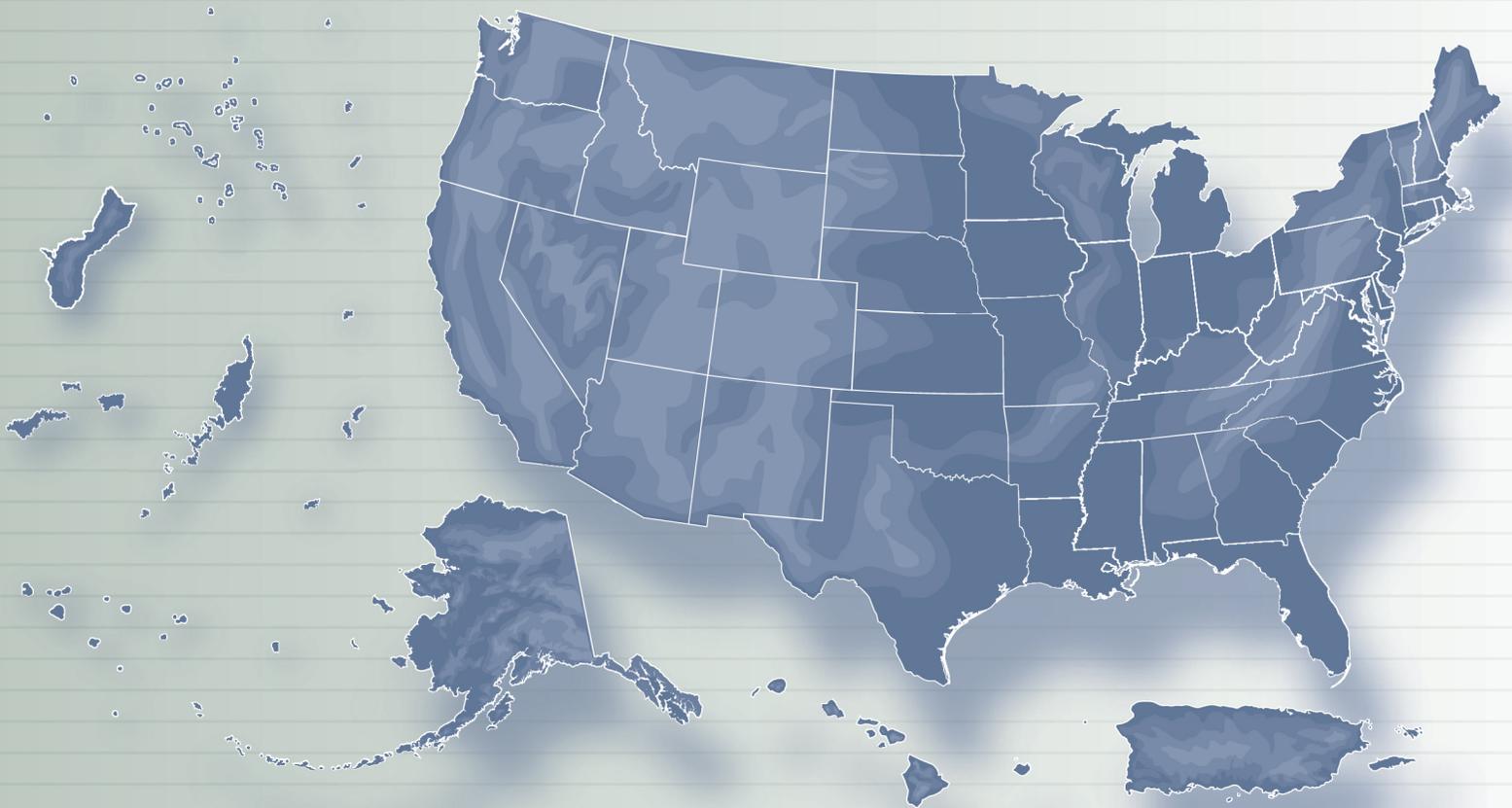


Trends

in Mental Health System Transformation

2005



The States Respond



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Substance Abuse & Mental Health Services Administration
Center For Mental Health Services
www.samhsa.gov

Trends

in Mental Health System Transformation

2005

The States Respond



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Substance Abuse & Mental Health Services Administration
Center For Mental Health Services
www.samhsa.gov

Acknowledgments

Numerous people contributed to the development of this document. The document was written by Susan Hills of the Advocates for Human Potential, Inc., and AFYA Inc., under Contract Number 280-02-0400, with Substance Abuse & Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS). Deborah Baldwin served as the Government Project Officer.

Disclaimer

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions or policies of SAMHSA or DHHS.

Public Domain Notice

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, DHHS.

Electronic Access and Copies of Publication

This publication may be accessed electronically through the following Internet World Wide Web connection: www.samhsa.gov. For additional free copies of this document, please call SAMHSA's National Mental Health Information Center at 1-800-789-2647 or 1-800-889-2647 (TTD).

Recommended Citation

Trends in Mental Health Systems Transformation: The States Respond. DHHS Pub. No. (SMA) 05-4115. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2006.

Originating Office

State Planning and Systems Development Branch, Division of State and Community Systems Development, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857

DHHS Publication No. (SMA) **05-4115**
Printed 2006

Contents

Introduction	1
Overarching Trends 2005	3
The Role of Planning Councils in State Systems	5
GOAL 1:	10
Americans Understand that Mental Health Is Essential to Overall Health	
Reducing Stigma, Raising Awareness	11
Preventing Suicide	14
Addressing Mental Health with the Same Urgency as Physical Health	16
GOAL 2:	18
Mental Health Care Is Consumer and Family Driven	
Person-Centered Planning	20
Consumer Input into System Design	21
Consumer Involvement in Service Delivery and Support	22
Protecting Consumer Rights	23
Housing for Consumers	24
Supported Employment	24
Mental Health and the Justice System	25
Creating a Comprehensive State Mental Health Plan	26
Financing Mental Health Services	27
GOAL 3:	28
Disparities in Mental Health Services Are Eliminated	
Recognizing Disparities	29
Building an Infrastructure to Support Cultural Competence	30
Addressing Consumer Needs Across Cultures	31
Reaching Rural Populations	32
GOAL 4:	34
Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice	
Promoting the Mental Health of Young Children	35
Improving and Explaining School Mental Health Programs	39
Screening, Assessment, and Referral	41
Moving Toward Integrated Services for Co-Occurring Disorders	42
Transitioning Youth to Adult Programs	45
Providing Mental Health Services to Older Adults	46
Linking Mental Health with Primary Care Services	48

cont.

Contents

GOAL 5:	50
Excellent Mental Health Care Is Delivered and Research Is Accelerated	
Planning and Guiding State Use of Evidence-Based Practices	51
Promoting Evidence-Based Practices Through Education	52
Evidence-Based Practices in Action	54
Promising and Emerging Practices	57
GOAL 6:	58
Technology Is Used to Access Mental Health Care and Information	
Using Telehealth to Improve Access and Coordination of Mental Health Care	59
Developing and Implementing Integrated Electronic Health Records	60
Providing Health Information to Consumers	61
State-Developed Resources Available to Others	63

Introduction

The Community Mental Health Services Block Grant, administered by the Center for Mental Health Services (CMHS) in the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), is awarded to States, Territories, and the District of Columbia (collectively referred to as States) to establish or expand a community-based system of care for adults with serious mental illnesses and children with serious emotional disturbances. States request funds by submitting annual applications (State Plans) that are approved by the Secretary of DHHS to receive Mental Health Block Grant funding.

In 2005, development of State Plans was guided by several intersecting factors: 1) SAMHSA's National Outcome Measures (NOMS); 2) the Office of Management and Budget's Program Assessment Review Tool (PART) score; 3) the final report of the President's New Freedom Commission on Mental Health; and 4) SAMHSA's Mental Health Transformation Action Agenda. The Commission's report, entitled *Achieving the Promise: Transforming Mental Health Care in America*, provides clear direction in the form of concrete goals and recommendations for achieving the promise of community integration that echoes SAMHSA's vision of "a life in the community for everyone." The Commission recognized that much of the work of system transformation takes place at the State and local level, using Federal resources as a catalyst for change. Indeed, States are at the very heart of mental health system transformation; their work informed, and is informed by, the work of the President's Commission.

In 2005, CMHS focused its mandated review of State Plans on the States' efforts to use Block Grant funds to address the New Freedom Commission's goals and recommendations. States are using Block Grant dollars—as well as other Federal and State funds, local resources, and private contributions—to transform the mental health service delivery system in their States from one dictated by outmoded bureaucratic and financial incentives to one driven by consumer and family needs that focuses on building resilience and facilitating recovery.

This 2005 report summarizes the activities that States are pursuing within the framework of the six goals articulated by the Commission. The report includes the following:

- A brief summary of overarching trends, including challenges States face in their transformation efforts;
- An overview of activities of the State Mental Health Planning Councils;
- Activities of the States discussed goalby goal, with 25 State programs featured in side-bars to represent accomplishments to date; and
- A table of State-developed resources listed according to goals addressed.

In addition, a companion CD to this report presents a profile for each of the States that captures key transformation activities based on the New Freedom Commission's goals. Profiles on the CD are presented both State by State and as a single comprehensive file. The search function in the comprehensive file helps users locate cross-State information, such as all States with supported employment programs.

Information in this report comes from three primary sources:

- 2005 Block Grant applications and 2004 implementation reports;
- Facilitated discussions with Federal reviewers and technical assistance staff; and
- Communication between States and the staff that compiled this report.

It should be noted that where lists of States that employ specific strategies appear, these lists are *illustrative but not exhaustive*. Because all States are involved in multiple activities related to the New Freedom Commission's six goals, it is impossible to catalogue them completely.

Activities highlighted in this report are funded by Block Grant dollars and by other resources. Each State profile articulates the ways that a State uses its Block Grant funding. Even though Block Grant funds represent a small percentage of State mental health budgets, State representatives have observed that this funding has an impact disproportionate to its size. In addition to funding State Mental Health Planning Councils, which bring diverse stakeholders together to play an often critical role, States have used these funds to support peer-operated services, evidence-based practices, pilots of promising practices, technical assistance, early intervention and prevention activities, suicide prevention, public outreach, family support, and many other crucial activities that have made a significant contribution to enhancing service quality.

Different constituents will use this report in different ways. For example, consumers and family members can use the report to understand how the goals of the New Freedom Commission report, which stress building resilience and facilitating recovery, can become reality in their communities. State mental health administrators, planners, and Planning Council members can review the State profiles to find specific evidence-based practices in which they are interested, e.g., Assertive Community Treatment (ACT) for a particular population. Local, State, and national legislators can use the report to learn more about how Federal resources are used in their States and communities to support mental health system transformation.

Whatever the specific use, this report will inform SAMHSA staff and technical assistance providers about State activities; educate State agencies, consumer groups, and providers; encourage networking among States; increase resource sharing; and aid Planning Councils in their advocacy and educational activities. Mental health system transformation is challenging work, and this report provides ample evidence that States are meeting this challenge in unique and innovative ways.

Overarching Trends 2005

Each State faces individual legislative, financial, and social constraints and uses different opportunities in its efforts to transform the mental health service delivery system. Yet they all confront similar challenges: shrinking resources, increasing needs, and a desire to provide the most effective treatments and services. A review of State activities in 2005 reveals these overarching trends:

- All States are working to move people from State psychiatric hospitals to full and productive lives in their communities. They are making progress even though in most States the lack of affordable housing is a significant barrier to timely discharge;
- The lack of financing for mental health treatment drives States to use a wide range of strategies to fund essential services. Advocacy groups lobby State legislators; agency staff apply for funding from various sources; State agencies apply for Medicaid waivers to fund specific forms of treatment; some States are working with insurance providers to encourage parity for mental health treatment; and, most notably, cash-strapped agencies are joining together to try to achieve more through partnership than they can independently;
- State agencies seek to adapt organizational structures, funding mechanisms, training, and strategic plans to promote Evidence-based practices (EBPs) as rapidly as possible. They struggle to find the balance between fidelity to a specific model and the need to address specific populations and funding circumstances. They may meet skepticism and resistance from the field. They may debate the point at which a particular strategy has crossed the line from “emerging” or “promising” to “evidence-based.” EBPs are being promoted by funders, legislators, community members, families, and the research community. Legislators want accountability for public funds; consumers want assurance of quality care; and State systems want to use limited resources as efficiently as possible to promote positive outcomes and continued support for their efforts;
- The need for effective ways to measure outcomes and share essential information across programs and agencies drives data management efforts that are becoming more and more complex. Although the rewards of such initiatives are great, the effort required to develop common definitions and to get State providers, as well as diverse agencies, working together is immense, consuming scarce staff resources;
- Most States are addressing serious workforce shortages primarily by cultivating close working relationships with universities and other institutions that train providers. Many states also fund internships and offer scholarships;

- More States are working in partnership with consumers as they plan, deliver, and assess mental health care. Asked to identify the most striking transformation underway in their mental health systems, many States pointed to the increasing influence of consumer groups in shaping the treatment system. Consumers and their family members influence State legislatures, analyze programs and trends, provide services, review feedback from treatment recipients, and enhance system resources by serving as mentors and guides;
- Many States have reorganized human service departments to allow agencies with related missions to work more closely together. The silos are coming down. In several States, substance abuse and mental health agencies are now in the same division, facilitating integrated care for consumers with co-occurring mental and substance use disorders. Statewide interagency task forces and high-level coordinating bodies are universal. With resources shrinking, agencies have succeeded in setting aside rivalries to provide collaborative systems of care, especially for the benefit of children with serious emotional disturbances and their families;
- There is widespread awareness and acceptance of New Freedom Commission goals in most States. Many Planning Councils find them helpful in their advocacy work and as they set their own priorities. State mental health agencies and consumer advocacy groups also use them frequently as touchstones for progress. The Commission's report often is used as a framework for communicating systemic needs and priorities to legislators, lending weight to locally driven initiatives;
- States are engaged in developing effective transition programs for youth who are ready for adult programs. These efforts include collaboration across agency lines to provide job opportunities and essential support;
- States are better able each year to capitalize on the opportunities technology offers to disseminate critical information and expertise to wider audiences more cost effectively. Information about mental illnesses and available treatments routinely is disseminated statewide and nationally by means of the Internet; and
- States are exploring the use of telemedicine to meet pressing treatment needs. Especially common is the practice of making psychiatrists available by teleconference in rural areas that have severe workforce shortages.

The Role of Planning Councils in State Systems

State Mental Health Planning Councils are required to conform to certain membership requirements and to perform specified duties. Membership must include representation from principal State agencies, such as Education and Medicaid; other public and private entities with mental health-related missions; consumers and family members; organizations that represent consumers and family members; and advocacy groups. At least half the members must not be either State employees or providers of mental health services.

The Planning Council is required to:

- review State Mental Health Plans and submit recommendations for modification to the State;
- serve as an advocate for adults with serious mental illnesses, children with severe emotional disturbances, and other individuals with mental illnesses or emotional problems;
- monitor, review, and evaluate the allocation and adequacy of mental health services within the State at least once each year; and
- work to improve mental health services within the State.*

Membership

Most Planning Councils include between 20 and 50 members (fewer than 10 Planning Councils have fewer than 20 members and fewer than 5 have more than 50). In many States, Planning Council activities are undertaken by subcommittees, which can include other interested parties. In Kansas, which is atypical, this structure involves more than 200 people through subcommittees and up to 500 on task forces.

Often, task forces are formed to address emerging issues. For example, in Maryland, members of the Joint Council participated in several ad hoc committees, including a committee to review and comment on the State's proposed restructuring of the system of hospital care and another to comment on Maryland's Blueprint for Children's Mental Health.

Many States exceed Block Grant requirements for non-State employee/non-provider Council membership. In more than a dozen States this membership on the Planning Council exceeds 55 percent. In Wyoming, for example, 71 percent of the 35-member Planning Council represents primary consumers, family members, and others who are not providers or State employees; among Idaho's 46 members, the proportion is 74 percent.

* See Block Grant application, pp. 21-24; references in Sections 1914(b) and 1914(c) of the Public Health Service (PHS) Act.

Many States give special emphasis to ensuring strong consumer voices, especially representation for children with serious emotional disturbances, on the Planning Council:

- In **South Dakota**, specific consumer membership “slots” are reserved for family members of children with severe emotional disturbances in early childhood, elementary school, and high school to ensure that issues throughout childhood are addressed;
- **Minnesota** supports consumer representative members by providing per diem and reimbursements for child care and travel costs. A consumer serves as the Chair of the Minnesota State Advisory Council on Mental Health;
- The **Illinois** Mental Health Planning and Advisory Council, which has 31 consumers, among its 53 members, recruits and selects its own new members—thus ensuring that consumer voices are represented in the composition of the Council as well as in its deliberations; and
- In **Nebraska, New Jersey, Ohio, South Dakota, and Wisconsin**, consumers and family members comprise at least 50 percent of Planning Council membership.

Some States have invited young consumers to represent their age group’s interests on the Council:

- In **Ohio**, two youth members are included on the Planning Council;
- A transition-age youth serves on the Planning Council in **South Dakota**; and
- **Utah** has recently added a youth voice to its Council.

