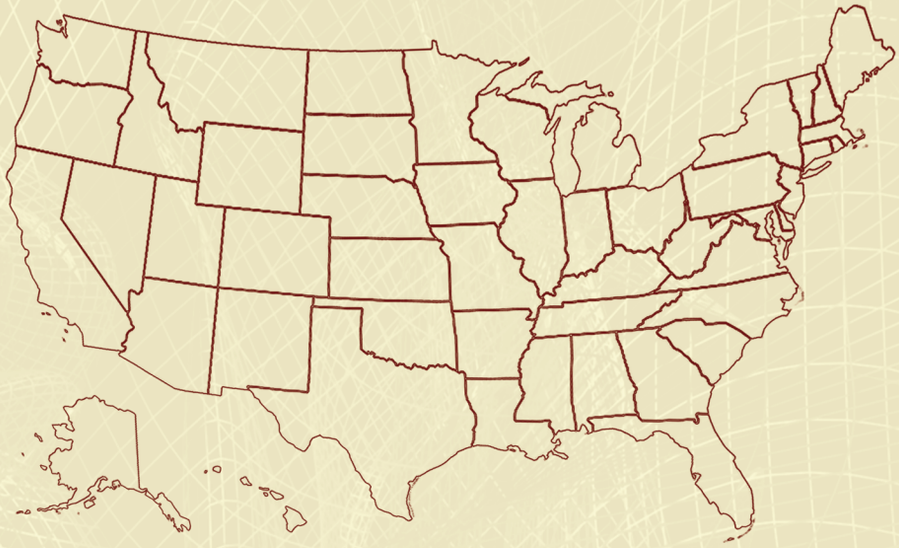
Funding and Characteristics of State Mental Health Agencies, 2010







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

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The views, opinions, and content of this report are those of the authors and do not necessarily reflect the views or policies of SAMHSA or HHS.

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Executive Summary

State Mental Health Agencies (SMHAs) are the state governmental agencies responsible for assuring the availability and delivery of mental health services to adults with serious mental illnesses (SMI) and children with serious emotional disturbances (SED). States have been involved in providing mental health services to their most in need citizens since the opening of the first state hospital by the Virginia colonial government in 1773. SMHAs have evolved from operating state psychiatric hospitals to overseeing a modern safety net system. This system provides predominately community-based mental health services (over 95 percent of consumers received mental health services provided in their community) designed to help consumers recover and live in their own communities.

In 2009, SMHA systems provided mental health services to more than 6.4 million individuals. During state fiscal year 2008, SMHAs spent over $36.7 billion to provide mental health services. This report provides an overview of the various ways SMHAs were organized and structured within state government, the major policy issues the SMHAs addressed, which clients were eligible for SMHA-funded services, how the SMHAs financed both state psychiatric hospital and community-based services, and how the SMHAs monitored and evaluated the quality and outcomes of the services they financed and provided.

Organization and Structure of SMHAs

SMHAs were usually organized as a division within a larger state umbrella agency (typically a Division of Mental Health or Behavioral Health combining mental health and substance abuse service) within a State Department of Human Services or Health and Human Services. The SMHA was an independent state agency in 11 states.

Most SMHA directors reported to a cabinet secretary (26 SMHAs); however, 5 SMHA directors reported directly to the Governor, and in 9 states, the director served as a member of the Governor's Cabinet.

Between 2008 and 2010, five states reorganized their SMHAs. Georgia, Louisiana, and Washington relocated their SMHAs into another department. Georgia reorganized its SMHA from a division-level agency into the Department of Mental Health. Louisiana folded substance abuse services into the SMHA. In Alaska, the responsibility for traumatic brain injury (TBI) and organic brain syndrome services was moved out of the SMHA. In California, the responsibility for TBI services was moved out of the SMHA.

Non-Mental-Health Disability Responsibilities

SMHAs often had responsibility for administering other disability services, including substance abuse and intellectual disability services. Substance abuse services and mental health services were integrated into 1 agency in 31 states and were located within the same umbrella agency as mental health in 15 additional states. Services for persons with intellectual disabilities (formerly referred to as "developmental disabilities" or "mental retardation") were the responsibility of the SMHA in 12 states. In 30 states, intellectual disability services were located within the same umbrella agency, but not within the SMHA. In 11 states, both substance abuse and intellectual disability services were combined with mental health into a single agency.

