

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (27.1 per 1,000 population)	50,328
Community Mental Health Utilization Rate (per 1,000 population)	26.2
State Psychiatric Hospital Residents at the Start of the Year (14.6 per 100,000 population)	271
Percentage of Hospital Residents with a Forensic Status at the End of the Year	40%
State Population	1,855,364

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	14	14
General Hospitals with Separate Psychiatric Units	0	12	13
Nursing Homes and Other ICF-MI and SNF Providers	4	0	4

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities do not administer mental health services.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$155.5 million
Revenue from Medicaid	$64.8 million
Expenditures for Community Mental Health Services (62% of Total SMHA)	$104.1 million
Expenditures for State Psychiatric Hospital Inpatient Care (36% of Total SMHA)	$50.9 million
Per Capita State Mental Health Expenditures	$83.87

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Court Evaluation of Mental Health Status	Responsibility of 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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

Individuals must have a diagnosable mental illness and/or addiction in order to be eligible for SMHA services. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Neither mental health nor substance abuse services are delivered via managed care. However, West Virginia uses an Administrative Services Only for Utilization Management for their mental health and substance abuse benefit.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	13,291	(5.3–18.0)
Estimated Eligible to Use Health Insurance Exchange	7,396	(3.1–12.8)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act (ACA). The State is not undertaking any activities with the State's Medicaid agency related to expanded Medicaid coverage under the ACA. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is not applying for a Medicaid plan amendment that would include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

Two of West Virginia's largest comprehensive behavioral health centers (CBHCs) have partnered with Federally Qualified Health Centers to place medical teams in their facilities. The medical teams address the issues people with serious mental illness are known to exhibit, namely hypertension, diabetes, obesity, and cardiovascular diseases. Chronic obstructive pulmonary disease is also a serious issue in West Virginia as a whole. Testing and treatment of pulmonary issues are also handled by the medical team embedded in the CBHCs.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. Two State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 260 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and has no plans to close or merge hospitals or hospital beds between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in 13 community mental health centers (CMHCs) and 2 State psychiatric hospitals. State hospitals and CMHCs are implementing nine EHR components. All State hospital EHRs and some community EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Wisconsin Mental Health 2013

Division of Mental Health and Substance Abuse Services, Department of Health Services
http://www.dhs.wisconsin.gov

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (16.1 per 1,000 population)	91,888
Community Mental Health Utilization Rate (per 1,000 population)	15.7
State Psychiatric Hospital Residents at the Start of the Year (11.9 per 100,000 population)	681
Percentage of Hospital Residents with a Forensic Status at the End of the Year	76%
State Population	5,711,767

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	67	68
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to fund county or city mental health authorities that, in turn, fund local provider agencies or directly provide mental health services statewide. County or city authorities administer mental health services statewide. Some counties merge together to form multicounty mental health authorities. There is a local contribution to pay for the services, and these local contributions are required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$589.0 million
Revenue from Medicaid	$177.5 million
Expenditures for Community Mental Health Services (66% of Total SMHA)	$386.1 million
Expenditures for State Psychiatric Hospital Inpatient Care (34% of Total SMHA)	$202.0 million
Per Capita State Mental Health Expenditures	$102.90

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Traumatic Brain Injury Services	No responsibility
Alzheimer's Disease	No responsibility
Court Evaluation of Mental Health Status	Responsibility of SMHA
Services to Persons with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Responsibility of SMHA

Location of Other State Agencies in Relation to the SMHA

Agency	Location
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

Both mental health and substance abuse services are being delivered via managed care. Behavioral health services are administered through Medicaid Research and Demonstration (1115), Medicaid 1915(b), and Medicaid 1915(c) Home and Community-Based Services waivers.

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	22,363[a]	(4.9–21.3)
Estimated Eligible to Use Health Insurance Exchange	25,076[a]	(4.7–25.3)

[a] These estimates are deemed unreliable as they satisfy the National Survey on Drug Use and Health's standard "precision-based" criteria for suppression; therefore, users are advised to use these numbers with caution. To help interpret all estimates, 95% confidence intervals are included to gauge the level of uncertainty. Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is either participating in efforts to expand eligibility for Medicaid or establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working with family and consumer groups to provide information about eligibility for new coverage programs. The SMHA is working with the State's Medicaid agency to educate consumers. The SMHA is working with the State's Medicaid agency on what mental health benefits will be included in alternative benefit plans, working on including SMHA providers within expanded Medicaid plans, and helping mental health providers become certified Medicaid providers. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care
The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care. The SMHA screens or assesses mental health consumers for physical health issues in community programs.

State Psychiatric Hospitals
The SMHA is responsible for operating State psychiatric hospitals. Two State psychiatric hospitals are accredited by the Joint Commission and certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 366 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult, child, adolescent, and forensic patients. The State neither closed nor merged State hospitals between FY 2011 and FY 2013 and has no plans to do so between FY 2014 and FY 2015.

Electronic Health Records
State psychiatric hospitals are implementing three electronic health record (EHR) components. No agreements allow the sharing of EHR client data between community providers and State hospitals, between State hospitals and general hospitals, between health management organizations and other managed care firms and the SMHA, or through a health information exchange.

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Wyoming Mental Health 2013

Behavioral Health Division, Mental Health and Substance Abuse Services, Department of Health
http://www.health.wyo.gov/mhsa/index.html

Utilization Rates, Fiscal Year (FY) 2012

Category	Rate
Number of Persons Served (30.4 per 1,000 population)	17,244
Community Mental Health Utilization Rate (per 1,000 population)	30.3
State Psychiatric Hospital Residents at the Start of the Year (20.2 per 100,000 population)	115
Percentage of Hospital Residents with a Forensic Status at the End of the Year	14%
State Population	568,158

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	14	0	14
Private Psychiatric Hospitals	NA	0	0
General Hospitals with Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0

NA = not applicable. ICF-MI = intermediate care facilities for persons with mental illness. SNF = skilled nursing facility

Mechanism Used in Delivering Community Mental Health Services

The primary mechanism used by the SMHA to fund community-based services is to directly fund, but not operate, local community-based agencies. County or city authorities administer mental health services only in selected parts of the State. There is a local contribution to pay for the services, and these local contributions are required by the State.

SMHA-Controlled Revenues and Expenditures for Mental Health

Revenues and Expenditures FY 2012	Dollars
Total SMHA-Controlled Revenue	$32.3 million
Revenue from Medicaid	NA
Expenditures for Community Mental Health Services (47% of Total SMHA)	$30.0 million
Expenditures for State Psychiatric Hospital Inpatient Care (49% of Total SMHA)	$31.6 million
Per Capita State Mental Health Expenditures	$56.36

NA = exact amount of revenues received not available

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Area	Responsibility
Children and Youth Mental Health Services	Responsibility of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	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
Substance Abuse Agency	Part of SMHA
Medicaid Agency	Same umbrella department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department
Health Department	Same umbrella department

Eligibility Criteria for State Mental Health Services

There are no eligibility restrictions for SMHA-funded and/or SMHA-operated services. There is neither an income cap nor an illness severity requirement for individuals to be eligible for SMHA services.

Medicaid

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

SMHA's Role in Health Care Reform

Number of Persons with Serious Mental Illness	Estimated Population	95% Confidence Interval
Estimated Eligible for Expanded Medicaid Coverage	2,006	(4.1–18.3)
Estimated Eligible to Use Health Insurance Exchange	2,813	(4.9–12.1)

Source: SAMHSA estimates prepared by Truven Health Analytics.

The State is neither participating in efforts to expand eligibility for Medicaid nor establishing a State-based or partnership marketplace under the Affordable Care Act. The SMHA is working on plans to use Medicaid health homes to provide services for individuals with chronic mental health conditions. The State is preparing an application for a Medicaid plan amendment that will include providing health home services targeting beneficiaries with mental health conditions.

Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, including the colocation of primary care in mental health programs and the colocation of mental health providers in primary care.

State Psychiatric Hospitals

The SMHA is responsible for operating State psychiatric hospitals. One State psychiatric hospital is certified by the Centers for Medicare & Medicaid Services (CMS). CMS has certified 15 State-operated psychiatric hospital beds.

State psychiatric hospital beds are used for civil status adult and forensic patients. The State neither closed nor merged State hospitals or hospital beds between FY 2011 and FY 2013 and has no plans to do so between FY 2014 and FY 2015.

Electronic Health Records

Electronic health records (EHRs) are implemented in the State psychiatric hospital and 13 community mental health centers (CMHCs). State psychiatric hospitals are implementing one EHR component, and CMHCs are implementing eight. All State hospital and some CMHC EHRs are certified to meet the Meaningful Use requirements. No agreements allow the sharing of EHR client data.

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Appendix B: Profiles of State Substance Abuse Agencies

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Alabama Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Substance Abuse Services Division

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	3.94
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	6.7%
Alcohol SUD	5.4%
Illicit drug SUD	2.4%
Marijuana SUD	1.2%
Pain reliever SUD	0.4%
Youth (12–17 years) with SUD	6.0%
Young adults (18–25 years) with SUD	15.9%
Adults with SUD (26 or older)	5.2%
Binge alcohol use past month	19.7%
Illicit drug use past month	7.6%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	16,096
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	1,833,954
Number of providers funded by SSA to deliver SUD prevention	23

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	11.7%
Illicit drug use (youth 12–17 years): past 30 days	9.2%
Marijuana use (youth 12–17 years): past 30 days	6.3%
Cigarette use (youth 12–17 years): past 30 days	8.8%
Perception of "great risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	44.1%
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	83.6%
Perception of "great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	60.7%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	93.6%
Share of SSA Substance Abuse Prevention and Treatment (SAPT) prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	23,216
Detoxification admissions (24-hour care)	681
Rehabilitation/residential admissions (24-hour care)	5,975
Ambulatory outpatient (nonintensive) admissions	2,232
Opioid replacement therapy admissions	956

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	93.8%
Rate of abstinence from illicit drugs at discharge (from outpatient)	75.0%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	96.1%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	99.2%
Percentage of clients attending self-help programs at discharge (from outpatient)	46.6%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$43.1
Expenditures on SUD treatment and prevention (other than primary prevention) services	$36.1
Expenditures on SUD primary prevention[a] services	$4.8
Expenditures on infrastructure (e.g., workforce) and administration	$2.2
State funding	$15.5
SAMHSA SAPT Block Grant	$23.9
Value of Medicaid funding managed by the SSA (if any)	$3.6
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.1

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid health home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Alaska Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	0.56
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	9.3%
Alcohol SUD	7.9%
Illicit drug SUD	2.7%
Marijuana SUD	1.7%
Pain reliever SUD	0.6%
Youth (12–17 years) with SUD	7.7%
Young adults (18–25 years) with SUD	19.2%
Adults with SUD (26 or older)	7.5%
Binge alcohol use past month	24.1%
Illicit drug use past month	13.6%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	106,476
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	440,357
Number of providers funded by SSA to deliver SUD prevention	24