Other States develop specific strategies to garner youth input. **Ohio**, for example, is planning a youth focus group to solicit input from youth on mental health services in the State.

Shaping Mental Health Services

Planning Councils have assumed a broad and diverse portfolio of responsibilities, which include and often exceed mandated roles. Planning Councils throughout the United States educate local and State legislators on mental health issues; they also advocate for legislation to address those issues. To stay abreast of legislative initiatives and opportunities, **Indiana’s** Mental Health Planning Council includes legislative updates in each meeting. Many councils work intensively when the State legislature is in session. For example, **West Virginia’s** Council sponsored a Legislative Day with the theme, “Resilience, Recovery, and Rehabilitation.” Information sheets were distributed to legislators to inform them of the accomplishments and challenges

faced by the **West Virginia** system and to educate them on the meaning of these key terms.

A council's advocacy efforts are often influential. In Missouri, for example, the Community Psychiatric Services State Advisory Council was instrumental in the passage of parity legislation. In **North Dakota**, advocacy by the Planning Council helped to forestall plans to co-locate a women's prison within a State psychiatric hospital. (The Planning Council felt the association between a prison and a psychiatric hospital would worsen the stigma around mental health care.) Legislative advocacy and education efforts in other States addressed a variety of topics, including Medicaid capitation and other funding for mental health care, child custody relinquishment, housing, and consumer rights.

In meeting their obligation to monitor, evaluate, and report on mental health services with the State, Planning Councils issue a variety of documents, many of which are available to the public:

- The **California** Mental Health Planning Council prepared a report entitled *California Mental Health Masterplan: A Vision for California*, which is available at www.dmh.ca.gov/MHPC/masterplan.asp; and
- A workgroup formed by **Connecticut's** State Mental Health Planning Council has focused specifically on services for transition-aged youth, providing recommendations for system improvement and age-appropriate services in its *Final Report on Transition Services (FY 2004)*.

Planning Councils also comment on funding decisions, sometimes participating directly in the dissemination of certain targeted funds:

- In the **Federated States of Micronesia**, the Substance Abuse and Mental Health Council reviews and evaluates competitive applications for substance abuse and mental health grants;
- The **Nevada** Mental Health Planning Advisory Council (MHPAC) supports consumer involvement in the mental health system by awarding funds to community-based services that benefit consumers directly, including consumer education and training programs. MHPAC also has funded a leadership academy for consumers, a staff exchange program between a mental health and primary health care clinic, and a peer recovery program for people with serious mental illnesses who are homeless; and
- In the **District of Columbia**, a Project Review Committee comprised of three State Mental Health Planning Council members and three staff from the Department of Mental Health reviews all proposed projects and makes recommendations to the Director.

The recommendations of the President's New Freedom Commission have been directly adopted as a working framework or explicitly addressed by most Planning Councils. For example, the **Minnesota** Mental Health Planning Council has created a Mental Health Action Group with the goal of transforming the mental health system in the State. (Information on their activities is available at www.citizensleague.net.)

Education and Training

Increasing knowledge and awareness of mental health issues is a priority of many Planning Councils. Activities to educate the general public about mental health, mental health services, and/or the CMHS Block Grant were undertaken in **Guam, Maine, Washington**, and other States. Planning Councils in several States also supported education and training activities targeting advocacy groups or providers. Here are some examples:

- **Guam's** Council has taken the video *Inside Outside* (SAMHSA funded and produced) "on the road" as part of a community awareness and anti-stigma campaign;
- **Maine's** Council sponsored three regional Block Grant Forums to educate the public, particularly consumers and family members, regarding the CMHS Block Grant and to elicit comments and response to both the planning process and the application itself; and
- **Maryland's** Joint Council annually cosponsors a seminar with the Mental Health Association for individuals who are members of local mental health advisory committees to help them review services in their communities and advocate for development and modification where needed.

Planning Councils also undertook efforts to further educate their own members about mental health issues. Technical assistance and training activities have been undertaken in several States, including **American Samoa, Arkansas, Florida, Iowa, North Carolina, Ohio**, and **South Dakota**; others, such as **Utah**, have identified the need for training as an important next step in improving the effectiveness and function of their Planning Council.

Topics of Concern

The Planning Council of each State plays a central role in identifying and bringing attention to topics of concern specific to their State. The following are among specific areas of concern highlighted by councils:

- Mental health concerns in the criminal justice system;
- Mental health services for children and youth, including the transition from children's to adult systems of care;
- Co-occurring disorders;

-
- Mental health services for elderly persons;
 - Olmstead requirements;
 - Cultural competence; and
 - Recruitment of mental health professionals.

GOAL 1

Americans Understand that Mental Health Is Essential to Overall Health

Significant barriers to mental health treatment include the stigma surrounding mental illness and the lack of awareness that effective mental health services are available and can make a difference. Overcoming these barriers is especially urgent in addressing suicide, the leading cause of violent death worldwide and the 11th leading cause of death among Americans. However, access to mental health care and funding (both public and private) for care are also major challenges.

The New Freedom Commission made two recommendations to address these challenges:

- 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.
- 1.2 Address mental health with the same urgency as physical health.

THE STATES RESPOND

Reducing Stigma, Raising Awareness

States are committed to reducing stigma surrounding mental illnesses and emotional disturbances and raising awareness about the availability and effectiveness of mental health treatment, and they address these issues in a variety of ways. Several States have sponsored public education efforts that place mental health consumers at the heart of the message. Some have produced documentaries, others use public media campaigns, others reach people through speakers and the arts, and still others provide training. In Virginia, Planning Council members report that consumer-run services have contributed to reducing stigma. They have helped change attitudes toward mental illness among consumers, providers, and the public.

Documentaries

- In **Idaho**, mental health consumers collaborated with **Idaho** Public television to produce a documentary on mental illness called *In Your Own Voice*. This documentary is available for purchase at www.idahoptv/productions/ownvoice.
- *Hearts and Minds*, a documentary on teens and mental illness produced by the **Idaho** Department of Health and Welfare and **Idaho** Public Television, was awarded an International Peabody Award.
- In cooperation with a local film company, the Children, Youth and Families Department of **New Mexico's** Department of Health created an Emmy Award-winning documentary, *See Mommy Cry*. Its purpose was to educate the public on the nature and scope of domestic violence and its effect on families, especially children. The 1½ hour television documentary aired during prime time. Related educational videos for “pathway communities” (legal, law enforcement, faith, and education) and a 30-minute follow-up program to the original documentary were also developed.
- *In Our Own Voice: Living with Mental Illness*, a program that presents an example of recovery from the point of view of an individual living with mental illness, has been presented at numerous community groups in **South Dakota** as a means of reducing the stigma surrounding mental illness.



Nebraska's Project Relate is a public relations effort aimed at reducing the stigma surrounding mental illness. Posters, ads, and brochures are used to publicize a Web-based clearinghouse of resources.

Public Education and Media Campaigns

- The National Alliance on Mental Illness, the Kim Foundation, **Omaha** Federation of Advertising, Catholic Charities, Lutheran Family Services, and other organizations collaborated in the development and support of Project Relate, a public relations effort aimed at reducing the stigma surrounding mental illness. They provide a Web-based clearinghouse of resources for mental health consumers, their families, and community members. In Nebraska, Project Relate Campaign activities included public service advertisements on television and radio, print ads, brochures, billboards, and posters. Information on Project Relate is available at www.projectrelate.org.
- Consumer groups and consumer advocacy groups often are active in promoting anti-stigma campaigns (examples include **Kentucky, Maryland, Minnesota, North Carolina, Rhode Island, Vermont, and Wyoming**). The specific groups that take the lead differ from State to State: NAMI chapters are particularly active in these efforts in **Virginia** and **New Mexico**, while **Michigan's** Clubhouse Programs take the lead in that State. **Maine, Pennsylvania, and South Carolina** are among the States that provide funding to consumer groups especially for anti-stigma and public education efforts.
- Public education and media campaigns also have been undertaken in **Alabama, Alaska, Guam, Louisiana, Michigan, New York, North Carolina, and South Carolina**. In **Puerto Rico** and **Delaware**, radio public service announcements were developed to provide public education and increase public awareness of mental illness and mental health services. State governments contribute by recognizing Mental Health Awareness Month in **Kansas, Wisconsin, and Delaware**; Mental Illness Awareness Week in **Kansas**; and Children's Mental Health Awareness Week in **Alabama**. Some States are fortunate to have high-profile support in their efforts: **Idaho's** First Lady participates in public education efforts, as does the First Lady of **Palau**, who is also a member of the International Women Leaders for Mental Health.
- To encourage and reward anti-stigma efforts, **Washington's** Planning Council has instituted "Way to Go" awards to recognize individuals who have contributed to reducing stigma for mental illness. Other awards have been made to several newspaper reporters for their contribution to reducing stigma about mental illness. Stories have included topics such as promoting insurance parity for mental illness, the need for services for people with mental illnesses in jail, and mental health services for children.

Hope for Tomorrow (Utah)

Speakers and the Arts

- Several States have used the arts to reach the public with information about mental illness. In **Michigan**, published consumer success stories and theatre troupes reach the public. **South Carolina** hosted an Art of Recovery showcase of art by people with mental illnesses.
- **Kansas** supports a Consumer Speakers Bureau on mental health issues.

Training

Another avenue for defeating stigma and raising awareness is training for service providers, especially those who are not mental health professionals. For example, the **Commonwealth of the Northern Mariana Islands** will be undertaking significant training efforts in 2005, targeting first responders (i.e., police officers, paramedics, firefighters, and the Community Health Center Emergency Room Department), paraprofessionals, and other health professionals.

Special Topics, Special Targets

In several States, public education is targeted to benefit high-risk groups. For example, **Iowa** recognizes the increased stigma that surrounds mental illness in many rural communities and funds indigenous workers to conduct outreach in rural areas. **Massachusetts** is focusing on reducing stigma among older adults, and **Louisiana** and **New Mexico** support special efforts to raise awareness of the importance of infant mental health.

Youth are being reached in many ways.

- The Kids on the Block puppet troupe has visited hundreds of thousands of school children in **Tennessee** and **Maryland**.
- **North Carolina** hosted a Stomp Out Stigma Youth Rally and is piloting anti-stigma campaigns in seven school districts.
- **Tennessee** advanced an “Erase the Stigma” campaign for children and youth. It also has developed a course for middle and high school students along the lines of “Mental Health 101.”
- **South Carolina** hosts a Teen Matters Web site (www.teen-matters.com) with information for adolescents on stress, depression, suicide, eating disorders, and similar issues. The Web site has had more than 470,000 hits since it went online in 2000.
- In Hawaii, children’s mental health is the topic of education and awareness materials developed in four languages for the general population.

After a startling statistic was disclosed by Salt Lake City’s East High School’s principal at a Parents, Teachers, and Students Association (PTSA) meeting—the school had at least one suicide each year for 12 years—the PTSA sought help to stop these tragic deaths. Funded in part with Block Grant funds, the Hope for Tomorrow program (HFT) was developed to help educate students, teachers, and families about mental health issues. Now available in 27 schools, HFT has been presented to more than 33,000 students, 1,700 teachers, and 3,000 parents, with plans to go statewide.

The program’s curriculum educates teachers, administrators, parents, and students about mood disorders, eating disorders, and addictive disorders. Delivery methods include in-class assemblies, parent forums, teacher inservices, and a student lunchtime forum.

Paul Hansen, the principal at Olympus High School in Salt Lake City, has said, “I was not sure what to do,” referring to a suicide at his school, “but I did know that to do nothing was wrong, so we embraced the Hope for Tomorrow program and we are grateful we did.”

For more information, contact:

Vickie Cottrell, NAMI Utah,
(801) 323-9900, (877) 230-6264 (toll-free), education@namiut.org.



National Suicide Prevention Lifeline

1 800 273-TALK (8255)
TTY: 1 800 799-4TTY (4889)

West Virginia's HOTT Coalition seeks to prevent teen suicide by enabling the public to recognize symptoms of depression and other precursors of suicide attempts.

Preventing Suicide

Preventing suicide has become priority for many States. A great number of States have developed task forces or coalitions specifically charged with planning and/or coordinating suicide prevention initiatives. These States include **Alabama, Alaska, Colorado, Connecticut, Florida, Georgia, Idaho, Massachusetts, New Hampshire, Oklahoma, Tennessee, and Washington**. Other States (**Arizona, the Federated States of Micronesia, Minnesota, and Nevada**) are just beginning their efforts. **Colorado** has a State Office for Suicide Prevention, and many States have State Suicide Prevention Plans in place. **Alaska, Mississippi, and South Dakota** are developing State plans.

Some States make a point of encouraging local-level suicide prevention initiatives. For example, **Alaska's** Community-Based Suicide Prevention Program provides support and assistance to communities to help them develop and implement their own locally designed projects to reduce self-destructive behavior and suicide and to increase individual, family, and community health. Assistance is in the form of grants, training, and a support and information network. **Ohio** operates a similar system of locally based efforts.

Hotlines or crisis lines are among the most common interventions for suicide prevention. These support lines operate in most States, including **Colorado, Guam, Kentucky, Louisiana, Missouri, the Commonwealth of the Northern Mariana Islands, and Tennessee**.

**Hotlines or crisis lines
are among the most
common interventions
for suicide prevention.**

SPEAK: A Suicide Prevention Kit (New York)

Training—for law enforcement personnel, educators, family service workers, criminal justice staff, and others—is another important and widely shared intervention. Training programs are planned or underway in Kentucky, the **Commonwealth of the Northern Mariana Islands, Puerto Rico, Tennessee, and Washington**. The **Tennessee** Suicide Prevention Network has developed training to help providers adopt effective suicide prevention strategies. Applied Suicide Intervention Skills Training (ASIST) is a 2-day, train-the-trainer module, and Question, Persuade and Refer is a train-the-trainer module that can be conducted in one day or less.

Public education efforts focused on suicide awareness and prevention are underway in **Arizona, Colorado, and Virginia**. As with stigma reduction efforts, some States have targeted particular audiences for suicide prevention activities. Given the dramatic rise in teen suicide, a number of States have focused on youth. These include **North Carolina, American Samoa, Alaska, Connecticut, Massachusetts, New Hampshire, New Jersey, the Federated States of Micronesia, West Virginia, and Utah**.

Other States, such as **Georgia and Maine**, focus their suicide prevention efforts on older adults. **Florida and Nevada** have used the Gatekeeper model for suicide prevention. In **Oregon**, the Department of Human Services' Public Health Unit has published and distributed *The Oregon Plan for Reducing Suicides in Older Adults*. This document provides a statewide older adult suicide prevention plan and is available for other States to review. Contact Sandra.Moreland@state.or.us.

These are some of the resources for suicide prevention that States have developed:

- A training video called *Students at Risk for Suicide—Assessment and Interview Techniques* developed with the help of University of Medicine and Dentistry of **New Jersey's** Technical Assistance Center, presents realistic scenarios between school clinicians/counselors and students at risk. More information is available through Val Casey, Division of Children's Behavioral Health Service, (609) 777-0740, val.casey@dhs.state.nj.us; and
- The Southeast **Nebraska** Suicide Prevention Curriculum, developed with the University of **Nebraska**, provides suicide awareness and prevention training for the general public and key helpers. The core curriculum is available in English and Spanish. Modules designed specifically for law enforcement personnel, health care personnel, clergy, and educators are also available. For more information and to download the curriculum, see www.neb-hands.nebraska.edu/Resources.htm#suicide.

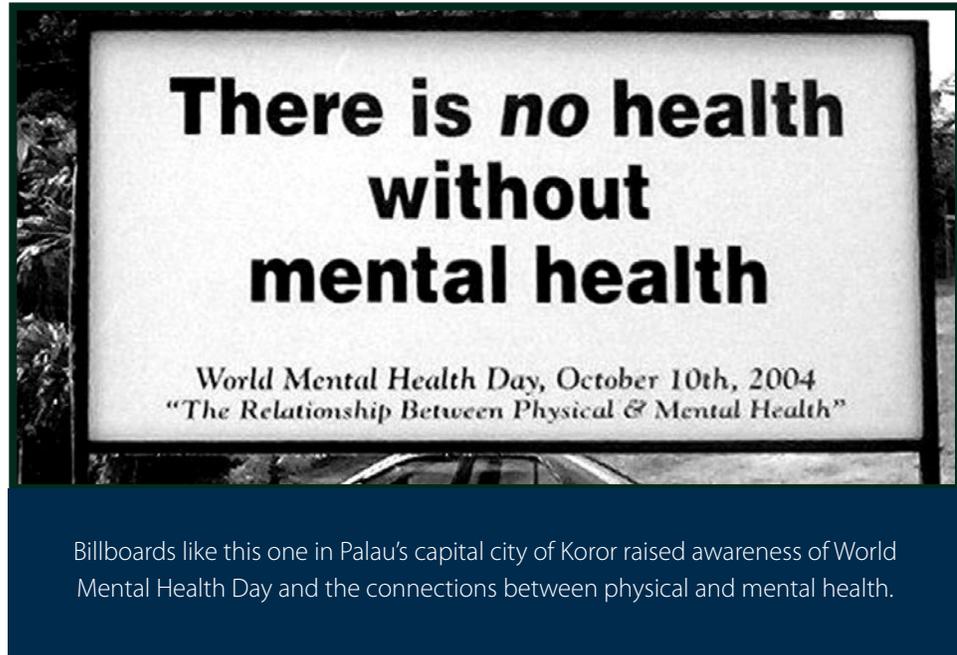
The Suicide Prevention Education and Awareness Kit includes information to help everyone understand the frequency and toll of suicide, and to discover ways and methods to help prevent it. The kit provides information about suicide and suicide prevention, the risk factors and the warning signs, resources about how to seek help for oneself or how to help others, and a poster. The kits include specific information about men and depression; women and depression; older adults, depression, and suicide; teen depression and suicide; facts about suicide; telephone hotlines across the State; and other information, all of which is accessible from the Web site.