Mental Health Service Responsibilities of SMHAs

SMHAs varied widely regarding the specific types of mental health services they provided and populations they served. In most states, the SMHA was responsible for both state psychiatric hospital services and community services for both children and adults; however, for some states, responsibilities for delivering some of these mental health services were vested outside of the SMHA. Thirty-six SMHAs were responsible for providing mental health services to both children and adolescents; however, in 12 states, the responsibility for children's services was shared between the SMHA and a separate state agency. Three states (Connecticut, Delaware, and Rhode Island) had a separate children's department responsible for services including child welfare, juvenile justice, mental health, substance abuse, and other social services for children and adolescents.

All state governments operated psychiatric inpatient beds, but not all states assigned this responsibility to the SMHA. In 44 states, the SMHA operated state psychiatric inpatient beds; however, separate agencies in Colorado, New Hampshire, New Mexico, North Carolina, and South Dakota were responsible for the provision of psychiatric inpatient beds.

In 2010, SMHAs funded and/or operated 18,785 organizations to provide mental health services. A total of 17,894* community mental health providers were the core of the SMHA mental health system. The vast majority (17,685) of the community mental health providers were funded, but not operated, by the SMHA. In addition to community mental health providers and state psychiatric hospitals, SMHAs also operated and funded an array of additional mental health providers. Eighteen SMHAs funded or operated 401 general hospital psychiatric units to provide inpatient psychiatric treatment. Seventeen SMHAs funded 120 private psychiatric hospitals to provide inpatient and other mental health services.

* The total includes a duplicated count of children and adult providers in Georgia.

Health-Mental Health Integration

Over the last decade, SMHAs have increasingly focused attention on the physical health needs of mental health consumers. Much of the focus on the health needs of mental health consumers has been energized by a study of mental health consumers in a sample of states who on average die decades prematurely, compared with the general population (Colton & Manderscheid, 2006). In 2008, the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council released a report, Measurement of Health Status for People with Serious Mental Illnesses (Parks, Radke, & Mazade, 2008). This report reviewed the high level of comorbid health conditions among mental health consumers and recommended a set of 12 health indicators for use by SMHAs. In 86 percent of SMHAs (44 SMHAs), there were initiatives to improve the integration of mental health with primary healthcare. In 2010, all 50 responding SMHAs reported they screened or assessed mental health consumers for physical health issues in state hospitals. All but one SMHA required health assessments for all patients at all state hospitals. Forty-five SMHAs supported the colocation of mental health providers in primary care, and in 46 states, community mental health centers were partnering with FQHCs. Forty-five SMHAs were supporting the colocation of primary care services in mental health programs.

Eligibility for SMHA Services

Each state determined the eligibility criteria a person must meet to receive services from the SMHA. The criteria can be inclusive or restrictive, based upon decisions made largely by each state's Governor and legislature. Half (27 SMHAs for adults and 27 SMHAs for children/adolescents) did not have strict eligibility requirements, meaning an adult or child with any mental illness was eligible for state general-funded services. Some SMHAs (19 for adults and 13 for children/adolescents) had eligibility requirements that restricted the provision of mental health services to only those individuals diagnosed with SMI or SED. In two states, adults with any mental illness were eligible for some services, but certain mental health services (such as Assertive Community Treatment) were limited to adults with SMI.

Community Mental Health Services

In 2009, 95 percent (6.1 million) of the 6.4 million consumers served by the 58 state and territorial SMHAs received community-based mental health services. Consumers of all ages received services in community settings. Of the different age groups served, consumers ages 21 to 64 made up the majority (64 percent), followed by children aged 0 to 17 (27 percent), young adults aged 18 to 20 (5 percent), and elderly aged 65 and over (4 percent).