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.4%
Illicit drug use (youth 12–17 years): past 30 days	11.1%
Marijuana use (youth 12–17 years): past 30 days	8.8%
Cigarette use (youth 12–17 years): past 30 days	7.8%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	39.7%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	73.8%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	65.2%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	46.3%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	7,626
Detoxification admissions (24-hour care)	2,193
Rehabilitation/residential admissions (24-hour care)	1,272
Ambulatory outpatient (nonintensive) admissions	3,014
Opioid replacement therapy admissions	48

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	77.8%
Rate of abstinence from illicit drugs at discharge (from outpatient)	74.9%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	91.4%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	96.7%
Percentage of clients attending self-help programs at discharge (from outpatient)	33.4%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$58.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	$37.3
Expenditures on SUD primary prevention[a] services	$14.3
Expenditures on infrastructure (e.g., workforce) and administration	$6.6
State funding	$41.2
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$4.2
Value of Medicaid funding managed by the SSA (if any)	$10.4
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$2.4

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Arizona Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	5.34
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	10.3%
Alcohol SUD	8.2%
Illicit drug SUD	3.1%
Marijuana SUD	2.4%
Pain reliever SUD	1.1%
Youth (12–17 years) with SUD	8.5%
Young adults (18–25 years) with SUD	21.3%
Adults with SUD (26 or older)	8.7%
Binge alcohol use past month	22.4%
Illicit drug use past month	9.5%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	16,598
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	11,226,726
Number of providers funded by SSA to deliver SUD prevention	13

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.7%
Illicit drug use (youth 12–17 years): past 30 days	11.3%
Marijuana use (youth 12–17 years): past 30 days	8.2%
Cigarette use (youth 12–17 years): past 30 days	8.8%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	42.9%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	76.9%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	65.8%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	92.1%
Share of SSA SAPT prevention spending used on evidence-based practices	24.3%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	152,759
Detoxification admissions (24-hour care)	1,600
Rehabilitation/residential admissions (24-hour care)	5,198
Ambulatory outpatient (nonintensive) admissions	67,273
Opioid replacement therapy admissions	5,133

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	13.9%

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$170.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	$153.8
Expenditures on SUD primary prevention[a] services	$8.6
Expenditures on infrastructure (e.g., workforce) and administration	$7.9
State funding	$12.3
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$37.9
Value of Medicaid funding managed by the SSA (if any)	$117.1
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$3.0

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Arkansas Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	2.39
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	6.8%
Alcohol SUD	5.3%
Illicit drug SUD	2.6%
Marijuana SUD	1.3%
Pain reliever SUD	0.8%
Youth (12–17 years) with SUD	6.0%
Young adults (18–25 years) with SUD	15.7%
Adults with SUD (26 or older)	5.5%
Binge alcohol use past month	19.0%
Illicit drug use past month	7.6%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	21,323
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	169,338
Number of providers funded by SSA to deliver SUD prevention	20

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.0%
Illicit drug use (youth 12–17 years): past 30 days	9.3%
Marijuana use (youth 12–17 years): past 30 days	6.1%
Cigarette use (youth 12–17 years): past 30 days	9.4%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	44.3%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	81.1%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	63.5%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	18.8%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	5,517
Detoxification admissions (24-hour care)	2,813
Rehabilitation/residential admissions (24-hour care)	3,077
Ambulatory outpatient (nonintensive) admissions	3,301
Opioid replacement therapy admissions	356

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	68.2%
Rate of abstinence from illicit drugs at discharge (from outpatient)	75.4%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	97.2%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.1%
Percentage of clients attending self-help programs at discharge (from outpatient)	38.6%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$24.9
Expenditures on SUD treatment and prevention (other than primary prevention) services	$21.0
Expenditures on SUD primary prevention[a] services	$2.5
Expenditures on infrastructure (e.g., workforce) and administration	$1.4
State funding	$7.1
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$12.3
Value of Medicaid funding managed by the SSA (if any)	$5.3
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.2

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	NA
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

California Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Alcohol & Drug Programs

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	30.69
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	9.2%
Alcohol SUD	7.4%
Illicit drug SUD	3.0%
Marijuana SUD	2.1%
Pain reliever SUD	0.7%
Youth (12–17 years) with SUD	8.8%
Young adults (18–25 years) with SUD	20.9%
Adults with SUD (26 or older)	7.0%
Binge alcohol use past month	22.0%
Illicit drug use past month	10.5%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	491,570
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	4,304,924
Number of providers funded by SSA to deliver SUD prevention	311

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.7%
Illicit drug use (youth 12–17 years): past 30 days	12.1%
Marijuana use (youth 12–17 years): past 30 days	9.4%
Cigarette use (youth 12–17 years): past 30 days	6.3%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	41.7%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	72.3%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	67.8%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	85.6%
Share of SSA SAPT prevention spending used on evidence-based practices	9.4%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	243,341
Detoxification admissions (24-hour care)	21,649
Rehabilitation/residential admissions (24-hour care)	34,295
Ambulatory outpatient (nonintensive) admissions	90,882
Opioid replacement therapy admissions	16,210

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	91.5%
Rate of abstinence from illicit drugs at discharge (from outpatient)	76.2%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	96.6%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	94.3%
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$587.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	$505.0
Expenditures on SUD primary prevention[a] services	$58.8
Expenditures on infrastructure (e.g., workforce) and administration	$23.7
State funding	$104.5
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$251.5
Value of Medicaid funding managed by the SSA (if any)	$222.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$9.6

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Colorado Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Behavioral Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	4.17
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	9.9%
Alcohol SUD	8.5%
Illicit drug SUD	3.0%
Marijuana SUD	1.9%
Pain reliever SUD	0.5%
Youth (12–17 years) with SUD	8.1%
Young adults (18–25 years) with SUD	23.6%
Adults with SUD (26 or older)	7.8%
Binge alcohol use past month	24.5%
Illicit drug use past month	13.4%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	60,456
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	1,800,445
Number of providers funded by SSA to deliver SUD prevention	54

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	15.5%
Illicit drug use (youth 12–17 years): past 30 days	13.2%
Marijuana use (youth 12–17 years): past 30 days	10.7%
Cigarette use (youth 12–17 years): past 30 days	8.6%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	36.4%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	73.4%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	66.3%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	88.0%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	80,496
Detoxification admissions (24-hour care)	52,238
Rehabilitation/residential admissions (24-hour care)	3,810
Ambulatory outpatient (nonintensive) admissions	10,786
Opioid replacement therapy admissions	1,176

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	86.3%
Rate of abstinence from illicit drugs at discharge (from outpatient)	78.4%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	95.0%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	97.0%
Percentage of clients attending self-help programs at discharge (from outpatient)	13.0%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$59.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	$46.5
Expenditures on SUD primary prevention[a] services	$11.5
Expenditures on infrastructure (e.g., workforce) and administration	$1.2
State funding	$21.8
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$26.1
Value of Medicaid funding managed by the SSA (if any)	$1.2
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$10.1

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Connecticut Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Dept. of Mental Health & Addiction Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	2.98
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	9.0%
Alcohol SUD	7.3%
Illicit drug SUD	2.7%
Marijuana SUD	1.6%
Pain reliever SUD	1.0%
Youth (12–17 years) with SUD	7.3%
Young adults (18–25 years) with SUD	21.2%
Adults with SUD (26 or older)	7.2%
Binge alcohol use past month	26.3%
Illicit drug use past month	9.1%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	1,665,024
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	9,983,887
Number of providers funded by SSA to deliver SUD prevention	72

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	16.8%
Illicit drug use (youth 12–17 years): past 30 days	10.3%
Marijuana use (youth 12–17 years): past 30 days	8.6%
Cigarette use (youth 12–17 years): past 30 days	8.0%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	37.7%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	74.4%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	67.7%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	55.8%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	40,289
Detoxification admissions (24-hour care)	9,942
Rehabilitation/residential admissions (24-hour care)	5,835
Ambulatory outpatient (nonintensive) admissions	15,888
Opioid replacement therapy admissions	4,569

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	78.5%
Rate of abstinence from illicit drugs at discharge (from outpatient)	73.5%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	93.8%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	97.3%
Percentage of clients attending self-help programs at discharge (from outpatient)	26.7%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$223.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	$194.6
Expenditures on SUD primary prevention[a] services	$12.1
Expenditures on infrastructure (e.g., workforce) and administration	$16.9
State funding	$184.2
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$17.5
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$21.8

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Delaware Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Substance Abuse and Mental Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	0.75
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	7.9%
Alcohol SUD	6.2%
Illicit drug SUD	2.8%
Marijuana SUD	1.5%
Pain reliever SUD	1.2%
Youth (12–17 years) with SUD	6.6%
Young adults (18–25 years) with SUD	19.2%
Adults with SUD (26 or older)	6.2%
Binge alcohol use past month	23.3%
Illicit drug use past month	9.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	5,537
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	268,073
Number of providers funded by SSA to deliver SUD prevention	3

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	14.6%
Illicit drug use (youth 12–17 years): past 30 days	11.2%
Marijuana use (youth 12–17 years): past 30 days	8.3%
Cigarette use (youth 12–17 years): past 30 days	8.2%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	39.6%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	73.6%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	65.8%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	46.0%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	9,043
Detoxification admissions (24-hour care)	1,645
Rehabilitation/residential admissions (24-hour care)	420
Ambulatory outpatient (nonintensive) admissions	4,424
Opioid replacement therapy admissions	779

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	71.8%
Rate of abstinence from illicit drugs at discharge (from outpatient)	50.3%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	68.3%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.6%
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$22.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	$19.0
Expenditures on SUD primary prevention[a] services	$3.0
Expenditures on infrastructure (e.g., workforce) and administration	$0.8
State funding	$14.5
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$6.7
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$1.5

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

District of Columbia Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Addiction Prevention & Recovery Administration

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	0.53
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	12.7%
Alcohol SUD	10.8%
Illicit drug SUD	3.4%
Marijuana SUD	2.6%
Pain reliever SUD	NA
Youth (12–17 years) with SUD	6.7%
Young adults (18–25 years) with SUD	21.3%
Adults with SUD (26 or older)	11.2%
Binge alcohol use past month	32.2%
Illicit drug use past month	13.6%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	1,000
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	3,790
Number of providers funded by SSA to deliver SUD prevention	6

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	14.2%
Illicit drug use (youth 12–17 years): past 30 days	14.5%
Marijuana use (youth 12–17 years): past 30 days	10.6%
Cigarette use (youth 12–17 years): past 30 days	6.0%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	43.5%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	66.5%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	63.1%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	13,675
Detoxification admissions (24-hour care)	992
Rehabilitation/residential admissions (24-hour care)	2,342
Ambulatory outpatient (nonintensive) admissions	1,780
Opioid replacement therapy admissions	1,457

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	94.0%
Rate of abstinence from illicit drugs at discharge (from outpatient)	73.4%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	95.7%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	94.1%
Percentage of clients attending self-help programs at discharge (from outpatient)	62.7%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$41.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	$29.4
Expenditures on SUD primary prevention[a] services	$2.5
Expenditures on infrastructure (e.g., workforce) and administration	$9.8
State funding	$34.4
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$6.7
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.4

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Florida Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Substance Abuse Program Office