The primary goal of the SPEAK education and awareness campaign is to reduce suicide in New York State. But the program also has the important secondary goal of reducing the stigma associated with getting help for emotional problems or mental illness.

For a free copy of this kit, contact:

The Office of Mental Health
Community Outreach &
Public Education Office,
44 Holland Avenue,
Albany, NY 12229,
(866) 270-9857 toll-free.

Also see the Web site at
www.omh.state.ny.us/omhweb/speak.



Billboards like this one in Palau's capital city of Koror raised awareness of World Mental Health Day and the connections between physical and mental health.

Addressing Mental Health with the Same Urgency as Physical Health

Two barriers to addressing mental health with the same urgency as physical health are the stigma associated with mental illness and mental health treatment, and the lack of access to care or funding for that care.

To decrease the stigma associated with mental health care, **Georgia, Puerto Rico, Rhode Island, Tennessee, and Washington** support integrative or collaborative efforts between primary care and mental health care providers. **Nevada** supports staff exchanges between medical and mental health providers. In **Washington**, the Mental Health Division and the Medical Assistance Administration sponsor community forums at which mental health and medical providers meet, learn about one another's services, and are encouraged to work together locally on behalf of their clients.

To promote equality in the treatment of both illnesses, **Alabama** and **Illinois** have passed legislation to create health insurance coverage. Preliminary data from **Alabama**, which passed its legislation in 2001, indicate that overall health costs were lower for those enrolled in plans with mental health parity than for those enrolled in other plans. **Iowa** also is working on parity legislation. **North Dakota** is encouraging Blue Cross/Blue Shield to provide parity in its coverage.

GOAL 2

Mental Health Care Is Consumer and Family Driven

The New Freedom Commission recognizes that the current mental health care delivery system is fragmented and overwhelmingly complex. Adults with serious mental illnesses and children with serious emotional disturbances come in contact with many different—and often disparate—systems, including mental health centers and hospitals, criminal and juvenile justice facilities, homeless shelters and child protective services, and the education system. The New Freedom Commission envisioned a coordinated mental health care delivery system that places consumers at its center.

At the consumer level, this orientation would be evident in individualized plans of care that address the true breadth of any person's life, including the need for stable housing and the desire for employment and educational success. At the programmatic level, a "no wrong door" approach would increase the ability of States and systems to meet the needs of citizens, whether they enter the system through a homeless shelter, a welfare office, a community-based mental health clinic, a school, or even a jail. At the system level, a consumer-centered approach would be manifested in funding structures that increase consumer choice and control. Such a system would be infused with a focus on recovery.

In order to develop and implement this vision, the New Freedom Commission made five recommendations:

- 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.
- 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.
- 2.3 Align relevant Federal programs to improve access and accountability for mental health services.
- 2.4 Create a Comprehensive State Mental Health Plan.
- 2.5 Protect and enhance the rights of people with mental illnesses.

O.T.H.E.R.S. Youth Group**(Massachusetts)****THE STATES RESPOND**

The concept of a mental health system with consumers at its center has been embraced in States across the Nation. Adults with serious mental illnesses, youth with serious emotional disturbances, and families of children with serious emotional disturbances have been invited into the development, implementation, delivery, and evaluation of mental health care across America through a broad range of strategies:

- Person-centered planning;
- Consumer input into system design; and
- Consumer involvement in service delivery and support.

States protect and promote the rights of mental health consumers through several strategies:

- Reducing or eliminating the use of seclusion and restraint;
- Providing mental health services in the least restrictive setting through development of community-based services, affordable housing, and supported employment; and
- Reducing consumers' involvement in the criminal justice system

Through Comprehensive State Mental Health Plans, States have been improving the coordination and integration of services. Finally, States have been creative in identifying new funding sources and finding ways to control costs.



The O.T.H.E.R.S. (Other Teens Help Everybody Respect Self) have fun while fighting stigma. Together, they created a powerful public service announcement focused on mental health issues for teens.

Teen recipe for success: introduce 10 really talented, creative, and energetic teens to one equally talented, popular disc jockey. Mix them together and throw in a full-day recording session at the radio station and the results are the creation of a very effective and moving public service announcement (PSA) geared toward teens struggling with various mental health issues in their lives, a PSA that won national recognition with a SAMHSA ECCO award.

In 2001, this group of teens officially became the O.T.H.E.R.S. (Other Teens Help Everybody Respect Self) Youth Group, a youth-driven group of teens that keep themselves busy by having fun while fighting stigma. O.T.H.E.R.S. is open to any teen, age 13 or older, who wants to make a difference by raising awareness. The group includes teens who are struggling with their own mental health needs, siblings, and friends. The group meets twice a month, with the teens generally setting the agenda.

Recently, a "spin-off" has formed: two members, a parent, and a social worker have joined together to run biweekly meetings for siblings of brothers and sisters with mental health needs. Activities, crafts, food, and fun provide a safe atmosphere to talk about being a sibling and all the issues that complicate it.

For more information, contact:

Rina Cavallini, (508) 767-9725,
rcrav@msn.com.

Person-Centered and Family-Centered Planning (Michigan)

Michigan mandates a person-centered planning process for adult mental health services and a family-centered planning process for children's mental health services. Individuals and families must be involved in the development of the individual plan of service, and their goals must be incorporated in that plan.

The Department of Community Health (MDCH) provides training to Community Mental Health Services Programs (CMHSPs) on person-centered and family-centered planning. A manual, *Planning for Yourself*, was developed with national expert Michael Smull and is used by several counties. A grant from the Robert Wood Johnson Foundation allowed four communities to pilot the family-centered training across all systems and sectors serving children and families; three additional communities have piloted the project since. CMHSPs are encouraged to focus on family-centered planning and practice, which is also integrated into the protocol used by MDCH site review teams.

For more information, contact:

Pamela Werner, Consumer-Directed Home & Community-Based Services Specialist,
(517) 335-4078,
wernerp@michigan.gov.



A consumer-run Pilates class is offered as one of a varied menu of Healthy Activities provided through Interact of Michigan, a program founded with support from the Michigan Department of Community Health. Participants report an increased sense of well-being after participating in healthy activities.

Person-Centered Planning

Several States have mandated person-centered planning in their mental health systems. Through contracts with community-based mental health clinics, department regulation, or even State statute, **Arkansas, Florida, Indiana, Iowa, North Carolina, and Ohio** are among the States that require consumers to be involved in and at the center of their treatment plans. Twenty-nine other States have either implemented individualized service plans directly or have done so through the adoption of Wellness Recovery Action Plans (WRAP) for adults with serious mental illnesses and wraparound systems for children with serious emotional disturbances.

Alabama, Connecticut, Illinois, Michigan, and Mississippi are among the States that have recently conducted training in person-centered planning. **Oregon** conducted training for consumers on how to facilitate the development of person-centered planning.

A growing number of States explicitly have identified recovery as the ultimate goal and central purpose of treatment, whether through the adoption of WRAP principles and processes or by other means. **Colorado, Florida, Georgia, Kentucky, Missouri, and Texas** are among the States that have fully adopted recovery principles. **Arizona, Kansas, Vermont, and Wisconsin** are advancing recovery principles through training and conferences.

Consumer Involvement in the Mental Health System (Maine)

“Consumer and family members bring us back to reality with their focus on ‘How are the consumer and family able to access appropriate care?’ In 1998, we opened our Medicaid formulary to include atypical (anti-psychotic) medications and SSRIs (anti-depressants) due to consumer and family pressure. They also keep housing on the front burner.”

Mental health planner, Department of Mental Health and Developmental Disabilities
(Tennessee)

Consumer Input into System Design

States have moved to engage consumers not just at the level of their own treatment plans, but also in the development of mental health systems. In addition to their mandated roles on State Mental Health Planning Councils, consumers often serve on a variety of advisory committees and oversight groups where their input can have real impact on system design and development. **Kentucky, Massachusetts, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, Oregon, South Carolina, and Washington** are among the States with local, regional, or statewide Consumer Advisory Groups. **Alabama, Arkansas, Louisiana, Montana, Virginia, and Wyoming** are among those that include consumers in planning activities. Other States ensure and strengthen consumer input in the following ways:

- In **South Dakota**, consumers serve on mental health program accreditation review teams and participate in provider trainings;
- In Idaho, providers are required to receive annual training from the family members of children with serious emotional disturbances;
- Regional Mental Health Boards in **Idaho** and **Virginia** include consumer representatives;
- **Maryland** provided consumer training to facilitate consumer participation in State and local policymaking. **Missouri** provided legislative advocacy training for consumers;
- More than 10,000 **New York** State consumers were involved in the development of a white paper: *Infusing Recovery-Based Principles into Mental Health Services*; and
- In **Ohio**, consumers serve on the Strategic Advisory Committee charged with addressing the recommendations of the New Freedom Commission.

Maine’s Office of Consumer Affairs (OCA) employs three full-time regional staff members. They facilitate consumer input in such areas as program development, implementation, and evaluation; training; contract management; development of policy regulations; and system advocacy. Specific activities include:

- Collaboration with the Advocacy Initiative Network of Maine to develop a statewide WRAP program;
- Sponsorship of 20 scholarships for the WRAP Correspondence Course, a prerequisite for facilitator training;
- Quarterly networking and training meetings for WRAP facilitators;
- Quarterly Regional Consumer Forums that offer an opportunity for Adult Mental Health Services staff to hear from consumers. Each forum addresses a topic related to quality improvement; and
- Bimonthly leadership meetings in each region that provide an opportunity for information sharing between representatives of consumer-run programs and the director/coordinator.

For more information, contact:
Katharine Storer, OCA,
(207) 941-4788,
Katharine.Storer@Maine.gov

**Peer Support Specialists
(South Carolina)**

South Carolina is implementing Peer Support, a service based on a person-centered model with a recovery focus developed by the State of Georgia. Consumers are certified as Peer Support Specialists and, under the supervision of a mental health professional, work with clients as specified in the client’s individual recovery plan. A Peer Support Specialist is a self-identified individual with a diagnosed mental illness who delivers mental health services to other adult consumers. The goal of this service is to facilitate a person’s recovery by offering hope that recovery is possible. Peer specialist training was offered in State Fiscal Year 2004, and community mental health centers (CMHCs) are now beginning to offer peer support services. Thus far 26 Peer Support Specialists have received training and have been certified. The 2004 State Plan goal was to have peer support services in six CMHCs; this goal has been exceeded. To date, 12 CMHCs have hired 22 of the certified Peer Support Specialists to offer services. South Carolina is the third State in the country to have Peer Support as a Medicaid-billable service.

For more information, contact:

Katherine Roberts,
Director, Consumer to Consumer
Evaluation Team
(803) 234-4200,
KMR50@SCDMH.org.

Also see :

www.state.sc.us/dmh/consumer_resources/consumer_resources.htm.



Consumer Involvement in Service Delivery and Support

In a variety of positions and with varying titles (for example, Consumer Service Assistants in **Nevada**, Peer Support Specialists in **South Carolina**, and Peer Outreach and Engagement Specialists in **Connecticut** and **Georgia**), consumers provide mental health services from a peer perspective and help other consumers navigate the mental health system.

Consumers also act as peers, mentors, supports, and role models as they operate consumer-run organizations throughout the States. Consumer-run organizations fill important roles in the service delivery system in more than 30 States. Many States provide funding for these organizations, and a number of States—including **Kentucky, Maine, Maryland, Texas, Utah, Virginia, and Wyoming**—offer training for consumers or for consumer-run organizations. **Rhode Island** is currently collecting outcome data on two peer counseling sites operating in that State.

In **Massachusetts** and **New Hampshire**, innovative and award-winning youth leadership and peer groups are promoting mental health for young people.

Consumer-Operated Services Grant Program (Texas)



Protecting Consumer Rights

The majority of States have offices of consumer affairs or staff positions dedicated to protecting and promoting the rights of mental health care consumers. **Palau** and **Kentucky** developed and distributed brochures to inform consumers about their rights within the mental health system. **Maryland** and **North Carolina** have conducted presentations and trainings for consumers on the mental health system. In **Rhode Island**, a database of consumer complaints is currently being analyzed, and findings will be used in future planning.

Reducing or eliminating the use of seclusion and restraint is central to any consideration of consumer rights within the mental health care system. **Florida, Louisiana, Nevada, New Jersey, Oregon, Palau, and Wisconsin** are among the States seeking alternatives to seclusion and restraint.

Providing mental health services in the least restrictive setting, another central tenet of consumer rights, may require further development of community-based services, support for affordable housing to allow consumers to live in the communities where services are provided, or both. **California, Guam, South Carolina, Virginia, and Washington** are among the States seeking to expand community-based services, especially for those in transition from residential to community-based care.

Targeted efforts to provide community-based services for children with serious emotional disturbances are underway in **Colorado** and **New York**, while **Wisconsin** focuses on providing community-based services to nursing home residents. A “foster home” model of Family Care in **Colorado** supports consumers who are ready to leave inpatient care but lack community-based supports.

In 2003, Texas began a unique grant program to stimulate and support the growth of local consumer-directed, consumer-operated organizations, providing peer support and other services to the mental health population. The Texas Department of State Health Services contracts with Texas Mental Health Consumers, a statewide consumer-directed, consumer-operated education and advocacy organization, to oversee the grant program.

The program uses a 5-year, incremental funding methodology. Interested groups must first apply for and be granted an establishment grant. Once a group has demonstrated it can successfully manage this \$1,500 grant, it can reapply in subsequent years for either a \$24,000 development grant or a \$65,000 sustainability grant. Targeted technical assistance at each funding level is designed to create viable organizations capable of managing contracts and producing deliverables.

For more information, contact:
Mike Halligan, Executive Director,
Texas Mental Health Consumers,
(512) 451-3191.

Seclusion and Restraint Initiative (Nevada)

In August 2003, Nevada's Division of Mental Health and Developmental Services (MHDS) began working with other agencies and stakeholders on an initiative to reduce and ultimately eliminate the use of seclusion and restraint in facilities that currently use these techniques when individuals pose a danger to themselves, others, or both. This initiative requires staff to develop new policies and procedures, forms, training formats, and data reporting.

During 2004, MHDS continued to work with the National Technical Assistance Center for State Mental Health Planning (NTAC) to provide statewide and regional training in the reduction and elimination of seclusion and restraint. In collaboration with NTAC, MHDS hosted two Western regional meetings in September 2003 and June 2004 in which key program providers and policymakers from seven Western States met in Las Vegas to review exemplary practices. MHDS data indicate a consistent decrease in the use of seclusion and restraint in Nevada.

For more information, contact:

Kevin Crowe, Ph.D.,
Chief of Planning and Evaluation,
(775) 684-5984.

Housing for Consumers

To overcome the barrier that housing presents to mental health care, some States provide transitional housing directly, as do the **Federated States of Micronesia**, the **Commonwealth of the Northern Mariana Islands**, **West Virginia**, and **Utah**; others provide rental assistance or housing subsidies for consumers to live independently, as do **Delaware**, **Minnesota**, **Nebraska**, **North Carolina**, **Oklahoma**, **Tennessee**, and **Vermont**. **Alaska**, **Mississippi**, **North Dakota**, **Tennessee**, and **Wisconsin** are among the States seeking to develop new housing. **Indiana**, **Nebraska**, **Ohio**, and **South Carolina** have all undertaken efforts to evaluate and address the housing crisis in their localities.

Often, State efforts to assure affordable housing for mental health consumers lead to coordinated initiatives with other State agencies that address housing and homelessness. **Iowa**, **Michigan**, and **West Virginia** are among the States that have convened interagency bodies to address the housing needs of people with serious mental illnesses.

Providing mental health services to people who are homeless is a major challenge for many reasons, including the difficulties of outreach and tracking. **Wisconsin** is among the States that provide training for mental health workers focused specifically on providing assistance to people who are homeless. States including **Hawaii**, **Maine**, and **Vermont** provide services specifically targeted to youth who are homeless or at risk of becoming homeless. Some States, including **Georgia**, **Minnesota**, and **Oklahoma**, have undertaken the creation of State plans for the elimination of homelessness.