Every SMHA funded community mental health services; however, SMHAs varied widely in how they organized and financed this community mental health system. Most SMHAs (39) funded private not-for-profit community providers, but many (19) states, particularly the large population states, funded city and/or county governments that were responsible for the delivery of community mental health services. A few SMHAs (14) operated community mental health provider agencies with state employees. SMHAs also used a wide mixture of financing sources and payment arrangements to cover mental health services. Medicaid has grown to be the largest single payment source of community mental health services, but SMHAs used a wide mixture of Medicaid waivers, options, and grants to pay for these services.

Psychiatric Hospitalization and Forensic Services

Every state operated some psychiatric inpatient beds, most of which were located in a specialty state psychiatric hospital. In 2009, state-operated psychiatric hospitals served 2.6 percent of all mental health consumers who received services provided by the SMHA, or 167,002 individuals, throughout the year. At the start of the year, 45,468 persons were residents in state psychiatric hospitals. These state psychiatric hospitals had expenditures of $10.3 billion, or 28 percent of all SMHA-controlled expenditures in fiscal year (FY) 2008. In 2010, 49 SMHAs operated or funded 216 state psychiatric hospitals that provided specialized inpatient psychiatric care. Rhode Island was the only state that did not have a stand-alone psychiatric hospital; however, Rhode Island's SMHA operated psychiatric beds within the state's general hospital.

Forty-four SMHAs were responsible for the operation of state psychiatric hospitals, whereas in six states, another agency was tasked with this responsibility, most commonly the Department of Health and Human Services. The rate of hospital residents per 100,000 state population, measured at the start of the year, was 15 for the United States and ranged from 3.9 in Arizona to 68.8 in the District of Columbia.

Forensic services provide evaluation and treatment to persons who have a mental illness and are involved with the criminal justice system. In most states, the SMHA was responsible for the provision of mental health assessments and treatment services for persons sent (to the SMHA) by courts because of their involvement with the criminal justice system. SMHA expenditures for forensic services in state hospitals have grown over the years and represented 37.6 percent of state hospital expenditures in FY 2008.

Impact of State Budget Shortages on Mental Health

A study by the National Governors Association (NGA) and the National Association of State Budget Officers (NASBO) found that "in response to the decline in revenue, 39 states cut their

enacted fiscal 2010 budgets by $18.3 billion. Additionally, 14 states enacted $4.0 billion in budget cuts for fiscal 2011. In fiscal 2009, 43 states cut $31.3 billion and in fiscal 2008, 13 states cut $3.6 billion.

A study conducted by the NASMHPD Research Institute, Inc. (NRI)/NASMHPD found that 78 percent of responding SMHAs (35 out of 45 SMHAs) had cuts to their mental health budget during FY 2010. Over the most recently completed 2 fiscal years (FY 2009 and FY 2010), SMHAs received reductions of $1.5 billion ($664 million in reductions during FY 2009 and an additional $817 million in reductions in FY 2010). In the fall of 2010, states were in FY 2011, and SMHAs had to make an additional $645 million in mental health budget reductions (36 states reporting). And SMHAs were expected to make additional reductions before the fiscal year was completed.

SMHA Policies

During 2010, SAMHSA identified eight major strategic initiatives for behavioral health: (1) Health Reform; (2) Prevention of Substance Abuse and Mental Illness; (3) Housing and Homelessness; (4) Military Families; (5) Trauma and Justice; (6) Health Information Technology; (7) Data, Quality, and Outcomes; and (8) Public Awareness and Support. SMHAs were addressing all eight of these areas.

Health Reform and Parity Implementation: The passage of the Patient Protection and Affordable Care Act (ACA) of 2010 portends major changes for the role of SMHAs in providing safety net services to individuals with mental illnesses. With the phased implementation of ACA over the next several years, many of the individuals traditionally served by SMHAs will gain new insurance benefits (through the expansion of Medicaid eligibility, the elimination of preexisting condition limitations, and the new individual insurance mandate). In the face of this historic shift to expand insurance coverage, SMHAs actively prepared for their future roles in assuring quality mental health services within their states.