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	15.87
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	7.5%
Alcohol SUD	5.9%
Illicit drug SUD	2.6%
Marijuana SUD	1.6%
Pain reliever SUD	0.7%
Youth (12–17 years) with SUD	6.6%
Young adults (18–25 years) with SUD	17.7%
Adults with SUD (26 or older)	6.1%
Binge alcohol use past month	19.9%
Illicit drug use past month	8.3%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	177,927
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	141,591
Number of providers funded by SSA to deliver SUD prevention	91

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.6%
Illicit drug use (youth 12–17 years): past 30 days	9.1%
Marijuana use (youth 12–17 years): past 30 days	6.8%
Cigarette use (youth 12–17 years): past 30 days	6.9%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	41.8%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	75.1%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	67.9%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	91.4%
Share of SSA SAPT prevention spending used on evidence-based practices	50.1%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	53,573
Detoxification admissions (24-hour care)	20,776
Rehabilitation/residential admissions (24-hour care)	9,350
Ambulatory outpatient (nonintensive) admissions	40,338
Opioid replacement therapy admissions	3,269

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$177.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	$140.1
Expenditures on SUD primary prevention[a] services	$25.4
Expenditures on infrastructure (e.g., workforce) and administration	$11.8
State funding	$72.5
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$99.6
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$5.2

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Georgia Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Addictive Diseases

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	7.94
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	6.9%
Alcohol SUD	5.6%
Illicit drug SUD	2.4%
Marijuana SUD	1.1%
Pain reliever SUD	0.4%
Youth (12–17 years) with SUD	6.3%
Young adults (18–25 years) with SUD	17.1%
Adults with SUD (26 or older)	5.2%
Binge alcohol use past month	19.4%
Illicit drug use past month	6.5%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	230,516
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	36,833
Number of providers funded by SSA to deliver SUD prevention	115

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	11.7%
Illicit drug use (youth 12–17 years): past 30 days	8.7%
Marijuana use (youth 12–17 years): past 30 days	6.5%
Cigarette use (youth 12–17 years): past 30 days	9.4%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	43.2%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	76.4%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	63.6%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	90.1%
Share of SSA SAPT prevention spending used on evidence-based practices	51.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	53,580
Detoxification admissions (24-hour care)	8,278
Rehabilitation/residential admissions (24-hour care)	2,974
Ambulatory outpatient (nonintensive) admissions	30,823
Opioid replacement therapy admissions	99

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$120.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	$102.1
Expenditures on SUD primary prevention[a] services	$14.0
Expenditures on infrastructure (e.g., workforce) and administration	$4.0
State funding	$46.1
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$50.7
Value of Medicaid funding managed by the SSA (if any)	$0.4
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$23.0

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Hawaii Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Alcohol and Drug Abuse Division

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	1.08
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.6%
Alcohol SUD	7.9%
Illicit drug SUD	2.1%
Marijuana SUD	1.7%
Pain reliever SUD	0.2%
Youth (12–17 years) with SUD	7.7%
Young adults (18–25 years) with SUD	20.0%
Adults with SUD (26 or older)	7.0%
Binge alcohol use past month	23.1%
Illicit drug use past month	8.8%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	34,113
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	38,794
Number of providers funded by SSA to deliver SUD prevention	13

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	14.2%
Illicit drug use (youth 12–17 years): past 30 days	10.9%
Marijuana use (youth 12–17 years): past 30 days	8.3%
Cigarette use (youth 12–17 years): past 30 days	6.7%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	41.8%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	70.6%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	64.6%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	83.4%
Share of SSA SAPT prevention spending used on evidence-based practices	45.2%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	4,454
Detoxification admissions (24-hour care)	440
Rehabilitation/residential admissions (24-hour care)	507
Ambulatory outpatient (nonintensive) admissions	2,821
Opioid replacement therapy admissions	9

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$30.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	$22.2
Expenditures on SUD primary prevention[a] services	$5.7
Expenditures on infrastructure (e.g., workforce) and administration	$2.4
State funding	$18.8
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$7.7
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$3.9

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Idaho Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Substance Use Disorders Program

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	1.26
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	9.2%
Alcohol SUD	7.4%
Illicit drug SUD	2.7%
Marijuana SUD	1.5%
Pain reliever SUD	1.1%
Youth (12–17 years) with SUD	7.3%
Young adults (18–25 years) with SUD	19.8%
Adults with SUD (26 or older)	7.5%
Binge alcohol use past month	21.6%
Illicit drug use past month	9.4%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	16,830
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	469,855
Number of providers funded by SSA to deliver SUD prevention	62

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.1%
Illicit drug use (youth 12–17 years): past 30 days	10.2%
Marijuana use (youth 12–17 years): past 30 days	7.5%
Cigarette use (youth 12–17 years): past 30 days	8.6%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	34.5%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	78.8%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	67.3%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	92.0%
Share of SSA SAPT prevention spending used on evidence-based practices	79.2%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	16,606
Detoxification admissions (24-hour care)	0
Rehabilitation/residential admissions (24-hour care)	750
Ambulatory outpatient (nonintensive) admissions	4,563
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	94.8%
Rate of abstinence from illicit drugs at discharge (from outpatient)	87.9%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	88.1%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	91.7%
Percentage of clients attending self–help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$29.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	$27.0
Expenditures on SUD primary prevention[a] services	$2.1
Expenditures on infrastructure (e.g., workforce) and administration	$0.6
State funding	$17.3
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$6.9
Value of Medicaid funding managed by the SSA (if any)	$1.6
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$3.9

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Illinois Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Alcoholism & Substance Abuse

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	10.64
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.4%
Alcohol SUD	6.9%
Illicit drug SUD	2.6%
Marijuana SUD	1.5%
Pain reliever SUD	0.4%
Youth (12–17 years) with SUD	6.4%
Young adults (18–25 years) with SUD	21.0%
Adults with SUD (26 or older)	6.4%
Binge alcohol use past month	25.3%
Illicit drug use past month	8.6%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	84,585
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	124,342
Number of providers funded by SSA to deliver SUD prevention	241

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.3%
Illicit drug use (youth 12–17 years): past 30 days	9.7%
Marijuana use (youth 12–17 years): past 30 days	7.6%
Cigarette use (youth 12–17 years): past 30 days	7.3%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	41.7%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	76.3%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	65.5%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	87.5%
Share of SSA SAPT prevention spending used on evidence-based practices	60.6%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	161,374
Detoxification admissions (24-hour care)	12,112
Rehabilitation/residential admissions (24-hour care)	14,355
Ambulatory outpatient (nonintensive) admissions	25,586
Opioid replacement therapy admissions	8,672

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	82.7%
Rate of abstinence from illicit drugs at discharge (from outpatient)	74.6%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	95.5%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	96.7%
Percentage of clients attending self-help programs at discharge (from outpatient)	28.9%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$210.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	$181.8
Expenditures on SUD primary prevention[a] services	$18.8
Expenditures on infrastructure (e.g., workforce) and administration	$9.6
State funding	$88.5
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$62.6
Value of Medicaid funding managed by the SSA (if any)	$50.1
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$9.0

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Indiana Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Addiction and Emergency Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	5.33
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.3%
Alcohol SUD	6.9%
Illicit drug SUD	2.4%
Marijuana SUD	1.4%
Pain reliever SUD	1.2%
Youth (12–17 years) with SUD	5.8%
Young adults (18–25 years) with SUD	19.3%
Adults with SUD (26 or older)	6.7%
Binge alcohol use past month	22.7%
Illicit drug use past month	9.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	19,412
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	19,412
Number of providers funded by SSA to deliver SUD prevention	12

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	11.6%
Illicit drug use (youth 12–17 years): past 30 days	9.1%
Marijuana use (youth 12–17 years): past 30 days	6.5%
Cigarette use (youth 12–17 years): past 30 days	8.1%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	38.9%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	83.3%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	65.6%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	91.3%
Share of SSA SAPT prevention spending used on evidence-based practices	80.8%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	44,173
Detoxification admissions (24-hour care)	1,150
Rehabilitation/residential admissions (24-hour care)	343
Ambulatory outpatient (nonintensive) admissions	21,739
Opioid replacement therapy admissions	443

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	79.5%
Rate of abstinence from illicit drugs at discharge (from outpatient)	66.2%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	92.8%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	95.9%
Percentage of clients attending self-help programs at discharge (from outpatient)	19.9%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$49.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	$39.5
Expenditures on SUD primary prevention[a] services	$8.2
Expenditures on infrastructure (e.g., workforce) and administration	$1.4
State funding	$10.1
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$33.1
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$5.9

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Iowa Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Public Health, Division of Behavioral Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	2.52
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.7%
Alcohol SUD	7.8%
Illicit drug SUD	2.2%
Marijuana SUD	1.5%
Pain reliever SUD	0.3%
Youth (12–17 years) with SUD	7.2%
Young adults (18–25 years) with SUD	21.2%
Adults with SUD (26 or older)	6.6%
Binge alcohol use past month	26.6%
Illicit drug use past month	6.4%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	136,286
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	398,669
Number of providers funded by SSA to deliver SUD prevention	25

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	15.8%
Illicit drug use (youth 12–17 years): past 30 days	8.6%
Marijuana use (youth 12–17 years): past 30 days	6.1%
Cigarette use (youth 12–17 years): past 30 days	10.8%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	37.2%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	79.0%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	62.7%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	93.5%
Share of SSA SAPT prevention spending used on evidence-based practices	4.8%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	57,744
Detoxification admissions (24-hour care)	929
Rehabilitation/residential admissions (24-hour care)	2,820
Ambulatory outpatient (nonintensive) admissions	11,117
Opioid replacement therapy admissions	93

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	85.9%
Rate of abstinence from illicit drugs at discharge (from outpatient)	89.3%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	96.5%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	80.6%
Percentage of clients attending self-help programs at discharge (from outpatient)	16.6%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$37.9
Expenditures on SUD treatment and prevention (other than primary prevention) services	$27.8
Expenditures on SUD primary prevention[a] services	$7.3
Expenditures on infrastructure (e.g., workforce) and administration	$2.8
State funding	$17.9
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$13.6
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$6.4

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Kansas Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	2.31
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.4%
Alcohol SUD	7.2%
Illicit drug SUD	2.6%
Marijuana SUD	1.6%
Pain reliever SUD	0.5%
Youth (12–17 years) with SUD	7.2%
Young adults (18–25 years) with SUD	19.5%
Adults with SUD (26 or older)	6.5%
Binge alcohol use past month	23.4%
Illicit drug use past month	6.7%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	5,953
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	78,797
Number of providers funded by SSA to deliver SUD prevention	14

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.3%
Illicit drug use (youth 12–17 years): past 30 days	8.4%
Marijuana use (youth 12–17 years): past 30 days	6.3%
Cigarette use (youth 12–17 years): past 30 days	9.6%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	37.1%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.8%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	60.1%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	96.4%
Share of SSA SAPT prevention spending used on evidence-based practices	4.9%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	24,447
Detoxification admissions (24-hour care)	1,956
Rehabilitation/residential admissions (24-hour care)	3,711
Ambulatory outpatient (nonintensive) admissions	9,436
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	97.9%
Rate of abstinence from illicit drugs at discharge (from outpatient)	97.5%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	99.0%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	99.3%
Percentage of clients attending self-help programs at discharge (from outpatient)	39.5%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$41.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	$36.3
Expenditures on SUD primary prevention[a] services	$4.0
Expenditures on infrastructure (e.g., workforce) and administration	$1.1
State funding	$15.7
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$12.6
Value of Medicaid funding managed by the SSA (if any)	$11.4
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$1.8

On health financing reform, has the State/SSA started:

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	NA
Planning to use Medicaid Health Home to provide services for those with SUD?	NA
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	NA
Working with other Federal agencies on integration of health with SUD services?	NA
Working on workforce capacity issues to address future needs?	NA
Collecting data to assess the changing needs as health financing reform progresses?	NA
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	NA

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

NA: Data not available.