Supported Employment

Adults with serious mental illnesses and youth with serious emotional disturbances may require supported employment programs to allow them to participate fully in their communities. The New Freedom Commission noted that vocational rehabilitation services often have failed to serve people with mental illnesses well. In addition to the many States that employ consumers in their own offices and programs, **American Samoa**, **Illinois**, and **Ohio** are examples of States undertaking staff training to improve and coordinate services between vocational rehabilitation and mental health systems. **Illinois** is one of several States that seek to coordinate State and Federal work benefits; it also helps consumers understand their choices—and the consequences of their choices—in regard to work and benefits. Medicaid Buy-In programs, such as the one operating in **Indiana**, allow working people with disabilities to buy in to Medicaid coverage, thus reducing the fear of losing health insurance, which is a disincentive to return to work.

Integrated Treatment Courts (Oregon)



Mental Health and the Justice System

According to the New Freedom Commission, approximately 7 percent of all incarcerated people have a serious mental illness. States recognize the need to provide mental health care to people within the criminal justice system, and, when appropriate, divert consumers to mental health systems of care.

Among the States working to ensure or improve the provision of mental health services to incarcerated adults and youth are **Alaska, the District of Columbia, Colorado, Louisiana, Maryland, Michigan, Oklahoma, Nebraska, Pennsylvania, Puerto Rico, and Wisconsin.**

Illinois and **Oregon** provide Assertive Community Treatment (ACT) services in local jails.

Mental Health Court programs designed to avoid unnecessary incarceration of adults with serious mental illnesses operate in States that include **Illinois, Indiana, Michigan, Minnesota, North Carolina, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, and Utah.** Similar programs for juveniles are highlighted in **Nebraska, Puerto Rico, and Oregon.**

In **Connecticut**, a Youth Violence Prevention Initiative seeks to prevent girls from becoming involved with the courts in the first place. Another **Connecticut** program targets women in the prison system; **South Dakota** has an outreach program for women in prison with serious mental illnesses.

Several programs for adults in the criminal justice system seek to reduce recidivism by providing transition planning and other supports. **Arizona, the District of Columbia, Georgia, Iowa, New Jersey, North Dakota, and South Dakota** are among the States with transition programs. In **Wisconsin**, an initiative is underway to more quickly reestablish disability and other benefits for offenders on release, thus reducing their risk of homelessness and recidivism.

In 2000, the Oregon Office of Mental Health and Addiction Services, in collaboration with the Oregon Judicial Department, was awarded Federal funds to implement Integrated Treatment Courts for juveniles and their families. This partnership resulted in an innovative statewide pilot project designed to address the growing concern about juvenile offenders with co-occurring disorders. The Integrated Treatment Court model was developed and pilot projects established in seven counties. More than 200 youth and families have participated in the project. Integrated Treatment Courts combine juvenile drug court concepts and service integration principles to increase accountability, promote service coordination across agencies and systems, support the use of evidence-based practices, and provide individualized behavioral health services for youth and families involved in the juvenile justice system. Preliminary outcomes include greater access to services and decreased recidivism.

For more information, contact:
Bill Bouska, Bill.Bouska@state.or.us

**Integrated Services
for Homeless Adults
(California)**

Originally begun as a demonstration program, California's Integrated Services for Homeless Adults with Serious Mental Illness program was recognized as an exemplary model by the President's New Freedom Commission on Mental Health. Individual projects, sometimes referred to as AB 2034 programs after the legislation that created them, provide services that include, but are not limited to, outreach, supported housing, supported employment, mental health and medical treatment, substance abuse treatment, benefits assistance, and other non-medical services. The programs establish close collaboration at the local level among core service providers, including mental health, law enforcement, veterans' services agencies, and other community agencies. The May 2003 report to the California Legislature on the effectiveness of these programs indicates that for individuals enrolled in the programs:

- Homeless days have been reduced by 67.3 percent;
- Psychiatric hospital days have been reduced by 55.8 percent;
- Jail days have been reduced by 72.1 percent; and
- 13.3 percent of people enrolled are involved in some type of employment activity.

For more information, contact:

Dee Leemonds, Section Chief,
Adult & Older Adult Program Policy,
(916) 654-3001.

Wisconsin's Redesign Initiative moves the State's adult system of mental health care delivery toward realization of the goals of the President's New Freedom Commission. The implementation of Comprehensive Community Services will support the creation of a flexible, consumer-oriented psychosocial recovery system for adults and children.

Creating a Comprehensive State Mental Health Plan

The New Freedom Commission called on States to develop Comprehensive State Mental Health Plans to address the provision of services across the life span and to coordinate and integrate services among multiple State agencies. Many—if not most—States are in the process of developing such a plan, and many are participating in efforts to redesign and integrate related services.

Service- or agency-based coordination efforts are underway in **Delaware**, where crisis staff are co-located in hospital emergency departments; in **Illinois**, where multiple partnerships between State and Federal agencies provide services for people with co-occurring disorders; and in other States to address issues of housing, long-term care, domestic violence, and disaster preparedness. **Texas** and **Wisconsin** are among the States that have reconfigured mental health and substance abuse agencies to facilitate coordination.

Service integration efforts often have the explicit endorsement of the political establishment, whether mandated by State Government, promoted in a Governor's report or initiative, or—as is the case with **Maine's** Children's Cabinet—chaired by the First Lady. This top-down support can be critical to breaking down barriers between State agencies and working through regulatory and bureaucratic differences.

Pro Bono Mental Health Program (Colorado)

Financing Mental Health Services

Increasing Medicaid revenue has been a priority in many States. In **Illinois**, a System Restructuring Initiative was undertaken that had the specific goal of increasing revenue for services billed to Medicaid. These funds will be used to support a system of recovery-based care. Other States sought and received reimbursement for home-based care; peer support services; and integrated medical, chemical dependency, mental health, and long-term care services.

States also have accessed other sources of funding for essential treatment for mental health disorders:

- Real Choice Systems Change Grants provided several States—including **Mississippi, Nebraska, Oregon, and Vermont**—with support to move forward in advancing recovery-oriented, consumer-based care;
- In **Michigan**, an Independence Plus grant helped advance consumer self-determination;
- In **Puerto Rico**, a \$1 billion perpetual trust supports services to impoverished communities; and
- A State appropriation in **West Virginia** helped expand the number of adults with serious mental illnesses and children with serious emotional disturbances who are eligible for services.

In addition to identifying revenue, States have worked to control costs:

- **Wisconsin** launched a psychiatrist-education initiative to advance the use of generic medications;
- **Colorado** recruits licensed mental health professionals to provide pro bono health care for people who are homeless; and
- **Florida's** self-directed care program allows the funding to follow the client, expanding client choice and control over services.

In Colorado's Pro Bono Mental Health Program, licensed and/or certified mental health professionals volunteer at more than 30 community agencies where people are already receiving non-mental health services. They provide free mental health services in the form of individual, group, and family psychotherapy, as well as psychological and psychiatric evaluations to low-income youth, families, older adults, and people who are homeless. The volunteers also benefit clients indirectly by providing case consultation, program consultation, and staff training to the host agency staff. The volunteers help these staff to recognize the symptoms of and treatments for mental illnesses and to better understand the needs of their clients with mental illnesses. Since 1986, more than \$7.5 million worth of services have been provided to the community for free.

For more information, contact:

Susie Street, Director of
Community Services,
Mental Health Association of Colorado,
(303) 377-3040.

GOAL 3

Disparities in Mental Health Services Are Eliminated

The New Freedom Commission recognized that access to quality mental health care is not equal across all segments of the American population. Racial and ethnic minorities, as well as rural populations, may face more significant barriers to care than others do; some also find recovery impeded by the lack of culturally appropriate care. In addition to these systemic failings, individuals in rural areas and from some cultural groups may struggle with increased stigma associated with mental illnesses and mental health treatment.

In an effort to better understand and address these issues, the New Freedom Commission made two recommendations:

- 3.1 Improve access to quality care that is culturally competent.
- 3.2 Improve access to quality care in rural and geographically remote areas.

THE STATES RESPOND

Recognizing Disparities

The Nation as a whole is experiencing significant demographic and cultural population shifts. These changes come at different speeds and in different forms. **Rhode Island** and **Delaware** have seen growth and shifts in their Hispanic populations. **Minnesota** officials recently traveled to Thailand to meet with and assess the needs of Hmong refugees who are likely to immigrate to Ramsay County, which already has a large Hmong population. In other States, a growing awareness of disparities or increasing understanding of cultural barriers to care drives efforts to adapt elements of the mental health system to better meet the needs of specific subgroups.

Developing a greater understanding of the disparities that exist within a State and the related cultural competence challenges faced by care providers is a critical step in advancing quality care for all citizens. To refine their understanding, **Massachusetts** and **Connecticut** are both engaged in an assessment of their States' ability to capture and analyze data on various cultural groups, their use of services, and their treatment outcomes. **California, Oregon, South Carolina, Ohio, and Arizona** also are planning assessment activities.

Building an Infrastructure to Support Cultural Competence

A number of States have developed councils, committees, work groups, task forces, and similar entities and charged them with identifying strategies to advance culturally competent care in the mental health system (e.g., **Alabama, California, Colorado, Delaware, Hawaii, Idaho, Massachusetts, Mississippi, Missouri, North Carolina, New York** and **Washington**).

In some States, specific offices or staff are designated to address issues of cultural competence or to support the delivery of quality care to cultural minority populations (e.g., **Arizona, Connecticut, Idaho, Kansas, Louisiana, Massachusetts, Nebraska, North Carolina, Oklahoma, Texas, and Washington**).

States also seek to enhance quality of care by hiring staff who reflect the culture of the target population and partnering with organizations that represent these populations. For example, **New York's** Office of Mental Health enhances its outreach efforts through partnerships with the Association of Hispanic Mental Health Professionals, Black Psychiatrists of Greater New York, and the Coalition for Asian American Mental Health.

Often, the councils, task forces, offices, or staff are charged with providing training in cultural competence to mental health providers in their States. Training also is provided through other avenues. More than 20 States have pro-

**Local Pilots for
Cultural Competence
(Pennsylvania)**

Pennsylvania has used Block Grant funds to foster cultural competence, selecting participating counties by inviting competitive concept papers. The pilots include the following initiatives:

- Allegheny County Department of Human Services is collaborating with Mayview State Hospital and Mercy Behavioral Health to address the over representation of African Americans in the hospital. The project will emphasize community supports for discharged patients;
- Bucks County will do outreach to providers with Latino consumers to inform them of the services Pan American Behavioral Health, Inc., can offer to the Latino population;
- The Northampton County Colonial Intermediate Unit 20, in collaboration with Touchstone Theater and RESOLVE, designed a psychoeducation project to create a dialogue among students of diverse cultural/ethnic backgrounds, teachers, and mental health professionals. This non-stigma/non-threatening (experiential) process will use students' cultural resilience while developing problem-solving skills around prejudice/discrimination; and
- Community Action Southwest, in Washington County, will be doing outreach to a rural population that traditionally does not seek mental health services. Outreach efforts will be integrated with services in the community.

For more information, contact:

Maria del Carmen,
Cultural Competence Coordinator,
(717) 705-8240,
c-mperez@state.pa.us.

See also

www.dmhas.state.ct.us/multicultural.htm.

vided some level of cultural competence training to mental health providers. Examples include the following:

- In **Ohio**, mental health providers are trained in the use of the Consolidated Culturalogical Assessment Tool (C-CAT), which enables them to assess their own cultural competence;
- In the **District of Columbia**, training provided by the Department of Mental Health Training Institute addresses not only traditionally recognized cultures such as that of the Latino community, but also gang cultures and the culture of commercial sex workers;
- In **Massachusetts**, the Department of Mental Health collaborated with the **Massachusetts** Office for Refugees and Immigrants to promote mental health in diverse racial, ethnic, and minority communities. In all, about 25 community forums were held and more than 90 primary care practitioners were trained; and
- **New York** has presented a training program—Cultural Competence: Maintaining an Asking Stance—to provider agencies, trade associations, social work education programs, and community groups throughout the State.

Addressing Consumer Needs Across Cultures

In some cases, cultural affinities are related to specific barriers to care for consumers. In **American Samoa**, the **Federated States of Micronesia**, and the **Commonwealth of the Northern Mariana Islands**, outreach, education, and empathy all are needed to address differing beliefs about the causes of and treatments for mental illness.

Massachusetts and **New Hampshire** are undertaking efforts to address stigma within the deaf and hard-of-hearing community. **Alabama**, **Guam**, **Kentucky**, **Maine**, **Massachusetts**, **North Carolina**, and **Virginia** also are undertaking outreach to deaf and hard-of-hearing communities.

Sometimes, language is the primary barrier to care. Efforts to address language and translation needs are underway in many States:

- To educate mental health consumers, family members, service providers, and the general public, **California** provides a multicultural mental health brochure series that is available through the Web at www.cimh.org/projects/translation.cfm;
- **Alabama** maintains a statewide funding pool to support translation services;
- **Minnesota** recently has validated a transcultural assessment tool; and

Rural Mental Health Vouchers (Nebraska)

- **Guam** and **Palau** translate materials into local languages to reach all segments of the population. For example, in Guam, pamphlets are translated into the Tagalog, Chuukese, and Palauan languages.

States provide a variety of programs to benefit specific cultural or ethnic populations identified as underserved or at-risk:

- **Minnesota** dedicates 25 percent of State Block Grant funds to meet the mental health needs of the Native American nations in the State;
- A Latino Mental Health Roundtable was formed to achieve accountability in meeting the behavioral health needs of **Colorado's** diverse Latino community;
- **Nebraska** is developing a transitional program specifically targeted to African American males involved in the juvenile justice system;
- **Washington** State commissioned a report on the mental health needs of American Indians in **Washington** State: www1.dshs.wa.gov/pdf/hrsa/mh/amindiashmneeds.pdf. Using Block Grant funds, the State also has developed a best practices guide for vulnerable populations, including Alaska Native/American Indian children and ethnic minorities: www1.dshs.wa.gov/mentalhealth/bestpracticesguide.shtml;
- Rural boards in **Ohio** receive support to implement evidence-based practices to ensure that quality services are available to **Ohio's** Appalachian and Amish communities; and
- In **Texas**, the Mental Health Interpreter project will deliver linguistically and culturally competent mental health services to people who are deaf and hearing impaired.

Reaching Rural Populations

Providing services to populations in rural and geographically remote areas is a challenge to many States. In **Oregon, Delaware, Illinois, Michigan, and Wisconsin**, the availability of mental health services throughout the jurisdiction is mandated by contract or legislation. Across the States, a variety of strategies have been adopted to extend mental health services to rural areas. These are some examples:

- Providing transportation or subsidies for transportation to enable providers to reach their more distant mental health clients, or to make it easier for clients to reach providers (e.g., **Alabama, American Samoa, Arizona, Idaho, Kentucky, Massachusetts, Mississippi, the Federated States of Micronesia, North Carolina, Oregon, Puerto Rico, Rhode Island, Tennessee, and Vermont**);

Cost-free, confidential mental health counseling for rural residents is provided through a voucher program Nebraska residents access through the Nebraska Farm Hotline. Rural residents calling the toll-free Nebraska Farm Hotline who seem to be in need of professional mental health treatment are informed of the voucher program. Eligible individuals include those who derive their livelihood from the rural economy and who often face the stress of low prices, increased costs, and drought. These include farmers, farm family members, those employed in agriculture-related businesses, small town businesses dependent on the agricultural economy, and others. Those who are eligible may request a voucher for outpatient mental health counseling. They also receive a list with contact information for all participating mental health providers in their area. Callers have 30 days to redeem the voucher and may request up to five additional vouchers through the hotline. Currently, 189 providers have signed up to participate in the voucher program. As of June 30, 2004, 68 providers were active. Many of these providers have strong farm backgrounds and a clear understanding of rural culture.

For more information, contact:

James Harvey,
Quality Improvement Coordinator,
(402) 479-5125, jim.harvey@hhss.ne.gov.

Healthcare Disparities Initiative
(Connecticut)

The Behavioral Health Disparities Initiative of the Connecticut Department of Mental Health and Addiction Services (DMHAS) is a multilevel, multidimensional, systematic effort to identify, reduce, and ultimately eliminate behavioral health disparities within the public sector State system. It is based on collaboration among DMHAS and academic partners (Yale University and the University of Connecticut), consumers and people in recovery, community leaders, providers, and other stakeholders. Component programs include

- the Health Disparities Forum—a periodic meeting of researchers and policymakers to discuss new findings and directions;
- the Health Disparities Research and Data Analysis Project—to identify health disparities through analysis of administrative databases and identify crucial components of culturally competent care;
- the Culturally Specific Programs Initiative—a cluster of programs serving the needs of specific racial or cultural groups; and
- Health Disparities Consultation Support—technical assistance provided by postdoctoral fellows from the Yale University School of Medicine.

For more information, contact:

Wayne Dailey,
(860) 418-6899,

Wayne.Dailey@po.state.ct.us.

See also

www.dmhas.state.ct.us/multicultural.htm.

Goal 3 Disparities in Mental Health Services Are Eliminated

- Providing services through rural networks or satellite offices (e.g., **American Samoa, Arizona, Idaho, Mississippi, North Carolina, Oregon, Palau, Pennsylvania, Puerto Rico, Vermont, and West Virginia**); and
- Using telemedicine to provide mental health services (e.g., **Alaska, Arizona, California, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Michigan, New Mexico, New York, Oklahoma, Oregon, Virginia, West Virginia, Wisconsin, and Wyoming**). Telemedicine is being piloted in **Nevada** and **South Dakota**.