Most SMHAs (34) had met to determine future roles for the SMHA in the implementation of ACA. Some of the roles SMHAs identified included defining the scope of services; expanding prevention services and integrated care programs; meeting the behavioral health needs that extend beyond healthcare reform, such as forensic services, employment supports, and housing supports; promoting and achieving a quality-focused, culturally responsive, and recovery-oriented system of care; assuring safety net services are available; providing education and consultation to the state Medicaid and health agencies; providing direction (training, technical assistance, and monitoring) to specialty mental health providers; working to include mental health in healthcare homes; providing training and preparation for the mental health workforce; and working to foster linkages between federally qualified health centers (FQHCs) and mental health providers.

In 2008, Congress passed and the President signed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act that guarantees mental health benefits are offered on a par with other medical and surgical health insurance benefits. SMHAs worked within their states to ensure the implementation of this new parity law. In 60 percent of states, the SMHA was involved in the implementation of the parity statute along with state partners such as the state insurance commissioners. SMHAs described roles including partnering with their state Medicaid agency, state insurance department, or Department of Health and Human Services, as well as businesses and consumer organizations within the state, about service needs, best practices, and insurance benefit requirements. In 15 states, the SMHA worked with Medicaid to make changes to Medicaid managed care plans to comply with the parity law.

Prevention and Early Intervention for Mental Health: Over half (55 percent) of the SMHAs (28 of 51) had early intervention programs for adults or children with mental illness. Examples of early intervention programs for children included an early childhood mental health consultation paradigm for childcare facilities (Colorado), early mental health consultation for Head Start and daycare providers, early screening for emotional/behavioral disorders, Child FIRST—an intensive in-home early intervention/treatment program (Connecticut), and school-based mental health programs (Tennessee). Examples of early intervention programs for young adults and adults with early signs of psychoses included the Portland Identification and Early Referral Program (Maine), and the Recovery After an Initial Schizophrenia Episode project funded by the National Institute of Mental Health.

Most SMHAs funded or operated suicide prevention programs. Suicide prevention programs for adolescents and children were the most frequent type of initiative SMHAs funded. Over 60 percent of all SMHAs also had a plan in place to reduce suicide attempts for each of the population groups. Seventy-four percent of SMHAs funded or operated suicide prevention programs for veterans or military personnel, and two-thirds (69 percent) had a plan to reduce these suicide attempts or to initiate a suicide prevention program for them. Seventy-one percent of SMHAs operated, funded, or participated in programs providing postsuicide support and treatment.

Housing and Homelessness: A major activity of SMHAs was helping mental health consumers live in their own communities. To help reduce hospitalizations and promote consumers' ability to live in their communities, SMHAs had a number of housing initiatives to provide rent subsidies and support services to help consumers live in housing of their own choice. In 2010, 41 SMHAs actively promoted the evidence-based supported housing services. Thirty-six SMHAs had a housing coordinator or specialist who was responsible for increasing affordable housing

opportunities for persons with SMI. SMHAs in 33 states developed a housing plan—a delineated set of strategies—to address the housing needs of persons with SMI.

Military Families: Most states (45) had specific initiatives to address the need for mental health services among returning veterans and their families. These initiatives focused on members of the state National Guard (40), veterans (39), family members of the military (37), the Reserve (33), and Active Duty military (29). SMHAs in 26 states had a plan to meet the mental health needs of returning veterans and their families, including posttraumatic stress disorder and TBI. SMHAs in 30 states had arrangements to refer or pay for the mental health service needs/coordination of care for returning veterans and their families who did not have access to military reimbursed or provided mental health services.

Trauma and Justice: Research had found that many persons with mental illness have experienced trauma in their lives that may negatively affect their mental health and that should be addressed in the course of mental health treatment. Forty-two SMHAs required or worked with mental health providers to screen for histories of trauma in the individuals they serve. In 29 states, the SMHA provided or made referrals for specialized trauma treatment or services.

Most SMHAs (43) had interventions to divert persons with mental illness from the criminal justice system into mental health treatment. The three major types of interventions in use by SMHAs included (1) mental health courts; (2) prebooking diversion programs; and (3) postbooking diversion programs. Thirty-seven states had mental health courts to help divert persons with mental illness from the criminal and juvenile justice systems. Prebooking diversion programs (designed to move clients into mental health services before they are "booked" or arrested) had been adopted in 36 states. Postbooking, preadjudication diversion programs (designed to divert clients after they have been arrested) had been adopted in 25 states.