Kentucky Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department for Behavioral Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	3.59
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	6.4%
Alcohol SUD	4.8%
Illicit drug SUD	2.5%
Marijuana SUD	1.0%
Pain reliever SUD	1.0%
Youth (12–17 years) with SUD	6.2%
Young adults (18–25 years) with SUD	15.5%
Adults with SUD (26 or older)	5.0%
Binge alcohol use past month	20.9%
Illicit drug use past month	6.9%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	1,002,186
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	40,866,867
Number of providers funded by SSA to deliver SUD prevention	17

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.8%
Illicit drug use (youth 12–17 years): past 30 days	8.5%
Marijuana use (youth 12–17 years): past 30 days	6.4%
Cigarette use (youth 12–17 years): past 30 days	11.7%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	43.4%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	82.3%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	63.8%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	93.7%
Share of SSA SAPT prevention spending used on evidence-based practices	53.5%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	18,153
Detoxification admissions (24-hour care)	5,581
Rehabilitation/residential admissions (24-hour care)	1,060
Ambulatory outpatient (nonintensive) admissions	15,855
Opioid replacement therapy admissions	64

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	79.7%
Rate of abstinence from illicit drugs at discharge (from outpatient)	67.6%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	96.3%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	96.6%
Percentage of clients attending self-help programs at discharge (from outpatient)	26.3%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$35.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	$28.5
Expenditures on SUD primary prevention[a] services	$6.0
Expenditures on infrastructure (e.g., workforce) and administration	$1.0
State funding	$14.4
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$20.6
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.6

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Louisiana Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Behavioral Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	3.69
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	7.5%
Alcohol SUD	6.3%
Illicit drug SUD	2.4%
Marijuana SUD	1.4%
Pain reliever SUD	0.7%
Youth (12–17 years) with SUD	5.6%
Young adults (18–25 years) with SUD	16.7%
Adults with SUD (26 or older)	6.0%
Binge alcohol use past month	22.8%
Illicit drug use past month	6.8%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	77,078
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	206,965
Number of providers funded by SSA to deliver SUD prevention	53

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	14.1%
Illicit drug use (youth 12–17 years): past 30 days	8.1%
Marijuana use (youth 12–17 years): past 30 days	5.5%
Cigarette use (youth 12–17 years): past 30 days	9.1%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	45.4%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.8%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	64.1%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	93.3%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	24,345
Detoxification admissions (24-hour care)	4,311
Rehabilitation/residential admissions (24-hour care)	8,362
Ambulatory outpatient (nonintensive) admissions	14,014
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	64.7%
Rate of abstinence from illicit drugs at discharge (from outpatient)	58.9%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	96.7%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.7%
Percentage of clients attending self-help programs at discharge (from outpatient)	43.6%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$72.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	$64.9
Expenditures on SUD primary prevention[a] services	$5.1
Expenditures on infrastructure (e.g., workforce) and administration	$2.6
State funding	$38.2
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$25.7
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$8.7

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Maine Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Substance Abuse

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	1.14
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	6.8%
Alcohol SUD	5.4%
Illicit drug SUD	2.2%
Marijuana SUD	0.8%
Pain reliever SUD	0.7%
Youth (12–17 years) with SUD	5.9%
Young adults (18–25 years) with SUD	18.4%
Adults with SUD (26 or older)	5.2%
Binge alcohol use past month	22.3%
Illicit drug use past month	9.6%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	3,443
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	1,195,079
Number of providers funded by SSA to deliver SUD prevention	35

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.4%
Illicit drug use (youth 12–17 years): past 30 days	10.5%
Marijuana use (youth 12–17 years): past 30 days	9.1%
Cigarette use (youth 12–17 years): past 30 days	8.9%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	35.1%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.3%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	65.5%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	13,061
Detoxification admissions (24-hour care)	1,135
Rehabilitation/residential admissions (24-hour care)	1,443
Ambulatory outpatient (nonintensive) admissions	6,269
Opioid replacement therapy admissions	1,997

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	82.5%
Rate of abstinence from illicit drugs at discharge (from outpatient)	77.3%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	91.3%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.0%
Percentage of clients attending self-help programs at discharge (from outpatient)	40.2%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$35.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	$31.1
Expenditures on SUD primary prevention[a] services	$2.5
Expenditures on infrastructure (e.g., workforce) and administration	$2.0
State funding	$14.5
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$6.7
Value of Medicaid funding managed by the SSA (if any)	$12.9
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$1.4

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Maryland Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Alcohol & Drug Abuse Administration

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	4.79
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	6.8%
Alcohol SUD	5.1%
Illicit drug SUD	2.6%
Marijuana SUD	1.3%
Pain reliever SUD	0.5%
Youth (12–17 years) with SUD	5.6%
Young adults (18–25 years) with SUD	17.5%
Adults with SUD (26 or older)	5.1%
Binge alcohol use past month	20.9%
Illicit drug use past month	7.4%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	10,049
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	146,822
Number of providers funded by SSA to deliver SUD prevention	24

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.6%
Illicit drug use (youth 12–17 years): past 30 days	8.9%
Marijuana use (youth 12–17 years): past 30 days	6.1%
Cigarette use (youth 12–17 years): past 30 days	5.9%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	43.9%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	71.9%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	66.2%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	71,753
Detoxification admissions (24-hour care)	5,139
Rehabilitation/residential admissions (24-hour care)	11,477
Ambulatory outpatient (nonintensive) admissions	20,975
Opioid replacement therapy admissions	3,788

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	87.8%
Rate of abstinence from illicit drugs at discharge (from outpatient)	75.8%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	97.0%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.8%
Percentage of clients attending self-help programs at discharge (from outpatient)	24.7%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$127.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	$104.7
Expenditures on SUD primary prevention[a] services	$6.4
Expenditures on infrastructure (e.g., workforce) and administration	$16.4
State funding	$75.9
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$32.1
Value of Medicaid funding managed by the SSA (if any)	$4.1
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$15.4

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Massachusetts Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Bureau of Substance Abuse Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	5.60
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	10.2%
Alcohol SUD	8.4%
Illicit drug SUD	2.8%
Marijuana SUD	1.5%
Pain reliever SUD	1.0%
Youth (12–17 years) with SUD	9.0%
Young adults (18–25 years) with SUD	23.4%
Adults with SUD (26 or older)	8.0%
Binge alcohol use past month	27.0%
Illicit drug use past month	11.5%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	0
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	56,428,996
Number of providers funded by SSA to deliver SUD prevention	31

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	15.8%
Illicit drug use (youth 12–17 years): past 30 days	12.9%
Marijuana use (youth 12–17 years): past 30 days	11.3%
Cigarette use (youth 12–17 years): past 30 days	8.2%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	36.0%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	75.1%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	66.4%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	99.1%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	68,307
Detoxification admissions (24-hour care)	48,289
Rehabilitation/residential admissions (24-hour care)	13,290
Ambulatory outpatient (nonintensive) admissions	33,678
Opioid replacement therapy admissions	7,271

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$121.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	$110.8
Expenditures on SUD primary prevention[a] services	$9.1
Expenditures on infrastructure (e.g., workforce) and administration	$1.9
State funding	$78.8
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$34.1
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$8.8

On health financing reform, has the State/SSA started:

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	NA
Planning to use Medicaid Health Home to provide services for those with SUD?	NA
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	NA
Working with other Federal agencies on integration of health with SUD services?	NA
Working on workforce capacity issues to address future needs?	NA
Collecting data to assess the changing needs as health financing reform progresses?	NA
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	NA

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

NA: Data not available.

Michigan Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Recovery Oriented Systems of Care

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	8.30
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.6%
Alcohol SUD	7.1%
Illicit drug SUD	2.5%
Marijuana SUD	1.6%
Pain reliever SUD	0.7%
Youth (12–17 years) with SUD	7.1%
Young adults (18–25 years) with SUD	18.5%
Adults with SUD (26 or older)	7.1%
Binge alcohol use past month	25.3%
Illicit drug use past month	10.7%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	133,690
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	128,048
Number of providers funded by SSA to deliver SUD prevention	154

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.7%
Illicit drug use (youth 12–17 years): past 30 days	11.0%
Marijuana use (youth 12–17 years): past 30 days	8.2%
Cigarette use (youth 12–17 years): past 30 days	8.4%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	37.5%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	75.3%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	65.1%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	93.4%
Share of SSA SAPT prevention spending used on evidence-based practices	NA

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	77,510
Detoxification admissions (24-hour care)	9,829
Rehabilitation/residential admissions (24-hour care)	11,364
Ambulatory outpatient (nonintensive) admissions	36,190
Opioid replacement therapy admissions	2,606

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	80.4%
Rate of abstinence from illicit drugs at discharge (from outpatient)	76.2%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	92.7%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	96.0%
Percentage of clients attending self-help programs at discharge (from outpatient)	28.1%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$151.3
Expenditures on SUD treatment and prevention (other than primary prevention) services	$135.3
Expenditures on SUD primary prevention[a] services	$14.0
Expenditures on infrastructure (e.g., workforce) and administration	$2.0
State funding	$43.3
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$56.2
Value of Medicaid funding managed by the SSA (if any)	$44.4
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$7.4

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Minnesota Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Alcohol and Drug Abuse Division

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	4.41
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	9.1%
Alcohol SUD	7.7%
Illicit drug SUD	2.5%
Marijuana SUD	1.7%
Pain reliever SUD	0.5%
Youth (12–17 years) with SUD	7.6%
Young adults (18–25 years) with SUD	21.3%
Adults with SUD (26 or older)	7.2%
Binge alcohol use past month	26.2%
Illicit drug use past month	8.2%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	10,984
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	1,833,000
Number of providers funded by SSA to deliver SUD prevention	27

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.1%
Illicit drug use (youth 12–17 years): past 30 days	9.3%
Marijuana use (youth 12–17 years): past 30 days	6.8%
Cigarette use (youth 12–17 years): past 30 days	8.7%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	34.7%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	81.1%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	67.7%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	72.4%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	30,301
Detoxification admissions (24-hour care)	0
Rehabilitation/residential admissions (24-hour care)	15,092
Ambulatory outpatient (nonintensive) admissions	0
Opioid replacement therapy admissions	1,149