States have developed a variety of creative outreach strategies, sometimes including home-based services. For example—

- The **Commonwealth of the Northern Mariana Islands** provides training for nurses and social workers on remote islands so they can monitor adults with serious mental illnesses. Monthly home visits also support adults receiving treatment;
- Treatment Foster Care is used in **Oregon** to better serve rural children who might otherwise be placed in more restrictive settings;
- **South Carolina** has developed Rural Assertive Community Treatment (ACT) teams, an initiative it hopes to expand statewide; and
- The **Utah** Frontier Project provides wraparound services to children and their families in rural and frontier communities.

In addition to these efforts to extend existing services to rural populations, States also are working to increase the availability of mental health care in rural areas by increasing the number of qualified workers in those areas. Many States specifically train, certify, and provide incentives for providers to deliver services in rural areas:

- Utah uses a State-funded Rural Mental Health grant to support the educational expenses of mental health staff working on clinical licensure in exchange for a commitment to work in an underserved rural area; and
- Efforts to increase the number and capacity of rural mental health workers are also underway in **Alaska, American Samoa, Arizona, Georgia, Kentucky, Minnesota, New Mexico, North Dakota, the Commonwealth of the Northern Mariana Islands, and Oklahoma**.

Rural Human Services System Project

(Alaska)

States have shown resourcefulness in meeting the challenge of funding rural services:

- The **Alabama** Rural Coalition for the Homeless was created to access U.S. Department of Housing and Urban Development funds to help provide a continuum of care for people with severe mental illnesses who are homeless; Tobacco Settlement Funds are used to advance services to children and adolescents in rural parts of the State;
- **South Dakota** has established a rural reimbursement rate that is 20 percent higher than the regular rate. This rural rate can be charged when mental health care providers must travel more than 20 miles from their office to provide care; and
- An additional barrier in rural **West Virginia** is the high poverty rate. However, only 25 percent of people living in rural areas qualify for Medicaid, compared to 43 percent of those who are poor and living in urban areas. The **West Virginia** Children's Health Insurance Program covers mental health and substance abuse treatment for more than 20,000 children who otherwise would be ineligible to receive these services.

States also have opened new avenues to care:

- **Utah** views Clubhouse programs as integral to rural outreach efforts;
- **Oregon** established Treatment Foster Care in order to avoid residential placement for youth from rural areas;
- In **Illinois**, the Farm Resource Center provides crisis services to rural families; and
- Mental health vouchers are available to Nebraskans through the Farm Hotline.

Such approaches also may help offset any stigma surrounding mental illnesses and mental health treatment in rural areas.

The Rural Human Services System Project (RHSSP) was designed to correct identified problems with the delivery of human services, particularly mental health and substance abuse services, in rural Alaska. RHSSP links the Division of Behavioral Health, regional mental health and substance abuse programs, and the University of Alaska to train, employ, and supervise village-based human service providers. Village residents are employed and supervised by the regional programs. The University of Alaska, College of Rural Alaska, offers a 30-hour certificate in Rural Human Services at five campuses across the State. The certificate program emphasizes community development, a holistic model of human functioning, and the integration of Native and Western counseling techniques. For every 5 to 10 village-based positions, the RHSSP provides funds to train and employ one master's level supervisor.

For more information, contact:

L. Diane Castro, Manager,
Prevention and Early
Intervention Services,
(907) 465-3033,
diane_castro@health.state.ak.us.

GOAL 4

Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

The New Freedom Commission recognized that early detection, assessment, and linkage with treatment and supports can lessen the long-term effects of some mental illnesses. They saw a clear need to identify people who can benefit from interventions and help them access the resources they need to recover before poor life outcomes accumulate. In particular, the Commission pinpointed the critical needs of children, for whom early detection, assessment, and links with treatment can prevent mental health problems from worsening. The Commission also noted that people with co-occurring mental and substance use disorders often are caught between the mental health and substance abuse systems, unable to access effective, integrated care. To address these challenges, the Commission made the following recommendations:

- 4.1 Promote the mental health of young children.
- 4.2 Improve and expand school mental health programs.
- 4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.
- 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

THE STATES RESPOND

Promoting the Mental Health of Young Children

In State after State, traditional boundaries are erased or crossed regularly as State agencies and their partners forge alliances to support children and families coping with serious emotional disturbances, who frequently must navigate multiple systems to receive the treatment and services they need. Together, these agencies are planning, sponsoring training, and implementing wraparound care programs that provide a wide variety of support.

These are some examples of alliances driven by top-down directives or legislative mandates:

- **Arizona's** Governor issued an Executive Order creating a Children's Cabinet to ensure cross-system coordination;
- The Governor's KidsFirst Initiative, unveiled in Spring 2004, seeks to coordinate all systems that serve children in **Wisconsin**;
- **Nebraska's** Governor appointed an Early Childhood Interagency Coordinating Council to establish a planning structure and process that engages the full spectrum of early childhood stakeholders;
- In **Missouri**, the Children's Mental Health Act of 2004 recognized that to adequately meet the mental health needs of children, multiple State agencies must be involved and coordinated leadership and funding is required. A Comprehensive System Management Team and a Stakeholder Advisory Committee will guide the integration effort; and
- The **Wyoming** Legislature mandated the Children and Families Initiative, which requires the Department of Family Services to develop a comprehensive, collaborative plan to improve the lives and futures of all children and families in **Wyoming**.

States' initiatives in behavioral health for children and their families involve an ever-expanding range of partners. The following examples are illustrative but far from exhaustive:

- **Arizona's** 300 Kids Project has become a statewide effort to develop, demonstrate, and disseminate a child and family team approach to assessment, service planning, and delivery;
- **Delaware** has a continuum of care that consists of Clinical Services Management Teams with a coordinator assigned to each client and more than 40 agencies providing a wide array of mental health and substance abuse services for children and adolescents;
- In **Florida**, a Multi-Agency Network for Students with Emotional Disturbance works at both State and local levels;

CASSP

(Child and Adolescent Service System Program)

**Service Teams
(Arkansas)**

The Child and Adolescent Service System Program (CASSP) was established in Arkansas in 1991. CASSP is based on the concept developed by the National Institute of Mental Health regarding the need for interagency collaboration and coordination in delivering services to seriously emotionally disturbed children. CASSP service teams are available throughout the State to develop multi-agency plans of care for individual children and adolescents with serious emotional disturbances when the current system is not adequately meeting their needs.

The goal is to provide an integrated system of care. Families participate in treatment planning and other meetings. Priorities include early childhood, the Head Start population, and discharge planning for those in hospitals or moving into the adult system. The CASSP Coordinating Council promotes the early childhood mental health initiative.

For more information, contact:

Anne Wells,

Assistant Director for Children's Services,
(501) 686-9489,

anne.wells@arkansas.gov.

- In **Guam**, an Inter-Agency Case Review Committee made up of representatives from various youth-serving agencies reviews multi-agency cases for children who have needs that tend to overwhelm the local system of care and who often are considered for off-island treatment;
- In **Illinois**, the Screening Assessment Support Services Initiative supports an integrated network of individualized services for children with serious emotional disturbances. Case management services employ a strengths-based, *wraparound approach* (p.57);
- **Massachusetts** reports positive results with supported child care, a strategy in which a clinical social worker is hired through a community health center and assigned to a local child care center to identify and support children who need intensive services;
- In **New York**, a multi-year training program in Functional Family Therapy is being delivered to 21 teams who represent a variety of mental health, juvenile justice, and social service agencies. Functional Family Therapy is a multi-systemic, family-based prevention program with an encouraging record of success; and
- **Rhode Island's** Local Coordinating Councils, located in eight catchment areas, meet regularly to review problematic child or adolescent cases and engage in joint problem solving.

Many States are striving to reach very young children with preventive, collaborative care.

- **Vermont's** CUPS (Children's Upstream Services) seeks to reduce the number and rate of children who enter kindergarten without the emotional and social skills necessary to be active learners. This program targets children from birth to age 6 who are experiencing (or are at risk of experiencing) serious emotional disturbances. Interagency collaborators at State and regional levels include representatives of families, early care and education providers, and health and mental health providers. Services include outreach, information and referral, consultation, and training. Initially grant-funded, the program is now sustained by State funds.
- In **Colorado**, Jefferson Center's Early Intervention Services teaches the building blocks of good parenting to parents who struggle with mental health issues in the family. This initiative provides timely and accessible mental health services to at-risk children from birth to age 8 and their families.
- In **Connecticut**, the Partnership Resources and Infrastructure Support Monies initiative implements prevention models for children (kindergarten through grade 5) and assesses them for improved skills, behaviors, family relations, and a reduction in violence and mental health problems. The ini-



Participants in Puerto Rico's system of care program enjoyed a family retreat in which children express themselves through art and painting. All family members of the children receiving treatment participated in this activity, which was held in Vista Mar Resort (2003).

tiative features an evidence-based bullying prevention program and interventions to strengthen families.

States also are working to provide appropriate care and support for youth with serious emotional disturbances, including those involved with the criminal justice system.

- **Delaware's** Individual Residential Treatment Services program (IRT) provides appropriate alternatives for youth ready to leave residential treatment but unable to live with their families. As of July 2004, the Division of Child Mental Health Services had five providers under contract (three of whom are operating on a statewide basis), and 42 clients had been served through the IRT initiative.
- In the **Federated States of Micronesia**, a broad range of sports, counseling, and awareness programs help youth and their families address mental health and substance abuse issues.
- With new funding received in 2004, **Mississippi's** Department of Mental Health opened a Specialized Treatment Facility for Youth with Emotional Disturbance, with priority given to youth referred through the court system.
- **North Dakota's** mental health system collaborated with the child welfare and juvenile justice systems to develop a *wraparound certification* (p.57) process with a Single Plan of Care.
- Several of **West Virginia's** behavioral health centers have developed volunteer-based youth mentoring programs for children with serious emotional disturbances who are 7 to 17 years old.

- In **Palau**, the Ministry of Health's Children's High Risk Clinic targets children ages birth to 21 with high-risk conditions. A multidisciplinary team provides assessment, diagnosis, treatment planning, and follow-up.
- In Alabama, law enforcement officials and emergency health services providers receive training to help them handle children and adolescents with serious emotional disturbances.
- A grant from the Federal Office of Juvenile Justice and Delinquency Prevention to the **South Dakota** Council of Mental Health Centers is supporting enhanced services to youth who live in rural regions of the State who are involved with—or at risk for involvement with—the State's juvenile justice system. Services provided through the grant include *wraparound services* (p.57) for youth and families, school-based/linked mental health services, community development/coordination, and professional training and development for service providers in rural and frontier areas.

States are seeking ways to support children and youth experiencing a crisis.

- **Louisiana** has developed a Child and Adolescent Response Team mobile crisis program.
- **Oklahoma** will establish the State's first Children's Crisis Stabilization Center in Fiscal Year 2005, offering new alternatives to hospitalization for children and allowing more immediate resolution of crises.
- **Ohio's** TEENLINE, a toll-free hotline, provides assistance to teens in crisis and refers adolescents to the nearest treatment provider.
- **New Jersey's** Department of Mental Health Services has dedicated \$500,000 annually in Block Grant funds to develop Traumatic Loss Coalitions in each of the State's 21 counties. A key purpose is to identify and train a network of professionals in each county to address issues related to mental health emergencies for youth subsequent to trauma.

States strive to reduce out-of-State placements for children and adolescents, often by providing the strongest possible support for the family.

Nebraska has the highest number of children per capita who are wards of the State. The National Association of State Mental Health Program Directors (NASMHPD) supported Nebraska's Department of Health and Human Services (DHHS) in efforts to address the issue of parents relinquishing custody of their children to access mental health services. In five of Nebraska's six behavioral health regions, Integrated Care Coordination Units work cooperatively with local family organizations and DHHS to provide *wraparound services* (p.57) for children who are at high risk for out-of-home placement and their families.

Many States are actively exploring new funding possibilities that will enable them to provide essential services.

- In **California**, the Children's System of Care Initiative will benefit from funds generated by the Mental Health Services Act, which pays for expanded mental health programs through a 1 percent surcharge on the income of all Californians who earn more than \$1 million per year.
- In Fiscal Year 2005, **Maine's** Children's Services will seek to expand the range of services available to children with mental retardation and autism by applying for a Home and Community-Based Medicaid waiver.
- **Maryland** is studying the feasibility of bringing child and adolescent respite care into the Medicaid benefit package on a limited basis.
- In **New Jersey**, resources from child welfare, mental health, and Medicaid agencies will be pooled to enable the system to meet the needs of children with emotional and behavioral disturbances and their families more effectively.
- In **Ohio**, Intensive Home and Community Based Services for Children are being developed as a distinct Medicaid service.
- In 2003, the **Oregon** Legislature passed a Budget Note (a resolution regarding the use of public funding) requiring the children's public mental health system to fully integrate Medicaid-covered services into managed care organizations.

Improving and Explaining School Mental Health Programs

States are working with schools in a wide variety of ways. Many, if not most, States offer interventions and referrals through schools.

- In **Hawaii**, children and youth who have educational disabilities receive school-level supports and services through their home school.
- **Idaho's** Department of Health and Welfare and its Department of Education have an interdepartmental agreement to jointly develop and implement school-based programs for children with serious emotional disturbances in all regions of the State. These programs blend mental health, education, and local school district funds to support a range of services from traditional day treatment models to intensive school-based services.
- **Illinois** uses school consultation teams and offers psychiatric expertise.
- **Vermont's** Success Beyond Six program provides mental health staff who work in partnership with the schools to link children and their families with an array of mental health and other community-based services.

The Red Flags Program

(Ohio)

A prevention program developed by the Mental Health Association of Summit County in concert with the Ohio Department of Mental Health, Red Flags helps students, parents, and school staff recognize and respond to signs of depression and related mental illnesses. The program includes an in-service training for school personnel, a video-based curriculum for students called *Claire's Story: A Child's Perspective of Childhood Depression*, and a seminar for parents, students, and the community. Red Flags is available at more than 600 schools.

For more information, contact:

www.redflags.org

or

Victoria Doepker,
Associate Director,
Mental Health Association
of Summit County
(800) 991-1311,
(800) 991-1311 (toll-free).

- **New Hampshire's** Positive Behavioral Interventions and Supports program helps schools approach children with intensive needs from a strengths-based perspective.
- In the **Commonwealth of the Northern Mariana Islands**, the Division of Public Health collaborated with the public school system to open an Adolescent Health Clinic at the Marianas High School campus. Services offered on-site include mental health and substance abuse counseling with support groups on topics such as anger management and grief recovery.
- In **Kansas**, Rock Creek School District credited the regular presence of case managers in their schools with a greatly reduced need to contact the mental health center for assistance with crisis response.

Training teachers and staff to respond appropriately to behavioral health needs is done in a variety of ways.

- In **Kansas**, Olathe Special Services adopted the Behavioral Intervention Support Team model (based on how teachers and staff respond to students' behaviors) to train staff. Regular classroom teachers are now attending the training as well.
- In **Missouri**, the Department of Mental Health and the University of Missouri-Columbia collaborate on the Center for the Advancement of Mental Health Practice in Schools. The Center helps ensure that university-trained teachers and school administrators are apprised of best practices in public mental health awareness and prevention initiatives, early identification and intervention efforts, and treatment services and supports in the school setting.
- **Pennsylvania's** Commonwealth Student Assistance Program (SAP) places SAP core teams, which include school staff and liaisons from the mental health and drug and alcohol systems, in the high schools and middle schools of each school district.
- **Minnesota's** Local Children's Mental Health Collaboratives and Family Services Collaboratives provide technical assistance and training to help educators address mental health issues in school settings.

Screening, Assessment, and Referral

States are developing screening tools and procedures for a variety of ages and venues. Many are seeking to identify children who need help as early as possible.

- In **American Samoa**, infants and toddlers served through the "Part C" program at the LBJ Tropical Medical Center benefit from early intervention, screening, identification, assessment, information, and referral services.

Clinical Assessment Tool and Process

(Arizona)

In evaluating people seeking behavioral health services in Arizona, the Arizona Department of Health Services, Division of Behavioral Health Services, found that most of the assessments were assessing parts of the person, but not collecting a comprehensive picture that included the person's mental health, substance abuse, culture, and related factors in one coherent process. In an effort to devise a more holistic approach to clinical assessment, a workgroup comprised of stakeholders and Division staff developed a streamlined and standardized assessment tool, in English and Spanish, to gather more comprehensive information. In addition to a core assessment component, the tool also includes a behavioral health and medical questionnaire and a provision for additional individual information to be gathered.

Division staff trained Regional Behavioral Health Authorities and providers on the new process, and implemented the tool statewide on January 1, 2004. An instructor's guide and training materials on the assessment are available as resources on Arizona's Web site (www.azdhs.gov/bhs/assessment_process.htm#assessment).

For more information, contact:

Dr. Michael Franczak,
Clinical Services Director,
ADHS/DBHS,
150 North 18th Avenue, Suite 220,
Phoenix, Arizona 85007,
(602) 364-4626,
FRANCZM@azdhs.gov.