In addition, 35 SMHAs adopted, funded, or operated programs designed to provide support for prisoners or jail detainees with mental illnesses and/or with co-occurring mental health and substance abuse disorders prior to their return to the community.

Health Information Technology: SMHAs worked to implement health information technology and expend resources on the implementation of electronic health records (EHRs) within mental health facilities. SMHAs also worked on participating in health information exchanges (HIEs) that share EHR information between mental health providers and physicians.

In addition, SMHAs shared personal health records that allowed consumers to access elements of their medical records and allowed the sharing of that information with persons chosen by the consumers.

Thirty-eight SMHAs had an EHR in operation or were installing EHR systems in state psychiatric hospitals and/or

community mental health systems. Sixteen SMHAs already operated EHRs in their state psychiatric hospitals, 13 SMHAs were installing EHRs, and 15 SMHAs were considering the implementation of EHRs. Within the community mental health service setting, the local mental health providers of 25 SMHAs were operating EHRs; in 11 SMHAs, the community service providers were installing EHRs; and in 5 SMHAs, community providers were considering the implementation of EHRs.

Many SMHAs had agreements that allowed the sharing of EHR information between providers to improve the coordination of mental health services. In 19 SMHAs, data-sharing agreements allowed state psychiatric hospitals within the state to share EHR information, whereas in 11 SMHAs, such agreements allowed the sharing of EHR client data between community mental health providers and state psychiatric hospitals. In six SMHAs, EHR client data were shared between community mental health service providers. Thirty-three SMHAs were involved in their state's HIE Cooperative Agreements with the Office of the National Coordinator for Health Information Technology. In 23 states, state psychiatric hospitals planned to participate in the HIEs being developed under the cooperative agreement. In 22 states, SMHA-funded community mental health providers planned to participate in such HIEs.

Data, Outcomes, and Research: Every SMHA had an information management office that collected data and measured the outcomes of mental health services. In 2010, 46 SMHAs had 1,075.3 full-time equivalent (FTE) staff working on information management functions for mental health. This number included 876.8 FTEs who worked within the SMHA and an additional 198.5 FTEs in another agency who worked on mental health information technology. Thirty-five SMHAs spent over $158 million to support the mental health-related information management functions.

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

Most SMHAs monitored a variety of client outcome measures. The client outcome measured by the most states was consumer perception of care, which was most commonly measured using the Adult Mental Health Statistics Improvement Program Consumer Survey. Other frequently measured client outcomes included assessments of client functioning, family involvement/satisfaction, and client employment status. Client outcomes were measured as part of a statewide

client outcome monitoring system in 31 states. In 10 SMHAs, the client outcome system provided clinicians with real-time information about mental health consumers' status, such as functioning or symptoms scales.

Public Awareness and Support: Many SMHAs (23) had public information initiatives to promote a better understanding of the role of mental health in overall health and/or had initiatives to raise awareness of mental illness as a public health or social welfare issue. These initiatives focused on children and adolescents in 21 SMHAs and on adults in 20 SMHAs.

Most SMHAs (42) engaged in activities to reduce stigma or discrimination about mental illnesses. Thirty-nine SMHAs implemented universal initiatives designed to address all groups within a state. Twenty-four SMHAs reported implementing targeted stigma initiatives focused on a specific population group.

I. Introduction

1.1 Background

State Mental Health Agencies (SMHAs) have evolved greatly over the last century. Their evolution began with government entities that devoted nearly all of their human and fiscal resources to the provision of inpatient care in large state psychiatric hospitals. In 2010, SMHAs supported community-based mental health provider agencies that receive SMHA funds, and the SMHA organized systems and monitored the quality of care. As persons with mental illnesses were moved out of state psychiatric hospitals, SMHAs began to broaden their focus from primarily providing inpatient services in large state hospitals to providing community-based mental health treatment and coordinating or providing essential support services to help persons with mental illnesses live in the community. As of 2010, SMHAs provided housing and housing support, employment and education support, and other supports beyond the traditional mental health treatments that were the focus in the past.