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	88.0%
Rate of abstinence from illicit drugs at discharge (from outpatient)	64.7%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	88.2%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	97.7%
Percentage of clients attending self-help programs at discharge (from outpatient)	70.6%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$150.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	$122.9
Expenditures on SUD primary prevention[a] services	$6.7
Expenditures on infrastructure (e.g., workforce) and administration	$21.2
State funding	$72.7
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$24.6
Value of Medicaid funding managed by the SSA (if any)	$32.3
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$21.1

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Mississippi Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Bureau of Alcohol & Drug Abuse

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	2.39
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	7.1%
Alcohol SUD	5.6%
Illicit drug SUD	2.8%
Marijuana SUD	1.5%
Pain reliever SUD	0.9%
Youth (12–17 years) with SUD	5.7%
Young adults (18–25 years) with SUD	16.4%
Adults with SUD (26 or older)	5.6%
Binge alcohol use past month	19.2%
Illicit drug use past month	8.2%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	50,792
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	343,122
Number of providers funded by SSA to deliver SUD prevention	28

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	11.9%
Illicit drug use (youth 12–17 years): past 30 days	9.6%
Marijuana use (youth 12–17 years): past 30 days	6.3%
Cigarette use (youth 12–17 years): past 30 days	9.4%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	49.0%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	81.7%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	62.3%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	55.0%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	9,413
Detoxification admissions (24-hour care)	0
Rehabilitation/residential admissions (24-hour care)	3,528
Ambulatory outpatient (nonintensive) admissions	6,593
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	83.2%
Rate of abstinence from illicit drugs at discharge (from outpatient)	71.4%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	99.3%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	25.3%
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$19.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	$15.3
Expenditures on SUD primary prevention[a] services	$2.8
Expenditures on infrastructure (e.g., workforce) and administration	$1.7
State funding	$5.1
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$14.2
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.5

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Missouri Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	4.96
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	7.3%
Alcohol SUD	5.6%
Illicit drug SUD	2.8%
Marijuana SUD	1.7%
Pain reliever SUD	0.9%
Youth (12–17 years) with SUD	7.0%
Young adults (18–25 years) with SUD	18.2%
Adults with SUD (26 or older)	5.5%
Binge alcohol use past month	22.7%
Illicit drug use past month	7.3%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	267,584
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	4,610,414
Number of providers funded by SSA to deliver SUD prevention	22

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	15.0%
Illicit drug use (youth 12–17 years): past 30 days	9.2%
Marijuana use (youth 12–17 years): past 30 days	7.3%
Cigarette use (youth 12–17 years): past 30 days	11.6%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	36.9%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.5%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	60.2%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	90.1%
Share of SSA SAPT prevention spending used on evidence-based practices	99.1%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	44,269
Detoxification admissions (24-hour care)	7,161
Rehabilitation/residential admissions (24-hour care)	10,008
Ambulatory outpatient (nonintensive) admissions	15,775
Opioid replacement therapy admissions	639

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	94.1%
Rate of abstinence from illicit drugs at discharge (from outpatient)	91.9%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	96.4%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	99.2%
Percentage of clients attending self-help programs at discharge (from outpatient)	32.3%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$111.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	$101.2
Expenditures on SUD primary prevention[a] services	$7.1
Expenditures on infrastructure (e.g., workforce) and administration	$3.2
State funding	$36.1
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$26.2
Value of Medicaid funding managed by the SSA (if any)	$39.8
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$9.4

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Montana Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Chemical Dependency Bureau

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	0.83
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	10.3%
Alcohol SUD	8.5%
Illicit drug SUD	2.8%
Marijuana SUD	1.8%
Pain reliever SUD	1.0%
Youth (12–17 years) with SUD	9.9%
Young adults (18–25 years) with SUD	23.5%
Adults with SUD (26 or older)	8.1%
Binge alcohol use past month	28.0%
Illicit drug use past month	12.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	7,605
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	367,900
Number of providers funded by SSA to deliver SUD prevention	12

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	17.2%
Illicit drug use (youth 12–17 years): past 30 days	12.7%
Marijuana use (youth 12–17 years): past 30 days	10.4%
Cigarette use (youth 12–17 years): past 30 days	11.7%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	33.7%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	72.5%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	64.8%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	87.1%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	7,811
Detoxification admissions (24-hour care)	1,038
Rehabilitation/residential admissions (24-hour care)	187
Ambulatory outpatient (nonintensive) admissions	3,034
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	86.2%
Rate of abstinence from illicit drugs at discharge (from outpatient)	86.8%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	93.3%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	95.1%
Percentage of clients attending self-help programs at discharge (from outpatient)	37.9%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$16.9
Expenditures on SUD treatment and prevention (other than primary prevention) services	$13.9
Expenditures on SUD primary prevention[a] services	$1.9
Expenditures on infrastructure (e.g., workforce) and administration	$1.1
State funding	$8.1
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$6.7
Value of Medicaid funding managed by the SSA (if any)	$2.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.1

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Nebraska Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	1.49
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.0%
Alcohol SUD	6.3%
Illicit drug SUD	2.3%
Marijuana SUD	1.2%
Pain reliever SUD	1.1%
Youth (12–17 years) with SUD	6.2%
Young adults (18–25 years) with SUD	19.2%
Adults with SUD (26 or older)	6.2%
Binge alcohol use past month	24.6%
Illicit drug use past month	6.7%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	461,441
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	104,589
Number of providers funded by SSA to deliver SUD prevention	60

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.8%
Illicit drug use (youth 12–17 years): past 30 days	7.8%
Marijuana use (youth 12–17 years): past 30 days	6.2%
Cigarette use (youth 12–17 years): past 30 days	8.9%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	37.9%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	80.0%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	63.0%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	3.6%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	20,617
Detoxification admissions (24-hour care)	10,166
Rehabilitation/residential admissions (24-hour care)	3,031
Ambulatory outpatient (nonintensive) admissions	11,705
Opioid replacement therapy admissions	937

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	81.5%
Rate of abstinence from illicit drugs at discharge (from outpatient)	85.9%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	95.8%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	96.5%
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$37.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	$35.2
Expenditures on SUD primary prevention[a] services	$1.8
Expenditures on infrastructure (e.g., workforce) and administration	$0.4
State funding	$23.2
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$7.8
Value of Medicaid funding managed by the SSA (if any)	$6.4
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.0

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Nevada Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division Public and Behavioral Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	2.20
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	10.5%
Alcohol SUD	9.0%
Illicit drug SUD	2.7%
Marijuana SUD	2.4%
Pain reliever SUD	1.1%
Youth (12–17 years) with SUD	7.8%
Young adults (18–25 years) with SUD	20.9%
Adults with SUD (26 or older)	9.2%
Binge alcohol use past month	24.5%
Illicit drug use past month	9.9%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	8,511
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	805,579
Number of providers funded by SSA to deliver SUD prevention	28

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.1%
Illicit drug use (youth 12–17 years): past 30 days	11.6%
Marijuana use (youth 12–17 years): past 30 days	8.5%
Cigarette use (youth 12–17 years): past 30 days	6.9%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	39.1%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.5%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	66.5%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	13,150
Detoxification admissions (24-hour care)	0
Rehabilitation/residential admissions (24-hour care)	2,143
Ambulatory outpatient (nonintensive) admissions	5,247
Opioid replacement therapy admissions	110

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$25.3
Expenditures on SUD treatment and prevention (other than primary prevention) services	$18.1
Expenditures on SUD primary prevention[a] services	$5.9
Expenditures on infrastructure (e.g., workforce) and administration	$1.4
State funding	$10.5
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$13.9
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.9

On health financing reform, has the State/SSA started:[a]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the Substance Abuse Block Grant statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

New Hampshire Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Alcohol and Drug Abuse Policy

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	1.13
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.7%
Alcohol SUD	6.7%
Illicit drug SUD	2.9%
Marijuana SUD	1.8%
Pain reliever SUD	0.7%
Youth (12–17 years) with SUD	8.9%
Young adults (18–25 years) with SUD	21.3%
Adults with SUD (26 or older)	6.7%
Binge alcohol use past month	24.1%
Illicit drug use past month	11.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	152,361
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	1,262,977
Number of providers funded by SSA to deliver SUD prevention	11

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	17.0%
Illicit drug use (youth 12–17 years): past 30 days	12.8%
Marijuana use (youth 12–17 years): past 30 days	11.4%
Cigarette use (youth 12–17 years): past 30 days	10.7%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	36.3%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	71.2%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	64.2%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	48.5%[a]
Share of SSA SAPT prevention spending used on evidence-based practices	5.1%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	7,753
Detoxification admissions (24-hour care)	613
Rehabilitation/residential admissions (24-hour care)	1,379
Ambulatory outpatient (nonintensive) admissions	3,741
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	60%[b]
Rate of abstinence from illicit drugs at discharge (from outpatient)	54%[b]
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	95.5%[b]
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	71.5%[b]
Percentage of clients attending self-help programs at discharge (from outpatient)	48%[b]

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$13.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	$10.8
Expenditures on SUD primary prevention[c] services	$1.8
Expenditures on infrastructure (e.g., workforce) and administration	$1.3
State funding	$5.0
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$6.1
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$2.7

On health financing reform, has the State/SSA started:[d]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] New Hampshire 2011Youth Risk Behavior Survey.

[b] Values provided by New Hampshire Office of Alcohol and Drug Abuse and Prevention.

[c] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[d] Information reported from State/SSA in June 2013.

New Jersey Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Mental Health and Addiction Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	7.33
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.2%
Alcohol SUD	6.5%
Illicit drug SUD	2.6%
Marijuana SUD	1.5%
Pain reliever SUD	0.8%
Youth (12–17 years) with SUD	7.5%
Young adults (18–25 years) with SUD	19.5%
Adults with SUD (26 or older)	6.6%
Binge alcohol use past month	24.5%
Illicit drug use past month	8.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	66,530
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	167,219
Number of providers funded by SSA to deliver SUD prevention	37

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	16.8%
Illicit drug use (youth 12–17 years): past 30 days	10.0%
Marijuana use (youth 12–17 years): past 30 days	8.0%
Cigarette use (youth 12–17 years): past 30 days	8.4%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	39.1%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.8%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	70.3%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	91.3%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	76,478
Detoxification admissions (24-hour care)	8,020
Rehabilitation/residential admissions (24-hour care)	13,433
Ambulatory outpatient (nonintensive) admissions	18,330
Opioid replacement therapy admissions	6,375

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	94.7%
Rate of abstinence from illicit drugs at discharge (from outpatient)	90.8%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	96.5%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.3%
Percentage of clients attending self-help programs at discharge (from outpatient)	59.8%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$144.7
Expenditures on SUD treatment and prevention (other than primary prevention) services	$123.9
Expenditures on SUD primary prevention[a] services	$13.9
Expenditures on infrastructure (e.g., workforce) and administration	$6.9
State funding	$98.7
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$45.4
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.6

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

New Mexico Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Behavioral Health Services Division