- In the **Federated States of Micronesia**, screening and diagnostic services for emotional problems are incorporated with routine pediatric care. Mental health staff also identify students with potential emotional disturbances through teacher interviews, review of school records, and student testing.
- In **Hawaii**, staff of the State mental health agency provide training for families, child care providers, and preschool staff to help them identify and support children with emotional and behavioral challenges.
- Through Georgetown University's National Technical Assistance Center, **Indiana** is receiving help in developing an Early Identification and Intervention plan. When the plan is fully implemented, all children entering the child welfare system will be screened for mental health and addiction issues.
- **Iowa's** Medicaid Early Periodic Screening, Diagnosis, and Treatment Program has received a grant to develop early screening and assessment of children's mental development from birth to age 3.
- In **Palau**, the Chief of the Behavioral Health Division and the social worker assigned to children visited each Head Start Center in **Palau** to screen the children who attend using the Temperament & Atypical Behavior Screen (TABS). Of 262 children who were screened, 10 percent scored high and were referred for further assessment.

Screening strategies for older children and adults, and for special circumstances, also are being developed and refined.

- **Ohio** is piloting Teen Screen, a computer-based mental health screening program.
- **Puerto Rico's** 12 centers of prevention and promotion help citizens and teachers identify emotional disorders in children and adolescents.
- **South Carolina** has selected screening tools to assess trauma in children under age 9 and children age 9 and older. Guided by a Trauma Initiative Task Force, the State will continue testing the tool at seven trauma screening/treatment pilot sites.
- In **Texas**, the Adult-TRAG makes it possible for clinicians at each local authority to assess mental health consumers on nine dimensions. (i.e., risk of harm, support needs, psychiatric hospitalizations, functional impairment, employment problems, housing stability, co-occurring substance use, criminal justice involvement, and response to medications). Along with principal diagnosis, the Adult-TRAG provides a methodology to facilitate rapid and consistent levels of care recommendations.

Moving Toward Integrated Services for Co-Occurring Disorders

States are working to screen, refer, and treat people with co-occurring mental and substance use disorders more effectively. These are examples of State-sponsored training efforts to help mental health and substance abuse clinicians coordinate care and use appropriate screening procedures.

- **American Samoa** and **Nevada** cross-train mental health and substance abuse providers to promote integrated treatment.
- In **Alabama**, the Department of Mental Health/Mental Retardation teamed with the Southern Coast Addiction Technology Transfer Center (ATTC) to train 900 mental health and substance abuse professionals in co-occurring disorders.
- In **Guam**, the Department of Mental Health and Substance Abuse conducts twice-yearly mental health training for drug and alcohol counselors and substance abuse training for mental health clinicians/social workers to increase awareness of co-occurring disorders.
- **Kentucky** provides training on co-occurring disorders for case managers, consumers, family members, and providers.

States are cognizant of the driving role played by licensure and State requirements in establishing competencies to address co-occurring disorders.

- In **Texas**, an administrative rule on co-occurring psychiatric and substance abuse disorders outlines competencies that mental health providers serving children with substance use/abuse disorders must have, beginning with assessment skills. The **Texas** Commission on Alcohol and Drug Abuse developed a similar rule regarding the competencies needed by substance abuse providers serving children with mental disorders.
- **Florida's** Common Licensure Standards now require training on assessment and treatment for co-occurring disorders.
- In **Rhode Island**, all eight community mental health centers are licensed to provide substance abuse services.

Many States are promoting screening of co-occurring mental and substance use disorders and linkages with integrated treatment strategies (e.g., **Alabama, Arkansas, Florida, Georgia, Mississippi, Nebraska, North Carolina, Minnesota, Montana, and Tennessee**). Some also have developed tools to meet their needs.

- **Alaska's** Department of Behavioral Health developed the **Alaska** Screening Tool to promote identification and service referrals for co-occurring mental health, substance use, traumatic brain injury, and fetal alcohol spectrum

disorders. Implementation of the tool is scheduled for 2005. A copy of this tool is available at <http://health.hss.state.ak.us/dbh/providers/doc/ToolsInstructions.doc>.

- **Delaware** is developing a customer satisfaction tool specifically for co-occurring disorders.

A significant number of States are particularly concerned with youth and young adults who have co-occurring disorders, including at-risk youth or those involved with the criminal justice system.

- **Alabama** has worked with juvenile courts to use a standardized screening test to identify youths who need treatment. Jefferson County will train case managers, probation officers, and Family Court staff on co-occurring disorders.
- **Colorado** developed a pilot program for young people ages 16 to 21 with severe emotional disturbances, focusing on youth with co-occurring disorders.
- In **Kentucky**, a Co-Occurring Workgroup focuses specifically on youth with co-occurring disorders in the juvenile justice system.
- In **Massachusetts**, a Substance Abuse Task Force is focusing on the issue of access to care for adolescents who have co-occurring disorders.
- **Oklahoma** provides integrated outpatient treatment for adolescents with co-occurring disorders.
- In order to screen for co-occurring mental and substance use disorders and provide linkages with integrated treatment strategies, **Puerto Rico** has four interdisciplinary teams for children and adolescents with co-occurring disorders.

Many States are benefiting from SAMHSA's Co-Occurring Disorders State Incentive Grants (COSIG) and from its National Policy Academy for Co-Occurring Disorders, both intended to foster major changes in infrastructure to provide essential screening, referral, and treatment. States actively working toward integrated care that are engaged in comprehensive planning to address co-occurring disorders, either with or without Federal assistance, include **Connecticut**, the **District of Columbia**, **Hawaii**, **Louisiana**, **South Carolina**, and **Washington**. To inform its planning efforts, **New Jersey** has distributed a survey to 400 mental health and substance abuse agencies to collect information on best practice techniques.



In Michigan, grandparents are being taught to recognize signs of substance abuse by playing “substance abuse bingo.”

Other examples of support for integrated treatment include the following:

- **California’s** Department of Mental Health annually sets aside \$8 million of its Block Grant funds to support county efforts to provide integrated treatment services for adults with co-occurring disorders.
- In **Delaware**, integrated treatment is now available in three counties.
- In **Indiana**, integrated treatment for children and youth with co-occurring disorders is delivered through the Division of Family and Community Services.
- **North Dakota’s** Off Main program offers comprehensive services to people with co-occurring disorders.
- In cooperation with the Division of Alcohol and Drug Abuse, **South Carolina’s** Department of Mental Health supports a residential treatment program for individuals with co-occurring disorders.
- **Tennessee** funds Foundation Associates to develop integrated services for adults with co-occurring disorders at agencies around the State. Also, the Co-Occurrence Project supports a resource center, self-help groups, vocational services, and provider education.
- In **Oklahoma**, integrated treatment is available in four residential and five outpatient settings.
- In **West Virginia**, integrated treatment is available at jointly funded crisis stabilization units.

Transitioning Youth to Adult Programs

A key challenge identified by States is the need to help adolescents with serious mental illness transition into the adult system.

Several States have been working on systemic issues in order to make a more seamless transition.

- **Alabama's** Child and Adolescent Task Force is addressing the issues.
- **Illinois** has developed a transitional protocol that specifies the responsibilities of all who must play a role in the process.
- **Maine's** Partnership for Youth in Transition also seeks to identify and resolve systemic barriers; two pilot sites are now testing a service model.
- **Missouri** has established a work group to study the issue and develop best practice guidelines.

Some States have developed specific strategies to assist youth during this transition.

- Noting an inadequate supply of age-appropriate services for transition-age youth, **Massachusetts'** Department of Mental Health is using Block Grant funds to contract with M* Power, a consumer-run organization, to create a peer mentoring project to assist youth in transition.
- **Michigan** has developed a mental health youth-to-adult transition services project that requires significant revisions to the local mental health services structure.
- In **New Mexico**, an Adolescent Transition Group involves representatives from both the adult and children's service systems in an analysis of service system issues and barriers. The group developed a checklist to document all the systems a young person must navigate in order to obtain the services he or she will need as an adult.
- **Oklahoma** uses Block Grant funds to provide a comprehensive array of services for youth ages 16 to 25 with serious emotional disturbances.
- In **Pennsylvania**, the Office of Vocational Rehabilitation (OVR) partners with Child and Adolescent Service System Programs to provide transition and pre-employment services for adolescents with physical and mental disabilities. The 14 OVR district administrators promote outreach and have been active supporters and participants in planning for adolescents at the local level.

Geriatric Mental Health Specialty Teams

(North Carolina)

In North Carolina, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services funds 20 community-based geriatric mental health specialty teams to provide consultation, training, and support to long-term care facilities and caregivers throughout the State. The teams were developed in response to the number of elderly individuals who are inappropriately admitted to State psychiatric hospitals. The teams help older adults with mental illnesses live in their communities by training staff in nursing homes, adult care homes, other agencies, and caregivers that serve older adults who have mental health treatment needs and who may be at risk of psychiatric hospitalization. The teams also educate other agencies that serve elderly individuals, such as senior centers and primary medical providers, on issues of mental illness and its effects on people as they age.

For more information, contact:

Debbie Webster,
Best Practice Team,
Community Program Coordinator,
(919) 715-2774,
debbie.webster@ncmail.net.

Providing Mental Health Services to Older Adults

States clearly recognize the special mental health needs of older adults.

Several States are in the process of planning or demonstrating models that address ways of providing mental health services for these citizens.

- **California's** Department of Mental Health has awarded Block Grant funds to four counties to implement Older Adult System of Care demonstration projects.
- In **Illinois**, a GeroPsych Specialist Initiative, now in the pilot stage, supports the development of local mental health and aging coalitions, and provides training and education on older adult mental health issues to Department of Mental Health and Department on Aging staff.
- **Iowa** is developing a best practice model for mental health outreach and treatment for older adults through partnerships between three community mental health providers and primary care physicians.
- In **North Dakota**, which faces a rapidly aging population, the Division of Mental Health and Substance Abuse Services has entered into an agreement with the Mental Health Association in **North Dakota** to identify existing mental health services for older individuals, develop an understanding of those services and collaborations among agencies, identify future service needs, and raise public awareness of the mental health needs of older adults.
- **New Hampshire**, the Referral, Education, Assistance, and Prevention (REAP) program, a substance abuse/mental health early intervention program, continues to expand outreach to older adults in low-income senior housing, senior centers, Service Link sites, and individuals' homes. The program is a collaborative effort among the **New Hampshire** Housing Finance Authority, the Bureau of Behavioral Health, the Bureau of Developmental Services, the Bureau of Elderly and Adult Services, and the Division of Drug and Alcohol Prevention and Recovery.

Many States have coordinating committees that play a role in providing comprehensive systems of care to older adults.

- The Older Adult System of Care Committee of the **California** Mental Health Directors Association provides a link between the Department of Mental Health and local efforts to create systems of care for older adults.
- An Advisory Committee on Geriatric Services coordinated by the Department of Mental Health with the **Illinois** Department on Aging provides training, consultation, and technical assistance in the area of mental health and aging.

-
- The **Kentucky** Mental Health and Aging Coalition reviews, advises, and advocates in concert with regional staff who represent older adults.
 - **Virginia** has a Gero-Psychiatric Workgroup that advises and monitors screening efforts among older Virginians.
 - In **Michigan**, a Geriatric Community Mental Health Team functions at the local level.

States also work to publicize the unique issues around mental health care for older adults.

- The Department of Mental Health for **Illinois** works with the State's Department on Aging to coordinate an annual Mental Health and Aging Conference.
- **Kansas** produced and distributed a publication titled *A Mental Health Guide For Older Kansans and Their Families*.
- In **Pennsylvania**, in recognition of Older American's Month and Mental Awareness Week, the Joint Committee on the Mental Health of Older Persons collaborated with the central region's Mental Health and Aging Coalition to coordinate a Web-based training series focused on mental health issues facing older Pennsylvanians and innovative treatment and recovery options available.
- In **South Dakota**, a diverse workgroup developed a Geriatric Resource Guide that lists trainings, conferences, and educational opportunities for mental health care providers.

Many States are working with models that train "gatekeepers" to identify older adults in need of assistance with mental health problems.

- **Massachusetts's** Department of Mental Health is collaborating with the Boston Department of Elder Affairs, the Boston Housing Authority, and an elder advocacy organization to develop a training module for janitors, security guards, facility service workers, and others who work in public elderly housing developments to help them identify elders with mental health and substance abuse problems and bring them to the attention of appropriate housing authority staff so that referrals and interventions can be made.
- In **Michigan**, Gatekeeper programs help community members identify elders at risk of suicide or in need of other mental health services. Also, Serving Elders at Risk in the Community and at Home (SEARCH) provides outreach to identify older adults in need of services, develops linkages with primary care physicians, and supports the empowerment of seniors to fully participate in health care decisions.

Great Start Minnesota

A grant from the Commonwealth Foundation supported the development of the Great Start Minnesota Project, which promotes strategic improvements in services to young children whose mental development is at risk. Great Start initiatives include:

- Co-location of children's mental health clinicians in primary care clinics;
- Implementation of DC-03, an innovative set of diagnostic criteria for young children that identifies preschoolers' mental health needs and appropriate Medicaid coverage;
- Efforts to develop a State consensus on screening tools, symptom measures, functionality measures, and level of care determination;
- Training to primary care clinics and public health nurses on the identification and referral of children with mental health needs; and
- Mental health screening during public health home visits that include children and parents and focus on maternal depression and appropriate development of the mother-child dyad.

For more information, contact:

Gary Cox,
(651) 296-5882, Gary.Cox@state.mn.us.

- As part of **Nevada's** Senior Mental Health Outreach Program, the program director trains community members and service providers to recognize and treat depression in older adults, address problem gambling, prevent suicide, and maintain good mental health later in life.

States also are working to screen older adults through more traditional forms of outreach.

In **Pennsylvania**, the State Hospital system volunteered the assistance of clinical personnel to do geriatric depression and alcohol abuse screenings at community health fairs and senior centers during May 2004. County mental health programs and Area Agencies on Aging were provided with detailed information and screening tools to use with older adults in their communities.

Linking Mental Health with Primary Care Services

States are working in a variety of ways to improve access to behavioral health care through primary care settings.

- **Idaho**, in conjunction with the Western Interstate Commission for Higher Education (WICHE), funded a training program for primary care physicians on the use of psychotropic medications. Training materials are available at http://WICHE.edu/mentalhealth/grand_rounds/primary_care.htm.
- **Louisiana** has two interagency initiatives related to screening for mental disorders in primary health care: the Adolescent School-Based Health Initiative and the Nurse Family Partnership Program.
- In **Texas**, an action plan to improve access and integration of primary care and behavioral health focuses on three areas: a seamless system of care, workforce training and development, and partnerships and collaboration. Also in **Texas**, the **Texas** Adolescent Mental Health in Primary Care Initiative is developing surveillance and assessment tools that can be used in primary care settings.
- As part of a movement to further integrate mental health services with primary care and allied health providers in communities, **Wyoming** successfully has piloted collaborative programs with primary care physicians and public health nurses at two sites.
- To help promote early mental health screening of adults and children, **Guam's** Department of Mental Health and Substance Abuse is working with the **Guam** Medical Society to educate primary care physicians about the need to screen for mental disorders and to make referrals where appropriate.



Wyoming's Department of Family Services is guiding a statewide collaboration to create policy direction, a strategic plan, and legislative initiatives to improve the lives of families. The plan will examine causes of the most serious problems facing children and families, including poverty, mental health needs, and violence.

- **Ohio's** Medical Director is currently developing a plan to increase mental health screening in the primary care setting.

States also are exploring a variety of strategies to raise awareness of mental health issues among primary care providers and to make these services more readily available in primary care settings.

- **Virginia** offers Continuing Medical Education credits in mental health care to physicians.
- **Idaho** supports physician training on mental health care, including training on children's mental health, to primary care doctors.
- **South Carolina** places primary care doctors in mental health clinics.
- In **Texas**, mental health providers are placed in Federally Qualified Health Clinics.
- In **Oregon**, a workgroup of Department of Human Services' staff and key stakeholders developed recommendations for linking and integrating behavioral health and primary care. The group's report is available online at www.dhs.state.or.us/mentalhealth/rec-int-hlth-primcare.pdf.

GOAL 5

Excellent Mental Health Care Is Delivered and Research Is Accelerated

Concerned about the length of time it takes for research that produces useful treatments to reach the field, members of the New Freedom Commission called for aggressive steps to publicize evidence-based practices, train providers to use them, and make them available to those who could benefit from them. The Commission also encouraged the use of emerging best practices, which are promising but have less thorough documentation of their efficacy.

Currently, SAMHSA recognizes six strategies as evidence-based: supported employment, integrated treatment for co-occurring disorders, Assertive Community Treatment (ACT), illness management and recovery, medication management, and family psychoeducation. Examples of emerging practices include wraparound services, jail diversion and community reentry programs, and therapeutic foster care.

The Commission made four recommendations for Goal 5:

- 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.
- 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.
- 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.
- 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

THE STATES RESPOND

Planning and Guiding State Use of Evidence-Based Practices

States report a growing consensus on the importance of evidence-based practices. Pressure to ensure their use as widely as possible comes from legislatures and funders concerned about making the best use of limited dollars, consumer and advocacy groups who want to ensure proven methods of care, and provider groups and researchers who are aware of emerging practices.