Although SMHAs varied widely in where they were organizationally located in state government, and in the service and disability responsibilities they were assigned, they shared some common elements. SMHAs:

- Operated inpatient psychiatric beds that provided critical services to individuals at risk of harm to themselves and/or others;
- Oversaw and funded community-based mental health services to meet the needs of individuals within their states.
- Planned the development of an array of comprehensive mental health services, and submitted an annual community block grant plan to the federal government;
- Worked with other state and federal government agencies to ensure the provision of essential mental health, health, and support services to persons with mental illnesses;
- Collected data on public mental health services and measured outcomes and system performance;
- Conducted an evaluation to improve mental health services;
- Played a key public health role in informing the residents of their states about the risks of mental illness, reducing stigma, preventing suicide, and encouraging needed treatments; and
- Served a public safety function in providing and coordinating services to individuals determined by the courts to be dangerous to themselves or others.

1.2 Methods

This report utilizes the 2010 cycle of the SMHA Profiling System (SPS) (National Association of State Mental Health Program Directors Research Institute, Inc. [NRI], 2010a) and the Fiscal Year (FY) 2008 State Mental Health Revenue and Expenditure Study Results (NRI, 2010b) (hereafter called the Revenue and Expenditure Study) as the primary sources of data. These sources are supplemented with data from the 2009 Uniform Reporting System (URS) (Center for Mental Health Services [CMHS], 2010) to describe the consumers served by the SMHAs.

1.2.1 SMHA Profiling System

The SPS is a database of information that describes the organization, funding, operation, services, policies, statutes, and clients of SMHAs. The information describes each SMHA's organization and structure, service systems, eligible populations, emerging policy issues, fiscal resources, client issues, information management, and research and evaluation structures. Questions are grouped into 10 components by topical area to facilitate SMHA review and completion of the profiles. Questions within each component address the specific needs of SMHA managers and others interested in public mental health systems, and they support decisionmaking, policy analysis, and research and evaluation.

With the guidance of a focus group comprising SMHA commissioners, planners, program staff, and researchers, NRI updated the contents of the existing SPS, and added a new component, to meet the needs of the SMHAs. The revised components for the 2010 information update cycle were sent to all SMHA commissioners/directors and their agencies' designated SPS contact persons for completion during 2010. Individual state responses to the profiles are available on NRI's Web site at **http://www.nri-inc.org**, where users can access state responses by keyword, state, and special topical reports.

The State of Connecticut submitted two sets of completed components—one for the adult division and the second for the children's division—because the responsibility for providing mental health services to children/adolescents was split out into a separate state agency. The Emerging Issues component was completed by 51 SMHAs, Organization and Structure by 51 SMHAs, Policy by 51 SMHAs, Services by 51 SMHAs, Workforce by 51 SMHAs, Finance by 52 SMHAs, Information Management by 51 SMHAs, Research and Evaluation by 49 SMHAs, Forensic by 50 SMHAs, and Managed Behavioral Healthcare by 51 SMHAs.

1.2.2 SMHA-Controlled Revenue and Expenditure Study

The Revenue and Expenditure Study describes the major expenditures and funding of the SMHAs. Every year, NRI works with the SMHAs to document the expenditures for mental health services controlled by the SMHAs and the major funding sources for these expenditures. The methodology for this effort is predicated on compiling actual

(rather than estimated) revenues and expenditures under the direct control of the SMHA. The depiction of actual figures, which are developed only after the state's fiscal year is completed and billing issues are fully reconciled, is considered necessary for reporting valid and reliable data. Without reference to specific financial reports indicating actual expenditures, it is difficult, if not impossible, to both verify figures and have an accessible database for followup and/or analysis.

A set of Excel spreadsheets containing four tables is used as the data collection instrument for the Revenue and Expenditure Study. The tables depict the mental health expenditures and revenues under the control of the SMHA. The funds include all state general funds to the SMHA, the federal Mental Health Block Grant, local funds (when required) to match state dollars, other funds the SMHA controls, and the total expenditures and revenues of the community mental health system. For this report, the FY 2008 cycle of the Revenue and Expenditure Study data received from 50 states and the District of Columbia is used to discuss the expenditures and funding sources of SMHAs.