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	1.67
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	9.2%
Alcohol SUD	7.0%
Illicit drug SUD	3.1%
Marijuana SUD	1.9%
Pain reliever SUD	0.6%
Youth (12–17 years) with SUD	9.3%
Young adults (18–25 years) with SUD	20.9%
Adults with SUD (26 or older)	7.1%
Binge alcohol use past month	20.3%
Illicit drug use past month	10.6%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	5,867
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	1,702,141
Number of providers funded by SSA to deliver SUD prevention	24

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.7%
Illicit drug use (youth 12–17 years): past 30 days	12.1%
Marijuana use (youth 12–17 years): past 30 days	9.3%
Cigarette use (youth 12–17 years): past 30 days	9.1%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	42.2%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	71.6%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	65.0%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	97.0%
Share of SSA SAPT prevention spending used on evidence-based practices	46.5%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	3,249
Detoxification admissions (24-hour care)	201
Rehabilitation/residential admissions (24-hour care)	288
Ambulatory outpatient (nonintensive) admissions	3,567
Opioid replacement therapy admissions	386

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	87.5%
Rate of abstinence from illicit drugs at discharge (from outpatient)	87.4%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	78.0%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	96.5%
Percentage of clients attending self-help programs at discharge (from outpatient)	55.2%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$39.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	$36.1
Expenditures on SUD primary prevention[a] services	$2.2
Expenditures on infrastructure (e.g., workforce) and administration	$1.1
State funding	$19.4
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$8.5
Value of Medicaid funding managed by the SSA (if any)	$4.1
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$7.4

On health financing reform, has the State/SSA started:

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	NA
Planning to use Medicaid Health Home to provide services for those with SUD?	NA
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	NA
Working with other Federal agencies on integration of health with SUD services?	NA
Working on workforce capacity issues to address future needs?	NA
Collecting data to assess the changing needs as health financing reform progresses?	NA
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	NA

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

NA: Data not available.

New York Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Alcoholism & Substance Abuse Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	16.42
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.4%
Alcohol SUD	6.6%
Illicit drug SUD	2.7%
Marijuana SUD	1.9%
Pain reliever SUD	0.6%
Youth (12–17 years) with SUD	6.8%
Young adults (18–25 years) with SUD	18.9%
Adults with SUD (26 or older)	6.7%
Binge alcohol use past month	23.7%
Illicit drug use past month	9.3%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	153,500
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	4,276,587
Number of providers funded by SSA to deliver SUD prevention	113

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	16.6%
Illicit drug use (youth 12–17 years): past 30 days	10.2%
Marijuana use (youth 12–17 years): past 30 days	8.1%
Cigarette use (youth 12–17 years): past 30 days	6.8%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	41.0%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.1%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	69.6%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	91.2%
Share of SSA SAPT prevention spending used on evidence-based practices	NA

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	137,536
Detoxification admissions (24-hour care)	21,102
Rehabilitation/residential admissions (24-hour care)	26,393
Ambulatory outpatient (nonintensive) admissions	60,498
Opioid replacement therapy admissions	6,794

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	85.4%
Rate of abstinence from illicit drugs at discharge (from outpatient)	74.2%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	94.6%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	95.6%
Percentage of clients attending self-help programs at discharge (from outpatient)	23.9%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$541.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	$420.6
Expenditures on SUD primary prevention[a] services	$51.9
Expenditures on infrastructure (e.g., workforce) and administration	$68.7
State funding	$413.7
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$119.4
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$8.1

On health financing reform, has the State/SSA started:

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	NA
Planning to use Medicaid Health Home to provide services for those with SUD?	NA
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	NA
Working with other Federal agencies on integration of health with SUD services?	NA
Working on workforce capacity issues to address future needs?	NA
Collecting data to assess the changing needs as health financing reform progresses?	NA
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	NA

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

NA: Data not available.

North Carolina Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Mental Health, Developmental Disabilities & Substance Abuse Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	7.80
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	7.0%
Alcohol SUD	5.5%
Illicit drug SUD	2.7%
Marijuana SUD	1.7%
Pain reliever SUD	0.6%
Youth (12–17 years) with SUD	6.7%
Young adults (18–25 years) with SUD	17.4%
Adults with SUD (26 or older)	5.3%
Binge alcohol use past month	19.5%
Illicit drug use past month	8.9%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	106,580
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	71,942
Number of providers funded by SSA to deliver SUD prevention	36

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.9%
Illicit drug use (youth 12–17 years): past 30 days	10.3%
Marijuana use (youth 12–17 years): past 30 days	8.0%
Cigarette use (youth 12–17 years): past 30 days	8.9%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	39.4%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	78.6%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	67.2%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	99.0%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	64,370
Detoxification admissions (24-hour care)	12,997
Rehabilitation/residential admissions (24-hour care)	8,040
Ambulatory outpatient (nonintensive) admissions	41,174
Opioid replacement therapy admissions	660

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	62.5%
Rate of abstinence from illicit drugs at discharge (from outpatient)	47.6%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	98.2%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	94.7%
Percentage of clients attending self-help programs at discharge (from outpatient)	20.9%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$162.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	$147.4
Expenditures on SUD primary prevention[a] services	$9.8
Expenditures on infrastructure (e.g., workforce) and administration	$5.4
State funding	$103.8
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$40.0
Value of Medicaid funding managed by the SSA (if any)	$15.9
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$2.8

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	NA
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

North Dakota Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Mental Health & Substance Abuse

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	0.55
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	9.4%
Alcohol SUD	8.8%
Illicit drug SUD	2.0%
Marijuana SUD	1.0%
Pain reliever SUD	0.2%
Youth (12–17 years) with SUD	6.8%
Young adults (18–25 years) with SUD	22.3%
Adults with SUD (26 or older)	6.9%
Binge alcohol use past month	30.5%
Illicit drug use past month	5.5%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	1,342
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	10,047,577
Number of providers funded by SSA to deliver SUD prevention	50

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	14.2%
Illicit drug use (youth 12–17 years): past 30 days	7.0%
Marijuana use (youth 12–17 years): past 30 days	4.8%
Cigarette use (youth 12–17 years): past 30 days	9.6%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	35.3%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	85.0%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	67.0%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	91.2%
Share of SSA SAPT prevention spending used on evidence-based practices	1.6%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	4,974
Detoxification admissions (24-hour care)	66
Rehabilitation/residential admissions (24-hour care)	733
Ambulatory outpatient (nonintensive) admissions	2,555
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	90.5%
Rate of abstinence from illicit drugs at discharge (from outpatient)	93.4%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	92.5%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	97.5%
Percentage of clients attending self-help programs at discharge (from outpatient)	19.7%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$20.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	$18.7
Expenditures on SUD primary prevention[a] services	$1.2
Expenditures on infrastructure (e.g., workforce) and administration	$0.5
State funding	$7.7
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$4.8
Value of Medicaid funding managed by the SSA (if any)	$6.1
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$1.8

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Ohio Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Alcohol & Drug Addiction Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	9.60
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.9%
Alcohol SUD	7.3%
Illicit drug SUD	2.8%
Marijuana SUD	1.9%
Pain reliever SUD	1.0%
Youth (12–17 years) with SUD	6.7%
Young adults (18–25 years) with SUD	19.7%
Adults with SUD (26 or older)	7.3%
Binge alcohol use past month	23.2%
Illicit drug use past month	8.5%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	628,336
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	2,205,783
Number of providers funded by SSA to deliver SUD prevention	168

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.5%
Illicit drug use (youth 12–17 years): past 30 days	9.8%
Marijuana use (youth 12–17 years): past 30 days	7.1%
Cigarette use (youth 12–17 years): past 30 days	9.6%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	38.1%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	78.5%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	63.6%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	89.0%
Share of SSA SAPT prevention spending used on evidence-based practices	25.6%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	76,582
Detoxification admissions (24-hour care)	3,034
Rehabilitation/residential admissions (24-hour care)	5,495
Ambulatory outpatient (nonintensive) admissions	45,511
Opioid replacement therapy admissions	4,634

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	87.4%
Rate of abstinence from illicit drugs at discharge (from outpatient)	78.9%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	89.4%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	97.4%
Percentage of clients attending self-help programs at discharge (from outpatient)	27.1%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$211.3
Expenditures on SUD treatment and prevention (other than primary prevention) services	$175.8
Expenditures on SUD primary prevention[a] services	$20.8
Expenditures on infrastructure (e.g., workforce) and administration	$14.7
State funding	$55.4
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$67.8
Value of Medicaid funding managed by the SSA (if any)	$69.2
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$18.8

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Oklahoma Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Mental Health and Substance Abuse Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	3.03
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.9%
Alcohol SUD	7.2%
Illicit drug SUD	2.5%
Marijuana SUD	1.4%
Pain reliever SUD	1.5%
Youth (12–17 years) with SUD	6.5%
Young adults (18–25 years) with SUD	18.0%
Adults with SUD (26 or older)	7.5%
Binge alcohol use past month	21.0%
Illicit drug use past month	9.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	244,799
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	90,765
Number of providers funded by SSA to deliver SUD prevention	19

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.8%
Illicit drug use (youth 12–17 years): past 30 days	10.1%
Marijuana use (youth 12–17 years): past 30 days	7.2%
Cigarette use (youth 12–17 years): past 30 days	10.2%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	41.0%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	78.7%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	59.4%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	99.6%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	26,820
Detoxification admissions (24-hour care)	2,051
Rehabilitation/residential admissions (24-hour care)	3,097
Ambulatory outpatient (nonintensive) admissions	9,092
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	85.2%
Rate of abstinence from illicit drugs at discharge (from outpatient)	78.1%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	96.0%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	99.0%
Percentage of clients attending self-help programs at discharge (from outpatient)	25.5%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$67.1
Expenditures on SUD treatment and prevention (other than primary prevention) services	$56.6
Expenditures on SUD primary prevention[a] services	$6.6
Expenditures on infrastructure (e.g., workforce) and administration	$3.8
State funding	$41.7
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$17.6
Value of Medicaid funding managed by the SSA (if any)	$2.7
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$5.1

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Oregon Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Addictions and Mental Health Division

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	3.25
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	9.8%
Alcohol SUD	7.8%
Illicit drug SUD	3.0%
Marijuana SUD	2.4%
Pain reliever SUD	0.9%
Youth (12–17 years) with SUD	8.0%
Young adults (18–25 years) with SUD	20.6%
Adults with SUD (26 or older)	8.2%
Binge alcohol use past month	22.3%
Illicit drug use past month	13.1%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	169,583
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	1,700
Number of providers funded by SSA to deliver SUD prevention	42

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	14.6%
Illicit drug use (youth 12–17 years): past 30 days	12.7%
Marijuana use (youth 12–17 years): past 30 days	10.3%
Cigarette use (youth 12–17 years): past 30 days	7.5%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	35.3%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	71.8%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	66.2%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	36.1%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	97,156
Detoxification admissions (24-hour care)	3,514
Rehabilitation/residential admissions (24-hour care)	5,456
Ambulatory outpatient (nonintensive) admissions	45,083
Opioid replacement therapy admissions	5,637

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$48.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	$42.8
Expenditures on SUD primary prevention[a] services	$4.6
Expenditures on infrastructure (e.g., workforce) and administration	$0.9
State funding	$14.2
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$17.8
Value of Medicaid funding managed by the SSA (if any)	$14.3
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$1.9