Some States have passed legislation endorsing the use of evidence-based practices. During 2003, the **Oregon** Legislature passed a bill endorsing the use of evidence-based practices in the public mental health system. The requirement for phased implementation ends with full implementation in 2009, when at least 75 percent of State and Federal treatment resources must be used to purchase services from programs that are confirmed to be evidence-based. A similar bill being drafted in **Kentucky** would require all mental health services in the State to be evidence-based practices within 6 to 8 years. The **Iowa** legislature specifically mandated that, as of July 1, 2004, 70 percent of Block Grant funds must be used to promote the use of evidence-based practices in the mental health care system, or for emergency services.

Many States are involving stakeholder groups to plan and oversee the use of evidence-based practices. For example, the **Connecticut** Coalition for the Advancement of Prevention, community-based organizations, and State agencies collaborate to develop comprehensive strategies to implement and evaluate evidence-based programs to promote mental health and prevent violence and substance abuse among **Connecticut's** children. A Preferred Practices Initiative identifies and implements evidence-based practices throughout the State system, while the Recovery Institute provides training on recovery-oriented practices. **Hawaii** has established a child- and youth-focused Evidence-Based Service Committee. Other States using this approach include **Illinois, New Mexico, Vermont, and Washington**. Many States also host conferences and sponsor training on evidence-based practices.

Some State mental health agencies are moving to integrate requirements for evidence-based practices into their arrangements with providers and regional entities. For instance, **Delaware's** Department of Substance Abuse and Mental Health, observing a growing consensus among behavioral health providers at all levels of government that publicly funded programs must promote the acquisition and use of evidence-based practices, has begun to incorporate these practices into its contractual relationships, State-managed systems of care, workforce development efforts, and program evaluation and performance outcomes. Also, in **Minnesota**, provision of integrated treatment for co-occurring disorders will be required of ACT teams, adult residential treatment centers, and hospitals with contracts to provide extended inpatient psychiatric services.

**Teletraining on
Evidence-Based Practices
(Iowa)**

The University of Iowa's Iowa Consortium of Mental Health (ICMH) was provided funding to develop and deliver a statewide training on evidence-based practices. This 7-week, 10.5 hour training was broadcast over the Iowa Communications Network to more than 900 registrants in dozens of locations throughout the State. Information about the series, including PowerPoint slides and streaming video, can be found at the ICMH Web site: www.icmentalhealth.org.

For more information, contact:

Dr. Michael Flaum,
Iowa Consortium for Mental Health,
Michael-flaum@uiowa.edu.

Promoting Evidence-Based Practices Through Education

States are using conferences, the Internet, regular meetings, training, and technical assistance resources to spread knowledge and use of evidence-based practices.

- In **Maine**, a recent statewide symposium provided an opportunity for providers, consumers, and other stakeholders to learn from national and local experts on evidence-based practices.
- In **North Dakota**, the State has implemented monthly evidence-based practices forums with regional Human Service Centers. These forums help to assess organizational readiness, increase provider knowledge and behavior, build consensus, increase access, and identify ongoing needs.
- **Minnesota** provides statewide monthly core trainings on adult evidence-based practices via videoconferencing. Between 200 and 400 individuals participate.
- The annual NAMI-VT provider conference focuses on innovative practices for treating individuals with severe mental illnesses in **Vermont**.
- A new institute for substance abuse and mental health staff and stakeholders hosts statewide unveilings of new plans or evidence-based models of treatment adapted for **Wyoming**.
- **Virginia's** Department of Mental Health, Mental Retardation, and Substance Abuse Services issues regular guidance bulletins to Community Services Boards regarding best practices in substance abuse treatment and other services.

To refine and promote evidence-based practices, many States are establishing centers specifically for this purpose, often with links to universities. Examples include a Center of Excellence in **Utah**, the **Hawaii** Center for Evidence-Based Practice, University of Maryland Evidence-Based Practice and Systems Evaluation Centers, Coordinating Centers for Excellence and Networks in **Ohio**, and **Iowa's** Technical Assistance Center for Evidence-Based Practices.

Some States also have established technical assistance centers to help them implement particular evidence-based practices, such as the ACT Technical Assistance Centers of **Indiana**.

A primary role of the Mental Health Block Grant program in Wyoming is to develop specific projects and pilots that show promise for statewide implementation.

Many States are producing resources to guide the implementation of evidence-practices.

- **Washington** used Block Grant funds to contract with the **Washington** Institute for Mental Illness Research and Training, which produced a resource guide, *A Summary of Best and Promising Mental Health Practices*.
- **Virginia's** interagency State Commission on Youth disseminated a collection of *Evidence-Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs*. (See the Resource section at the end of this report for more information on these resources.)
- **New York**, the State Mental Health Association established a Web site to promote the use of evidence-based practices; the site allows visitors to search a database of programs and treatments. The site's address is www.mhanys.org/ebpdb.

Most State mental health agencies have forged close relationships with local universities and research centers to inform and support their use of evidence-based practices. Often, they sponsor targeted research through these institutions and look to them as a source of expert trainers.

Many States also have established scholarships and internship programs through these institutions to address workforce shortages.

- **Maryland's** Mental Hygiene Administration has established academic linkages with Coppin University, Georgetown University, the University of **Maryland**, and the Johns Hopkins University to help infuse evidence-based treatments into everyday practices.
- **Kentucky** sponsors research on recovery and works regularly with the University of Louisville and the University of **Kentucky** to adapt evidence-based practices for use by the State and providers.

**Supported Independence
Projects
(Wyoming)**

Two outstanding supported employment programs in Wyoming have received national recognition. One operates in a urban environment and the other in a more rural environment. Thus, they are different in how they approach a “place and train,” client-led model of supported employment.

Employment statistics for the urban program indicate that 54 percent of 160 clients are employed, with length of employment ranging from a few months to more than 8 years. The program credits a collaborative buy-in from core team members, who include a primary therapist, a job coach, and a vocational rehabilitation counselor, along with the client and employer (if the client is placed). Together, they develop a job plan and provide intensive on-site supervision for the client. One outcome has been a noticeable change in the attitude of clients and their families about work.

In the rural settings, not enough jobs are available, so mental health innovators started their own company. Washakie Works is a vocational program operating as a free-standing business. Its services include yard and garden work, household moving, painting, and miscellaneous small jobs. As client workers became skilled at carpentry, they began remodeling an apartment complex and building duplexes for purchase

continued on next page

In New Hampshire, a Dollars and Sense pilot project supported individual career accounts where consumers design and fund their own work readiness and transitional employment programs.

Evidence-Based Practices in Action

States use all SAMHSA-recognized evidence-based practices in varying degrees. ACT, supported employment, and integrated treatment for co-occurring disorders were mentioned most frequently in Block Grant applications, followed by illness management and recovery, medication management, and family psychoeducation.

Programs for Assertive Community Treatment (PACT) and ACT teams have been promoted for many years and are now widely used. Some States have used SAMHSA toolkits or research centers to ensure model fidelity, and others have adapted the model to serve specific audiences, meet identified needs, or add essential components.

- In four areas of **South Dakota**, Individualized and Mobile Programs of Assertive Community Treatment (IMPACT) have been developed. An IMPACT Step-Down Program has been developed for individuals currently receiving IMPACT services who require a less intense level of service. The Step-Down Program is operated with an open door for people who may later require more intensive intervention or support.
- **Maine** and **Louisiana** have modified ACT programs to serve children.
- In **North Carolina**, some ACT teams participate in jail diversion programs.
- **Hawaii** emphasizes the need to adapt ACT protocols to fit the unique cultural needs of its communities.
- Certified Community Support Programs are **Wisconsin’s** version of Assertive Community Treatment programs, which operate in 62 of 72 counties.
- **Utah’s** Assertive Community Outreach Treatment is specifically designed to meet the needs of consumers living in rural areas.

Supported Independence Projects (Wyoming)

continued from previous page

as their own residences. Now licensed as a building contractor with crews supervised by professional job coaches to ensure quality work, Washakie Works provides construction/remodeling services at competitive prices and often will be the low bidder for small jobs that are not profitable for larger commercial companies. The project is self-supporting and takes advantage of available job training funds.

For more information, contact:

Urban model –

Michael Huston, Director,
and

Paul Demple, Program Manager,
Psychiatric Rehabilitation Program,
Central Wyoming Counseling Center,
Casper, Wyoming, (307) 237-9583.

Rural/frontier model –

Lonnie Gerherter, Interim Director,
and
Lew Markley, Adult Program Manager,
Washakie Mental Health Center,
Worland, Wyoming, (307) 347-6165.

In Virginia, ACT teams reduced hospitalizations, increased stability, and reduced involvement with police among recipients.

Supported employment programs are varied, with many successful examples. Programs that report successful outcomes generally involve close alliances with key agencies and prospective employers.

- In **Vermont** (one of three original recipients of Supported Employment grants from the Johnson and Johnson Foundation), the Division of Mental Health has partnered with Vocational Rehabilitation, the Department of Corrections, and Child Welfare and Youth Justice to offer supported employment programs and intensive case management to transition-aged youth in JOBS programs throughout the State.
- **Ohio** is developing an Employment Network to further disseminate evidence-based supported employment practices.
- In **New Hampshire**, supported employment has in large part replaced partial hospitalization programs. The Individual Placement and Support model has been enhanced through flexible supports, including support in mastering work-related skills and behaviors in integrated work settings.
- In **South Dakota**, Block Grant dollars augment Extended Employment Services for adults with serious mental illnesses. Employment coaching, job shadowing, and assistance with locating and maintaining employment are provided by private agencies through contracts with the State.

Pathways to Independence (Wisconsin)

A joint effort by the Division of Disability and Elder Services, Bureau of Mental Health and Substance Abuse Services, and the Department of Workforce Development, Division of Vocational Rehabilitation, Pathways to Independence is a research and development project that seeks to develop and test innovative policy and service strategies to reduce employment barriers for people with severe disabilities. A collaborative effort between Federal, State, and county governments, Pathways provides comprehensive, integrated, team-based, consumer-centered vocational services.

In order to facilitate an informed decision regarding employment, Pathways staff provide consumers with an analysis of the impact of potential earnings and asset accumulation on continued cash, health care, transportation, and housing supports. Programs that reduce work disincentives have been integrated in the array of services available through Pathways. Such programs include Federal earnings waivers and the Wisconsin Medicaid Purchase Plan, which allows individuals to buy into Medicaid services.

For more information, contact:

John Reiser,
Director,
(608) 266-3062,

<http://dhfs.wisconsin.gov/WIpathways>.



A Peer Support Advocate helps a consumer rate symptoms and side effects—an illness teaching and monitoring activity conducted during a medication visit. Michigan consumers were hired and trained to serve as Peer Support Advocates in the Michigan Assertive Community Treatment (ACT) program.

Most States are promoting *integrated treatment for co-occurring disorders*; many have pilots, planning committees, and task forces in place to promote the use of this evidence-based practice. A summary of their work in this area is contained under Goal 4 of this report.

Illness management and recovery is taught in many States. One proponent of this practice is **New Jersey's** Division of Mental Health Services, which contracted with the Center of Excellence in Psychiatry to pilot Team Solutions, a program shown to have positive results in improving overall physical and mental status using illness self-management and self-directed care techniques. The program is being provided in all adult State psychiatric hospitals and in selected community mental health settings.

Medication management has become increasingly widespread, with many States promoting SAMHSA's medication management toolkit. Key elements include: use of a systematic plan for medication management, objective outcome measures, clean and thorough documentation, and consumer and provider involvement in decision-making. The New Freedom Commission highlighted the Texas Medication Algorithm Project as an example of an evidence-based practice that "results in better consumer outcomes, including reduced symptoms, fewer and less severe side effects, and improved functioning" (p. 68). Similar efforts are underway in **Florida, Kentucky, Michigan, New Jersey, Oregon, and Pennsylvania.**

Family psychoeducation also is used in a number of States. However, States did not provide details on how this model is used.

Promising and Emerging Practices

One of the most frequently mentioned promising or emerging practices is *therapeutic foster care*, which is identified as widespread in **Arkansas, Colorado, Hawaii, Kentucky, Mississippi, Puerto Rico, and Vermont**. This strategy is sometimes cited as an alternative to out-of-State placements, which most States are striving to avoid.

Supportive housing strategies are common, though States are struggling to find adequate funding to meet the need. These are some notable examples:

- **North Carolina** has several supportive housing projects, usually in cooperation with local public housing authorities, nonprofit organizations, and the U.S. Department of Housing and Urban Development. Efforts are being made to expand Shelter Plus Care rental assistance and to increase permanent and transitional units for people with mental illnesses who are homeless;
- The PILOTS program, a supportive housing initiative for people who are homeless, is a public/private collaborative effort in **Connecticut** that fosters the development of solutions for long-term housing and service needs of individuals and families coping with psychiatric disabilities and/or chemical dependency. The PILOTS program consists of transitional and/or permanent housing subsidies with funding for supportive services; and
- **California's** Supportive Housing Initiative Act has awarded \$48.2 million in State General Fund dollars to 46 supportive housing projects serving approximately 8,300 low-income individuals throughout California, including people with mental disorders.

Another cited strategy is *wraparound services* for children and adolescents (see Goal 4 (p.36 *approach*,³⁷ *certification*,³⁸ *services*) for further discussion of children's services).

GOAL 6

Technology Is Used to Access Mental Health Care and Information

The New Freedom Commission recognized the application of information technology to health care as “perhaps the most important medical advance of the 21st century” (p. 79). The Commission envisioned the development of two critical components for a national health information infrastructure to support quality mental health care delivery, especially in rural and other underserved areas, and made these two recommendations:

- 6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.
- 6.2 Develop and implement integrated electronic health record and personal health information systems.

THE STATES RESPOND

Using Telehealth to Improve Access and Coordination of Mental Health Care

Telecommunications technologies using computers, video cameras, telephones, and the Internet to relay information have created a new tool for health care—telehealth. Telehealth systems can be used to provide long-distance clinical care and consultation, patient and professional health-related education, and public health and health administration.

A large number of States use telehealth technology, most often to provide direct access for consumers to mental health care providers via teleconference. Assessment, consultation, development of treatment plans, medication management, and commitment hearings have been held via teleconference. States with large rural populations have taken the lead in using these technologies to serve their populations.

Most of the Mountain States (including **Arizona, Colorado, Montana, Nevada, and New Mexico**) and Appalachian States (including **Kentucky, North Carolina, Tennessee, Virginia, and West Virginia**) have developed telehealth systems. Telehealth systems are used in **Illinois, Iowa, Oregon, Texas, and Wisconsin**. Consumer satisfaction with the services has been high in those States where it has been measured.

As an alternative to direct service provision via teleconferencing, the technology is used in **California, Hawaii, and North Dakota** to link specialists to other providers. In **Oklahoma** and **Tennessee**, commitment hearings can be held via teleconference. A number of States including **Arizona, Colorado, Iowa, Minnesota, and Oklahoma** also use teleconferencing to provide training to mental health care providers—yet another strategy for increasing service availability in rural regions.

The States below have found other innovative uses of teleconferencing technology to advance mental health services and systems.

- **Maine** frequently uses teleconferences to glean feedback from consumers and family members.
- **Ohio** held forums on the New Freedom Commission via teleconference.
- In **Virginia**, families can use teleconference technology to “visit” relatives in distant hospitals and facilities and to participate in therapy.
- **Alabama** and **North Carolina** use teleconferencing to provide American Sign Language translation to consumers who are deaf or hard of hearing.

Medication Management by Telemedicine (Idaho)

Geographic distance can be a significant impediment to receiving appropriate and timely mental health treatment. Community mental health centers in two regions in Idaho are addressing this barrier by offering medication monitoring follow-up services to consumers who are willing to use this technology. Physicians located in the central office can serve consumers in a satellite office with the aid of an 8x8 set-top videophone connected through the regular phone line and the use of speaker phones.

In Region 1, an average of 5 to 10 consumers a month use the service, and consumer satisfaction is reported to be high because this service eliminates the 45-minute travel time between offices, the need to miss time from work or school to attend appointments, and the need to arrange child care. Consumers who do not like the system are accommodated with face-to-face appointments in the central office. Telemedicine contacts are used for medication follow-up appointments only; all initial psychiatric assessments are conducted in person. Medicaid reimbursement for telemedicine services is available for pharmacological management and psychotherapy with medical evaluation.

For more information, contact:

Anne Bloxham, (208) 334-5716,
bloxhama@idhw.state.id.us.

Also, see

Telehealth Idaho at

<http://telida.isu.edu/telida/index.php>.

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

Initial implementation of Kansas' interactive telepsychiatry network, begun in 1988, created one of the largest televideo systems in the world for the delivery of mental health services. It has now grown to 80 video units across 27 community mental health centers.

The States' commitment to telehealth is demonstrated in the development of comprehensive infrastructure to support and enhance its use.

- In **Mississippi**, new adult crisis centers are equipped for telemedicine.
- In **Louisiana**, 90 percent of all community mental health centers have direct access to telemedicine and teleconferencing.
- **Kentucky** has begun billing Medicaid for telemedicine services,
- **Alabama** is in the process of developing billing codes and procedures for telemedicine services.