1.2.3 The Uniform Reporting System

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

The URS, comprising 21 tables developed by the federal government in consultation with SMHAs, compiles state-by-state and national aggregate information, including numbers and sociodemographic characteristics of persons served by the states, outcomes of care, use of selected evidence-based practices, client assessment of care, and insurance status. SAMHSA uses the tables to calculate the 10 mental health National Outcome Measures for state and national reporting. For this report, 2009 data submitted by the 50 states, the District of Columbia, and 7 U.S. territories are used to describe clients served by the SMHAs (data can be accessed from the SAMHSA Web site at the following address: **http://www.samhsa.gov/dataoutcomes/urs/**).

1.2.4 Limitations

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

While this report includes SMHA-controlled expenditures, it should not be assumed

that the revenues and expenditures reported here include all expenditures for mental health services within a state government. State governments expend considerable resources for mental health services through other state government agencies not included in this report.

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

An additional limitation of the revenue and expenditures data is the reporting period. Data for the revenues and expenditures are based on actual expenditures data from state fiscal year 2008, lagging behind the SPS and URS data used in this report.

1.3 Overview of the Rest of the Report

Section II discusses the organization and structure of SMHAs, including their location within state government, disability service responsibilities, number of mental health organizations funded and/or operated, characteristics of mental health consumers served by SMHAs, and financing of state mental health services.

Section III describes the policies that determine the operation of SMHAs and their relationships with other state agencies. Major policy initiatives of SMHAs, including health-mental health integration and services for Armed Forces veterans and National Guard members, are discussed.

Section IV presents SMHAs' responsibilities for community mental health services and the characteristics of persons served in community settings. This section also briefly discusses the FY 2008 financing of community mental health services.

Section V discusses state psychiatric hospitals and forensic services, including characteristics of persons served as well as the FY 2008 financing of state psychiatric hospitals.

Section VI presents information about the mental health workforce of SMHAs. The section addresses workforce shortages and recruitment and retention initiatives, as well as SMHA initiatives to assure a culturally competent workforce.

Section VII describes SMHAs' health information technology activities including the organization and capability of SMHAs' data systems, the measurement of outcomes, and the implementation and use of electronic health records by state psychiatric hospitals and community mental health agencies.

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

II. Organization and Structure of SMHAs

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

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

2.1 SMHA Location in State Government

The majority of SMHAs operated as divisions under an umbrella agency. In 24 states, the SMHA was organized as a division within the Department of Human Services. In 10 states, the SMHA was organized as a division within a Department of Health, and in 5 states, the SMHA fell under the responsibility of the Health and Human Services Department. The SMHA was an independent department in 11 states.

Most SMHA directors reported to a cabinet secretary (26 SMHAs); however, 5 SMHA directors reported directly to the Governor, and in 9 states, the director served as a member of the Governor's Cabinet. In 14 states, the SMHA director reported to a mental health board or council charged with oversight of the SMHA. Table 1 shows the organizational structure of each SMHA and the number of layers that exist between the SMHA commissioner and the Governor.

Table 1: Organization of SMHAs Within State Government

State	Organization and Structure		
	SMHA Located in State Department	Levels Between Commissioner & Governor	SMHA Director Reports to Mental Health Board/Council
Alabama	Independent	0	No
Alaska	Human Services	2	No
Arizona	Health Department	1	No
Arkansas	Human Services	2	No
California	Human Services	1	Yes
Colorado	Human Services	2	No
Connecticut	Independent	0	Yes
Delaware	Human Services	1	No
District of Columbia	No Response	No Response	No Response
Florida	Human Services	2	No
Georgia	Independent	0	Yes
Hawaii	Health Department	2	Yes
Idaho	Health Department	2	No
Illinois	Human Services	3	No
Indiana	Human Services	1	No
Iowa	Human Services	2	No
Kansas	Human Services	2	No
Kentucky	Human Services	2	No
Louisiana	Health Department	1	No
Maine	Health and Human Services	1	Yes
Maryland	Health Department	2	No
Massachusetts	Health and Human Services	1	Yes
Michigan	Health Department	1	No
Minnesota	Human Services	2	No
Mississippi	Independent	1	Yes
Missouri	Independent	1	Yes
Montana	Human Services	2	Yes
Nebraska	Health and Human Services	1	No
Nevada	Human Services	1	Yes
New Hampshire	Health and Human Services	2	No
New Hampshire	Health and Human Services	2	No