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Pennsylvania Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Drug & Alcohol Programs

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	10.68
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.9%
Alcohol SUD	7.1%
Illicit drug SUD	2.7%
Marijuana SUD	1.8%
Pain reliever SUD	0.8%
Youth (12–17 years) with SUD	7.0%
Young adults (18–25 years) with SUD	19.6%
Adults with SUD (26 or older)	7.3%
Binge alcohol use past month	24.5%
Illicit drug use past month	8.1%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	168,261
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	332,378
Number of providers funded by SSA to deliver SUD prevention	54

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	14.1%
Illicit drug use (youth 12–17 years): past 30 days	9.3%
Marijuana use (youth 12–17 years): past 30 days	7.2%
Cigarette use (youth 12–17 years): past 30 days	9.6%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	38.7%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.4%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	63.4%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	91.0%
Share of SSA SAPT prevention spending used on evidence-based practices	NA

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	76,546
Detoxification admissions (24-hour care)	8,765
Rehabilitation/residential admissions (24-hour care)	16,625
Ambulatory outpatient (nonintensive) admissions	37,005
Opioid replacement therapy admissions	1,351

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$108.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	$67.7
Expenditures on SUD primary prevention[a] services	$24.1
Expenditures on infrastructure (e.g., workforce) and administration	$16.7
State funding	$45.8
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$57.1
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$5.6

On health financing reform, has the State/SSA started:

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	NA
Planning to use Medicaid Health Home to provide services for those with SUD?	NA
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	NA
Working with other Federal agencies on integration of health with SUD services?	NA
Working on workforce capacity issues to address future needs?	NA
Collecting data to assess the changing needs as health financing reform progresses?	NA
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	NA

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

NA: Data not available.

Rhode Island Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Healthcare Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	0.90
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	10.7%
Alcohol SUD	9.1%
Illicit drug SUD	2.9%
Marijuana SUD	2.1%
Pain reliever SUD	0.9%
Youth (12–17 years) with SUD	7.4%
Young adults (18–25 years) with SUD	23.0%
Adults with SUD (26 or older)	8.7%
Binge alcohol use past month	27.9%
Illicit drug use past month	14.5%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	13,241
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	3,000
Number of providers funded by SSA to deliver SUD prevention	6

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	15.0%
Illicit drug use (youth 12–17 years): past 30 days	13.4%
Marijuana use (youth 12–17 years): past 30 days	11.1%
Cigarette use (youth 12–17 years): past 30 days	8.4%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	37.4%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	71.2%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	67.2%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	36.8%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	8,659
Detoxification admissions (24-hour care)	1,615
Rehabilitation/residential admissions (24-hour care)	1,128
Ambulatory outpatient (nonintensive) admissions	2,504
Opioid replacement therapy admissions	860

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	86.4%
Rate of abstinence from illicit drugs at discharge (from outpatient)	83.4%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	95.2%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	97.6%
Percentage of clients attending self-help programs at discharge (from outpatient)	23.7%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$24.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	$18.4
Expenditures on SUD primary prevention[a] services	$3.4
Expenditures on infrastructure (e.g., workforce) and administration	$2.9
State funding	$5.6
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$6.9
Value of Medicaid funding managed by the SSA (if any)	$5.6
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$6.5

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

South Carolina Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Alcohol and Other Drug Abuse Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	3.81
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.1%
Alcohol SUD	6.5%
Illicit drug SUD	2.6%
Marijuana SUD	1.5%
Pain reliever SUD	0.6%
Youth (12–17 years) with SUD	6.8%
Young adults (18–25 years) with SUD	17.4%
Adults with SUD (26 or older)	6.6%
Binge alcohol use past month	22.8%
Illicit drug use past month	7.4%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	8,384
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	5,230,977
Number of providers funded by SSA to deliver SUD prevention	33

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.3%
Illicit drug use (youth 12–17 years): past 30 days	8.8%
Marijuana use (youth 12–17 years): past 30 days	6.4%
Cigarette use (youth 12–17 years): past 30 days	9.7%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	44.4%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	78.8%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	61.9%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	55.5%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	37,206
Detoxification admissions (24-hour care)	2,911
Rehabilitation/residential admissions (24-hour care)	476
Ambulatory outpatient (nonintensive) admissions	20,426
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	89.8%
Rate of abstinence from illicit drugs at discharge (from outpatient)	87.1%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	98.0%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.1%
Percentage of clients attending self-help programs at discharge (from outpatient)	21.6%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$32.0
Expenditures on SUD treatment and prevention (other than primary prevention) services	$23.5
Expenditures on SUD primary prevention[a] services	$6.8
Expenditures on infrastructure (e.g., workforce) and administration	$1.8
State funding	$6.2
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$20.2
Value of Medicaid funding managed by the SSA (if any)	$1.3
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$4.2

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

South Dakota Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Community Behavioral Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	0.67
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	10.0%
Alcohol SUD	8.9%
Illicit drug SUD	2.2%
Marijuana SUD	1.2%
Pain reliever SUD	0.5%
Youth (12–17 years) with SUD	8.4%
Young adults (18–25 years) with SUD	20.3%
Adults with SUD (26 or older)	8.3%
Binge alcohol use past month	27.5%
Illicit drug use past month	6.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	2,817,471
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	2,974,091
Number of providers funded by SSA to deliver SUD prevention	22

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	16.4%
Illicit drug use (youth 12–17 years): past 30 days	8.1%
Marijuana use (youth 12–17 years): past 30 days	5.8%
Cigarette use (youth 12–17 years): past 30 days	10.2%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	33.8%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	83.4%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	64.8%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	95.3%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	28,595
Detoxification admissions (24-hour care)	4,349
Rehabilitation/residential admissions (24-hour care)	3,509
Ambulatory outpatient (nonintensive) admissions	6,608
Opioid replacement therapy admissions	227

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	82.9%
Rate of abstinence from illicit drugs at discharge (from outpatient)	84.9%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	86.1%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.2%
Percentage of clients attending self-help programs at discharge (from outpatient)	25.6%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$20.0
Expenditures on SUD treatment and prevention (other than primary prevention) services	$14.8
Expenditures on SUD primary prevention[a] services	$4.0
Expenditures on infrastructure (e.g., workforce) and administration	$1.3
State funding	$8.5
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$4.9
Value of Medicaid funding managed by the SSA (if any)	$2.1
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$4.5

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Tennessee Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Substance Abuse Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	5.28
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.2%
Alcohol SUD	6.1%
Illicit drug SUD	2.9%
Marijuana SUD	1.8%
Pain reliever SUD	1.2%
Youth (12–17 years) with SUD	6.8%
Young adults (18–25 years) with SUD	19.1%
Adults with SUD (26 or older)	6.6%
Binge alcohol use past month	18.4%
Illicit drug use past month	7.6%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	16,638
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	303,124
Number of providers funded by SSA to deliver SUD prevention	60

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	11.0%
Illicit drug use (youth 12–17 years): past 30 days	8.9%
Marijuana use (youth 12–17 years): past 30 days	6.2%
Cigarette use (youth 12–17 years): past 30 days	9.2%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	41.8%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.5%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	62.5%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	95.1%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	14,824
Detoxification admissions (24-hour care)	2,447
Rehabilitation/residential admissions (24-hour care)	8,402
Ambulatory outpatient (nonintensive) admissions	2,436
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	81.7%
Rate of abstinence from illicit drugs at discharge (from outpatient)	70.7%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	97.2%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	96.9%
Percentage of clients attending self-help programs at discharge (from outpatient)	72.0%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$62.0
Expenditures on SUD treatment and prevention (other than primary prevention) services	$39.7
Expenditures on SUD primary prevention[a] services	$9.9
Expenditures on infrastructure (e.g., workforce) and administration	$12.3
State funding	$26.4
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$32.2
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$3.4

On health financing reform, has the State/SSA started:

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	NA
Planning to use Medicaid Health Home to provide services for those with SUD?	NA
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	NA
Working with other Federal agencies on integration of health with SUD services?	NA
Working on workforce capacity issues to address future needs?	NA
Collecting data to assess the changing needs as health financing reform progresses?	NA
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	NA

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

NA: Data not available.

Texas Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Mental Health and Substance Abuse Division

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	20.17
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.0%
Alcohol SUD	6.6%
Illicit drug SUD	2.5%
Marijuana SUD	1.6%
Pain reliever SUD	0.6%
Youth (12–17 years) with SUD	6.5%
Young adults (18–25 years) with SUD	17.5%
Adults with SUD (26 or older)	6.3%
Binge alcohol use past month	24.0%
Illicit drug use past month	7.1%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	226,242
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	8,198,737
Number of providers funded by SSA to deliver SUD prevention	86

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	12.1%
Illicit drug use (youth 12–17 years): past 30 days	9.1%
Marijuana use (youth 12–17 years): past 30 days	6.3%
Cigarette use (youth 12–17 years): past 30 days	7.1%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	42.9%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	76.2%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	64.6%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	92.3%
Share of SSA SAPT prevention spending used on evidence-based practices	85.6%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	52,223
Detoxification admissions (24-hour care)	9,083
Rehabilitation/residential admissions (24-hour care)	12,931
Ambulatory outpatient (nonintensive) admissions	14,561
Opioid replacement therapy admissions	1,424

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$170.3
Expenditures on SUD treatment and prevention (other than primary prevention) services	$114.3
Expenditures on SUD primary prevention[a] services	$43.3
Expenditures on infrastructure (e.g., workforce) and administration	$12.7
State funding	$23.7
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$136.5
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$10.2

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Utah Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Substance Abuse and Mental Health

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	2.18
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	6.3%
Alcohol SUD	4.6%
Illicit drug SUD	2.8%
Marijuana SUD	1.4%
Pain reliever SUD	0.9%
Youth (12–17 years) with SUD	5.6%
Young adults (18–25 years) with SUD	14.2%
Adults with SUD (26 or older)	4.5%
Binge alcohol use past month	14.2%
Illicit drug use past month	5.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	186,308
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	18,030
Number of providers funded by SSA to deliver SUD prevention	39

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	7.6%
Illicit drug use (youth 12–17 years): past 30 days	5.9%
Marijuana use (youth 12–17 years): past 30 days	3.7%
Cigarette use (youth 12–17 years): past 30 days	5.1%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	52.3%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	82.8%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	74.1%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	19,383
Detoxification admissions (24-hour care)	4,194
Rehabilitation/residential admissions (24-hour care)	2,144
Ambulatory outpatient (nonintensive) admissions	7,701
Opioid replacement therapy admissions	619

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	85.1%
Rate of abstinence from illicit drugs at discharge (from outpatient)	76.8%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	89.6%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.4%
Percentage of clients attending self-help programs at discharge (from outpatient)	33.4%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$44.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	$33.5
Expenditures on SUD primary prevention[a] services	$6.5
Expenditures on infrastructure (e.g., workforce) and administration	$4.2
State funding	$9.8
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$15.9
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$18.6

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Vermont Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Alcohol and Drug Abuse Programs