Developing and Implementing Integrated Electronic Health Records

A number of States are improving their data collection and management and implementing electronic health records. A wide variety of technology and approaches are being used.

- **Alabama** is using Data Infrastructure Grant funding to develop a uniform health record to link hospital and community service records.
- **Florida's** new electronic medical records system tracks residential files and assists in treatment decisions.
- **Maryland** has contracted with APS Healthcare to institute a Web-based system for the registration and authorization of mental health services.
- The Enterprise Information System integrates services and billing information in **Maine**.
- **Puerto Rico** and **Palau** have begun to explore integrated record keeping for children's mental health services.
- **Nevada** has adopted the AVATAR software, which will allow for client billing, assessment, medical records, and treatment planning to be maintained in a single Master Patient Index.
- **Utah** is implementing E-charting.

The Performance Indicator Project (Vermont)

Network of Care, an individualized mental health resource Web site that was identified as a model program by the New Freedom Commission, is used in California, Maryland, New York, Ohio, and Virginia.

- **Texas** is implementing WebCARE, a Web-based system for registration, diagnosis, and assessment, as well as workflow and data management reporting.
- **Alaska** has modified a SAMHSA-provided data collection tool called WITS (Web Infrastructure for Treatment Services) to reflect both mental health and substance abuse treatment services.
- **Florida** uses Web-based technologies to share community needs assessments and better place individuals in less restrictive settings.
- **New Jersey's** new management information system enhances the quality and efficiency of the State's supported employment system.
- In **Florida, Hawaii, Missouri, and New York**, decision-support technologies help health care providers develop evidence-based treatment plans.

Providing Health Information to Consumers

A number of States use information technology to link service providers or to link mental health service providers to others who encounter people with mental illnesses. Most States provide consumer information via their department Web pages.

- Connecticut maintains a clearinghouse of behavioral health information for consumers and providers at www.ctclearinghouse.org.
- In **Virginia**, a Web-based program called WorkWORLD™ helps people with disabilities make decisions regarding paid employment, work incentives, and government benefits.

Extensive use of sophisticated information technology is a core component of the Vermont Division of Mental Health's CMHS-funded Performance Indicator Project (PIP). In-house information resources include an integrated database that stores extensive data describing community-based service recipients and the services they receive. Data are provided directly by community providers using a Web-based reporting system. All of these components are integrated with fiscal data and person-level staffing data by means of cost center codes and staff ID numbers. These data provide the basis for a variety of standard reports as well as focused studies.

The PIP also makes extensive use of these internal data in conjunction with administrative databases from a wide range of government agencies and private-sector service providers for mental health services research and program evaluation. The core objective of the PIP is to support rational data-based thinking and decision making within systems of care in Vermont by producing and electronically distributing brief data reports to more than 250 service providers, consumers, administrators, advocates, and others on a weekly basis. All PIP reports are available online at www.state.vt.us/dmh/docs/pips/pips-by-date.html.

For more information, contact:
John A. Pandiani, Chief,
Research and Statistics,
Vermont Department of Health,

State-Developed Resources Available to Others

GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health		
State	Resource	Where Available
AK	Alaska Suicide Prevention Plan	Alaska Division of Behavioral Health 3601 C St., Suite 878 Anchorage, AK 99503 (907) 269-3600
CO	Population in Need Report	www.cdhs.state.co.us/ohr/mhs/Reporting%20and%20Evaluation%20Folder/Index.htm
CT	Juvenile Justice Programming	Ann Macintyre –Lahner Program Director (860) 723-7202 Ann.Macintyre-Lahner@po.state.ct.us
CT	Managed Service Systems and Enhanced Care Coordination	Ann Adams Program Director (860) 550-6327 ann.adams@po.state.ct.us
CT	Youth Suicide Prevention Packet; Youth Suicide Advisory Board; K-12 Mental Health Initiative	Deanna Paugas-Lia Director of Prevention (860) 550-6637 Deanna.paugas@po.state.ct.us
FL	Preventing Suicide in Florida: A Strategy Paper by the Florida Task Force on Suicide Prevention	www.myflorida.com/myflorida/government/governorinitiatives/drugcontrol/suiide_prev.doc
FSM ¹	Suicide: Finding a Better Way Out video	www.micsem.org/cvideo/videotapes.htm
ID	Hearts and Minds: Teens and Mental Illness video	Ross Edmunds (208) 334-5726 edmundsr@idhw.state.id.us
ID	In Our Own Voice consumer documentary	www.idahoptv.org/productions/ownvoice
ID	Idaho's Suicide Prevention Plan	www.spanidaho.org
ID	Training program for primary care physicians on the use of psychotropic medications	http://WICHE.edu/mentalhealth/grand_rounds/primary_care.htm
KY	Preventing Suicide in Kentucky: Progress Report – June 2004	http://mhmr.ky.gov/mhsas/html/PDFs/Final%20June%202004%20KSPPG%20Progress%20Report%20web.pdf
NE	Project Relate (anti-stigma media campaign)	www.projectrelate.org

¹ Federated States of Micronesia

GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health		
State	Resource	Where Available
NE	Southeast Nebraska Suicide Prevention Curriculum	www.nebhands.nebraska.edu/Resource%20Information/Suicide%20Prevention%20Info%20Link.htm
NJ	Students at Risk for Suicide— Assessment and Interview Techniques training video	Val Casey Division of Children’s Behavioral Health Service (609) 777-0740 val.casey@dhs.state.nj.us
NM	See Mommy Cry documentary	Matt Dillman mdillman@cyfd.state.nm.us
OK	Online publications	www.odmhsas.org/publications.htm
OR	Recommendations for linking and integrating behavioral health and primary care	www.dhs.state.or.us/mentalhealth/rec-int-hlth-pricare.pdf
OR	The Oregon Plan for Reducing Suicides in Older Adults	Sandra.Moreland@state.or.us
SC	Teen Matters Web site	www.teen-matters.com

GOAL 2: Mental Health Care Is Consumer and Family Driven		
State	Resource	Where Available
AL	Information on the State plan to consolidate and close mental health facilities	www.mh.state.al.us/Commissioner/ConsolidationPlans2003.asp
AL	Information on the Wyatt case and settlement, which established minimum standards for providing treatment and habilitation in State mental health and mental retardation facilities	www.mh.state.al.us/admin/downloads/wyatt.html
AZ	A Sourcebook for Families Coping with Mental Illness – A Guide for Preventing the Other Shoe from Dropping	Community Partnership of Southern Arizona (CPSA) 4575 East Broadway Tucson, AZ 85711 (520) 325-4268
CA	California Mental Health Master Plan: A Vision for California	www.dmh.ca.gov/MHPC/masterplan.asp
CA	Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness (AB 2034) legislative report	http://www.dmh.ca.gov/AOAPP/Int_Services/docs/AB2034_may2003.pdf
FL	Florida guide to supportive housing and strategic plan for supportive housing	www.state.fl.us/cf_web
FL	Florida's Elimination of Barriers Initiative	www.dcf.state.fl.us/mentalhealth/ebi/index.shtml
GA	A Mental Health Consumer's Guide for Participation in and Development of Medicaid Reimbursable Peer Support Services.	http://mhddad.dhr.georgia.gov/DHR-MHDDAD/DHR-MHDDAD_CommonFiles/16618139ConsumerManual403.pdf
GA	Georgia Certified Peer Specialist Project	www.gacps.org/Home.html
GA	Information and Application to Become a Provider of Medicaid Reimbursed Mental Health and Addictive Diseases Rehabilitation Option Services	http://mhddad.dhr.georgia.gov/DHR-MHDDAD/DHR-MHDDAD_CommonFiles/14874954medprovapman.pdf
IA	Reports from the Iowa Mental Health, Mental Retardation, Developmental Disabilities and Brain Injury Commission on the State's Mental Health System Redesign	www.dhs.state.ia.us/publications.asp

KS	Pathways to Recovery: A Strengths Recovery Self-Help Workbook	Rebecca Rinehart, State Planner Kansas Mental Health Authority (785) 296-3471 RCXR@srskansas.org
GOAL 2: Mental Health Care Is Consumer and Family Driven		
State	Resource	Where Available
KY	Kentucky Partnership for Families and Children	www.kypartnership.org
KY	Opportunities for Family Leadership	http://mhmr.ky.gov/mhsas/OFL%20Trainings.asp?sub6
LA	Project Legacy: Transforming Mental Health Services in Louisiana (State report on transformation that aligns Louisiana goals with New Freedom Initiative)	www.dhh.louisiana.gov/offices/publications/pubs-153/project%20legacy.pdf
LA	The Louisiana Mental Health Planning Council: goals and operations summary	www.dhh.louisiana.gov/offices/?ID=153
MS	Case Management brochure	www.dmh.state.ms.us/pdf/CaseManagementBrochureBinder.pdf
MS	Office of Constituency Services brochure	www.dmh.state.ms.us/pdf/OCSBinder.pdf
NC	Hospital downsizing initiative	Laura White, Program Manager State Operated Services Team (919) 733-3654 laura.white@ncmail.net
NC	North Carolina Jail Diversion Report: 2003-2004	www.dhhs.state.nc.us/mhddsas/justice/jaildiversion/ncjaildiv03-04report.pdf
NE	Psychological First Aid for disasters	www.disastermh.nebraska.edu
NM	Smart Money	Michael Basarab (505) 281-5402 Basarab@earthlink.net
PR	Training materials in Spanish	Edwin Montañez Director of the Training Institute (787) 767-9415 edwinm@assmca.gobierno.pr
SC	Peer Support	www.state.sc.us/dmh/consumer_resources/consumer_resources.htm
SC	Recovery for Life/consumer empowerment	SCShare@bellsouth.net
TN	Criminal Justice and Mental Health Services reports, training curriculum, and manuals	www.state.tn.us/mental/cj/cj1.html
TN	Housing Within Reach, a consumer housing resource system	www.housingwithinreach.org

TX	State Action Plan to End Chronic Homelessness	www.tich.state.tx.us
VA	Training audiotapes and PowerPoint presentations on human rights protection and advocacy	www.dmhmrsva.org/OHR-Training.htm

GOAL 3: Disparities in Mental Health Services Are Eliminated.		
State	Resource	Where Available
AR	Cultural Competence training materials	Vanessa Davis Assistant Director for Minority Affairs (501) 686-1693 vanessa.davis@arkansas.gov
CA	Multicultural Mental Health Brochure Series/Interactive CDs	www.cimh.org/projects/translation.cfm
CO	Colorado Mental Health Services Cultural Competency Plan	www.cdhs.state.co.us/ohr/mhs/Cultural%20Competency%20Folder/Index.htm
CT	Cultural Competency (assessment, workforce development, plans)	William Rivera, Director Division of Multicultural Affairs (860) 550-6569 William.rivera@po.state.ct.us
CT	Family Advocacy Services; Behavioral Health Data System; Multiculturalism Subcommittee; Multiculturally Competent Contract Management Guidance	Susan R. Smith, Program Supervisor Contracts and Information Systems (860) 550-6695 susan.smith@po.state.ct.us
CT	Health Advocacy Program	Aurele Kamm Health Program Supervisor (860) 723-7217 Aurele.Kamm@po.state.ct.us
CT	Services and Programs for Girls	Gayle Brooks Program Director (860) 550-6540 Gayle.Brooks@po.state.ct.us
MN	Tools for translation/transculturation	www.dhs.state.mn.us
NC	Interim Report on Geriatric Mental Health Specialty Teams, 2004	www.dhhs.state.nc.us/mhddsas/manuals/reports/leg10-1-04interimreport.pdf

GOAL 3: Disparities in Mental Health Services Are Eliminated.		
State	Resource	Where Available
TN	The Strategic Plan for Cultural Competence; includes training curriculum for interpreters	Lygia Williams (615) 253-5078 Lygia.Williams@state.tn.us
WA	The Mental Health Needs of American Indians in Washington State	www1.dshs.wa.gov/pdf/hrsa/mh/amindiansmhneeds.pdf
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.		
State	Resource	Where Available
AK	Alaska Screening Tool	http://health.hss.state.ak.us/dbh/resources/publications.htm
AR	The Child and Adolescent Service System Program (CASSP) brochure	www.state.ar.us/dhs/dmhs/cassp_brochure.htm
CA	Final Report of the Co-Occurring Disorders Workgroup	www.dmh.ca.gov/AOAPP/Co_Occuring/docs/COD%20Workgroup%20Final%20Report.pdf
CO	Colorado System of Care Collaborative	http://cosystemofcare.org
CT	Connecticut Community KidCare; Partnership for Kids (PARK) Project; Administrative Service Organization	Karen Andersson Director of KidCare (860) 550-6683 Karen.Andersson@po.state.ct.us
CT	Early Childhood Consultation Partnership	Mary-Ann Dayton Fitzgerald, Program Supervisor Infant and Early Childhood Mental Health (860) 560-5070 Maryann.Dayton-Fitzgerald@po.state.ct.us
CT	Transitional Youth and Young Adult Services	Sara A. Lourie Program Director (860) 560-5096 sara.lourie@po.state.ct.us
KS	A Mental Health Guide For Older Kansans and Their Families	Leslie Huss, Program Manager Kansas Mental Health Authority (785) 296-3471 LXXH@srskansas.org
MO	Practice Guidelines Initiative	www.dmh.mo.gov/cps/issues/pracguide.htm

² Republic of the Marshall Islands

GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.		
State	Resource	Where Available
MO	Screening Children & Adolescents for Substance Abuse, Developmental Disability and Mental Illness	www.dmh.mo.gov/cps/issues/screenchild.pdf
RMI ²	Report on peer outreach program Youth to Youth in Health	www.spc.int/youth/Best_Practice/youth_to_youth_in_health.htm
TX	Children's Mental Health Toolkit	www.dshs.state.tx.us/mhprograms/RDMChildResources.shtm
WY	The Future of Wyoming's Children Search Conference Report, April 7-8, 2003	http://mhd.state.wy.us/initiatives/wy_search_conf_0403.pdf

GOAL 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated.		
State	Resource	Where Available
AR	Training materials for law enforcement regarding mental illness	Billy Burris Assistant Director for Forensic Services (501) 686-9174 billy.burris@arkansas.gov
CO	Colorado Work Group for Evidence Based Mental Health Practices Final Report	www.cdhs.state.co.us/ohr/mhs/index.html
CT	Connecticut Center for Effective Practice; Training for Community Service Providers; Evaluation of Evidence-Based Practices RFA	Michael Schultz Director of Research (860) 550-5034 Michael.Schultz@po.state.ct.us
CT	Consumer Perception of Care Surveys	Joan Twiggs Statistician (860) 560-5091 joan.twiggs@po.state.ct.us
CT	Hartford Youth Project (HYP)	Reginald Simmons Program Supervisor (860) 560-5087 Reginald.Simmons@po.state.ct.us
CT	Intensive In-Home Services (IICAPS, MDFT, Family Support Teams, FFT); Care Coordination; Community-Based Services	Robert Plant, Director Division of Community-Based Services (860) 560-5035 Robert.plant@po.state.ct.us
CT	Multi-Systemic Therapy and Substance Abuse Treatment	Peter Panzarella, Director Substance Abuse Division (860) 550-6527 Peter.Panzarella@po.state.ct.us
FL	Employment guidebook	www.state.fl.us/cf_web

GOAL 5: Excellent Mental Health Care Is Delivered and Research Is Accelerated.		
State	Resource	Where Available
HI	Hawaii Center for Evidence-Based Practice	www.amhd.org/cebp
IA	Teletraining on evidence-based practices	www.icmentalhealth.org
ID	ACT Team Standards	Jerry Anderson (208) 334-5527 anderso6@idhw.state.id.us
KS	Kansas Planning Grids for the President's New Freedom Commission and Evidence-Based Practices	Rebecca Rinehart, State Planner Kansas Mental Health Authority (785) 296-3471 RCXR@srskansas.org
UT	Preferred Practice Manual	www.dsamh.utah.gov
VA	Virginia Commission on Youth: Collection of Evidence-Based Treatment Modalities for Children and Adolescents with Mental Health Treatment Needs	http://coy.state.va.us/docs/ModalitiesSection1.pdf
WA	A Summary of Best and Promising Mental Health Practices	www1.dshs.wa.gov/mentalhealth/bestpracticesguide.shtml

GOAL 6: Technology Is Used to Access Mental Health Care and Information.		
State	Resource	Where Available
CA MD NY OH VA	Network of Care for Mental Health Internet resource	http://networkofcare.org/home.cfm
NC	Data warehousing project	Deborah Merrill Information Systems Team Leader (919) 715-7774 Deborah.Merrill@ncmail.net

Federal Resources.		
	Resource	Where Available
FED	Transforming Mental Health Care in America - The Federal Action Agenda: First Steps	www.samhsa.gov
FED	The President's New Freedom Commission on Mental Health – Achieving the Promise: Transforming Mental Health Care in America	www.samhsa.gov
FED	National Mental Health Information Center	www.store.mentalhealth.org (800) 789-2647 (toll free) (866) 889-2647 (TDD)