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	0.54
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	10.0%
Alcohol SUD	7.2%
Illicit drug SUD	3.3%
Marijuana SUD	2.6%
Pain reliever SUD	1.5%
Youth (12–17 years) with SUD	9.0%
Young adults (18–25 years) with SUD	25.2%
Adults with SUD (26 or older)	7.4%
Binge alcohol use past month	25.3%
Illicit drug use past month	15.3%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	2,826
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	132,215
Number of providers funded by SSA to deliver SUD prevention	5

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	17.8%
Illicit drug use (youth 12–17 years): past 30 days	15.4%
Marijuana use (youth 12–17 years): past 30 days	14.0%
Cigarette use (youth 12–17 years): past 30 days	10.5%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	33.2%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	75.1%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	63.8%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	8,948
Detoxification admissions (24-hour care)	1,499
Rehabilitation/residential admissions (24-hour care)	2,120
Ambulatory outpatient (nonintensive) admissions	5,116
Opioid replacement therapy admissions	195

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$29.1
Expenditures on SUD treatment and prevention (other than primary prevention) services	$24.8
Expenditures on SUD primary prevention[a] services	$3.5
Expenditures on infrastructure (e.g., workforce) and administration	$0.8
State funding	$7.1
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$5.4
Value of Medicaid funding managed by the SSA (if any)	$15.2
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$1.4

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Virginia Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Substance Abuse Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	6.56
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.2%
Alcohol SUD	6.9%
Illicit drug SUD	2.5%
Marijuana SUD	1.5%
Pain reliever SUD	0.7%
Youth (12–17 years) with SUD	7.0%
Young adults (18–25 years) with SUD	20.6%
Adults with SUD (26 or older)	6.2%
Binge alcohol use past month	23.2%
Illicit drug use past month	8.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	24,724
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	707,143
Number of providers funded by SSA to deliver SUD prevention	30

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.0%
Illicit drug use (youth 12–17 years): past 30 days	9.5%
Marijuana use (youth 12–17 years): past 30 days	7.2%
Cigarette use (youth 12–17 years): past 30 days	7.0%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	40.8%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	80.2%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	68.2%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	85.8%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Service

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	38,857
Detoxification admissions (24-hour care)	3,230
Rehabilitation/residential admissions (24-hour care)	4,281
Ambulatory outpatient (nonintensive) admissions	31,991
Opioid replacement therapy admissions	1,779

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	71.3%
Rate of abstinence from illicit drugs at discharge (from outpatient)	66.5%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	92.5%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	97.6%
Percentage of clients attending self-help programs at discharge (from outpatient)	41.3%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$91.1
Expenditures on SUD treatment and prevention (other than primary prevention) services	$79.0
Expenditures on SUD primary prevention[a] services	$9.1
Expenditures on infrastructure (e.g., workforce) and administration	$3.0
State funding	$47.6
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$43.0
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$0.5

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	No
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Washington Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health & Recovery

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	5.63
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.7%
Alcohol SUD	7.2%
Illicit drug SUD	2.7%
Marijuana SUD	2.3%
Pain reliever SUD	1.3%
Youth (12–17 years) with SUD	7.2%
Young adults (18–25 years) with SUD	21.1%
Adults with SUD (26 or older)	6.8%
Binge alcohol use past month	23.4%
Illicit drug use past month	11.9%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	42,759
Preventive contacts per capita made by SSA population-based SUD prevention initiatives	0.01
Number of providers funded by SSA to deliver SUD prevention	130

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.2%
Illicit drug use (youth 12–17 years): past 30 days	12.5%
Marijuana use (youth 12–17 years): past 30 days	9.6%
Cigarette use (youth 12–17 years): past 30 days	8.6%
Perception of risk from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years; percent reporting moderate or great risk)	38.2%
Perception of risk from smoking marijuana once or twice a week (youth 12–17 years; percent reporting moderate or great risk)	75.7%
Perception of risk from smoking one/more packs of cigarettes per day (youth 12–17 years; percent reporting moderate or great risk)	63.6%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	93.4%
Share of SSA SAPT prevention spending used on evidence-based practices	52.2%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons provided treatment services (unduplicated count)	37,418
Detoxification admissions (24-hour care)	12,289
Rehabilitation/residential admissions (24-hour care)	12,155
Ambulatory outpatient admissions	18,646
Opioid replacement therapy admissions	1,945

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	82.8%
Rate of abstinence from illicit drugs at discharge (from outpatient)	67.4%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	94.5%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	88.6%
Percentage of clients attending self-help programs at discharge (from outpatient)	28.7%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$158.7
Funding for SUD treatment and prevention (other than primary prevention) services	$8.7
Funding for SUD primary prevention[a] services	$143.8
State funding	$60.1
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$31.3
Value of Medicaid funding managed by the SSA (if any)	$60.5

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	Yes
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

West Virginia Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division on Alcoholism and Drug Abuse

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	1.56
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	7.1%
Alcohol SUD	5.3%
Illicit drug SUD	2.6%
Marijuana SUD	1.4%
Pain reliever SUD	1.3%
Youth (12–17 years) with SUD	6.1%
Young adults (18–25 years) with SUD	19.3%
Adults with SUD (26 or older)	5.4%
Binge alcohol use past month	20.5%
Illicit drug use past month	8.0%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	11,839
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	667,614
Number of providers funded by SSA to deliver SUD prevention	18

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	14.7%
Illicit drug use (youth 12–17 years): past 30 days	10.1%
Marijuana use (youth 12–17 years): past 30 days	7.3%
Cigarette use (youth 12–17 years): past 30 days	11.8%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	38.1%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.5%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	63.4%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	96.5%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	17,486
Detoxification admissions (24-hour care)	431
Rehabilitation/residential admissions (24-hour care)	433
Ambulatory outpatient (nonintensive) admissions	6,193
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	NA
Rate of abstinence from illicit drugs at discharge (from outpatient)	NA
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	NA
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	NA
Percentage of clients attending self-help programs at discharge (from outpatient)	NA

NA: Data not available.

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$19.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	$16.7
Expenditures on SUD primary prevention[a] services	$2.4
Expenditures on infrastructure (e.g., workforce) and administration	$0.7
State funding	$9.6
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$7.9
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$2.3

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	Yes
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	NA
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Wisconsin Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Mental Health and Substance Abuse Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	4.75
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.6%
Alcohol SUD	6.8%
Illicit drug SUD	2.4%
Marijuana SUD	1.9%
Pain reliever SUD	0.5%
Youth (12–17 years) with SUD	6.5%
Young adults (18–25 years) with SUD	18.1%
Adults with SUD (26 or older)	7.2%
Binge alcohol use past month	27.2%
Illicit drug use past month	7.8%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	632,750
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	2,692,401
Number of providers funded by SSA to deliver SUD prevention	94

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	13.9%
Illicit drug use (youth 12–17 years): past 30 days	9.3%
Marijuana use (youth 12–17 years): past 30 days	6.4%
Cigarette use (youth 12–17 years): past 30 days	8.1%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	35.6%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.4%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	65.9%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	97.5%
Share of SSA SAPT prevention spending used on evidence-based practices	100.0%

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	54,101
Detoxification admissions (24-hour care)	6,649
Rehabilitation/residential admissions (24-hour care)	2,690
Ambulatory outpatient (nonintensive) admissions	18,636
Opioid replacement therapy admissions	49

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	81.0%
Rate of abstinence from illicit drugs at discharge (from outpatient)	87.5%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	95.6%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	96.9%
Percentage of clients attending self-help programs at discharge (from outpatient)	34.9%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$34.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	$24.2
Expenditures on SUD primary prevention[a] services	$10.3
Expenditures on infrastructure (e.g., workforce) and administration	$0.1
State funding	$3.7
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$26.1
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$4.8

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	Yes
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	Yes
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	Yes
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

Wyoming Substance Abuse Profile 2013

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division Mental Health and Substance Abuse Services

Substance Use Disorder Prevalence

Characteristic	Number/%
State population12+ years (U.S. Census Bureau) in millions	0.46
Population with a substance use disorder (SUD; alcohol and/or illicit drugs)	8.3%
Alcohol SUD	7.3%
Illicit drug SUD	2.2%
Marijuana SUD	1.2%
Pain reliever SUD	0.5%
Youth (12–17 years) with SUD	6.9%
Young adults (18–25 years) with SUD	19.0%
Adults with SUD (26 or older)	6.6%
Binge alcohol use past month	22.4%
Illicit drug use past month	7.1%

SSA Substance Use Disorder Prevention Services

Characteristic	Number/%
Persons served by SSA-supported individual-based SUD prevention programs/strategies	6,696
Persons served by SSA-supported population-based SUD prevention initiatives (persons may get multiple preventive services per year, through, for example, media campaigns)	9,801,042
Number of providers funded by SSA to deliver SUD prevention	25

National Outcome Measures:

Characteristic	Number/%
Alcohol use (youth 12–17 years): past 30 days	14.0%
Illicit drug use (youth 12–17 years): past 30 days	8.5%
Marijuana use (youth 12–17 years): past 30 days	5.3%
Cigarette use (youth 12–17 years): past 30 days	11.3%
Perception of “great risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	38.2%
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	80.0%
Perception of “great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	67.1%
Percentage of parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	NA
Share of SSA SAPT prevention spending used on evidence-based practices	99.1%

NA: Data not available.

SSA Substance Use Disorder Treatment Services

Characteristic	Number/%
Persons served (unduplicated count; includes persons admitted in previous years)	9,839
Detoxification admissions (24-hour care)	0
Rehabilitation/residential admissions (24-hour care)	62
Ambulatory outpatient (nonintensive) admissions	2,076
Opioid replacement therapy admissions	0

National Outcome Measures:

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	62.9%
Rate of abstinence from illicit drugs at discharge (from outpatient)	74.1%
Percentage of clients without arrests (prior30 days) at discharge (from outpatient)	92.0%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.9%
Percentage of clients attending self-help programs at discharge (from outpatient)	30.5%

SSA Financial Data ($ in millions)

Characteristic	Number/%
Total annual budget	$42.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	$30.7
Expenditures on SUD primary prevention[a] services	$9.4
Expenditures on infrastructure (e.g., workforce) and administration	$2.7
State funding	$36.3
SAMHSA Substance Abuse Prevention and Treatment Block Grant	$3.5
Value of Medicaid funding managed by the SSA (if any)	$0.0
Funding from other sources (e.g., Federal capacity expansion grants, local governments)	$2.9

On health financing reform, has the State/SSA started:[b]

Characteristic	Response
Expanding Medicaid eligibility or establishing a health insurance marketplace?	No
Planning to use Medicaid Health Home to provide services for those with SUD?	Yes
Working with Federally Qualified Health Centers (FQHCs) on SUD services?	No
Working with other Federal agencies on integration of health with SUD services?	No
Working on workforce capacity issues to address future needs?	No
Collecting data to assess the changing needs as health financing reform progresses?	No
Participating in other redesign/transformation activities (e.g., a 1115 Medicaid waiver that addresses SUD)?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG statute, early intervention activities should not be included as part of primary prevention.

[b] Information reported from State/SSA in June 2013.

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SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities

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