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

State	Organization and Structure		
	SMHA Located in State Department	Levels Between Commissioner & Governor	SMHA Director Reports to Mental Health Board/Council
New Jersey	Human Services	2	No
New Mexico	Human Services	1*	No
New York	Independent	1	No
North Carolina	Human Services	2	Yes
North Dakota	Human Services	1	No
Ohio	Independent	0	No
Oklahoma	Independent	1	Yes
Oregon	Human Services	1	No
Pennsylvania	Human Services	1	No
Rhode Island	Health Department	No Response	No Response
South Carolina	Independent	1	Yes
South Dakota	Human Services	1	No
Tennessee	Independent	0	No
Texas	Health Department	2	No
Utah	Human Services	1	No
Vermont	Human Services	1	Yes
Virginia	Independent	1	No
Washington	Human Services	2	No
West Virginia	Health and Human Services	1	No
Wisconsin	Health Department	1	No
Wyoming	Health Department	1	No
	Independent = 11	0 (Direct Gov) = 5	Yes = 14
	Human Services = 24	1 (One Level) = 26	No = 35
	Health Department = 10	2 (Two Levels) = 17	No Response = 2
	Health & Human Services = 5	3 (Three+ Levels) = 1	
	No Response = 1	No Response = 2	

*The SMHA director in New Mexico serves as the Chief Executive Officer (CEO) of the New Mexico Behavioral Health Collaborative as well as the Director of the New Mexico Behavioral Health Services Division. As the CEO of the New Mexico Behavioral Health Collaborative, the SMHA director reports to the three co-chairs of the Collaborative (Secretaries for the Department of Health, Human Services Department, and Child, Youth and Families Department). As the Director of the New Mexico Behavioral Health Services Division, the SMHA director reports directly to the New Mexico Human Services Department Cabinet Secretary.

2.2 Other Responsibilities of SMHAs

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

2.2.1 Substance Abuse

Substance abuse services were the responsibility of the SMHA in 31 states, and within the same umbrella agency in 15 additional states. These services were located within a different department outside of the SMHA in five states; however, all of these states had an interagency agreement with the other department to provide these services.

2.2.2 Intellectual Disability

Services for persons with intellectual disabilities (formerly referred to as "developmental disabilities" (DD) or "mental retardation" (MR)) were the responsibility of the SMHA in 12 states. In 30 states, these services were located within the same umbrella agency, but not within the SMHA. Intellectual disability services were located within a different department outside of the SMHA in eight states.

2.2.3 Medicaid

In New York and Pennsylvania, the state Medicaid agencies were part of the SMHA, and these agencies were within the same umbrella agency in 29 states. The state Medicaid agency was located within a different department outside the SMHA in 19 states; however, in all of these states, the SMHA had an interagency agreement with the Medicaid agency for the planning and delivery of Medicaid-funded mental health services.

2.2.4 Housing

In Florida and North Carolina, the SMHA and the state housing agency were located within the same umbrella agency. The state housing agency was located within a different department outside the SMHA in 46 states. In 14 of these states, the SMHA had an interagency agreement with the state housing agency for the planning and delivery of affordable housing to persons with mental illnesses.

2.2.5 Public Health

In Hawaii and New Mexico, the state public health agency was combined with the SMHA, and this agency was within the same umbrella agency in 23 states. The state health department was located within a different department outside the SMHA in 24 states; however, in 11 of these states, the SMHA had an interagency agreement with the state health department for the planning and delivery of mental health services.

Table 2: SMHA Relationship to Other State Agencies

State	SMHA Relationship to Other State Agencies				
	Substance Abuse	Intellectual Disabilities (MR/DD)	Medicaid	Housing	Public Health
Alabama	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
Alaska	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Arizona	Part of SMHA	Other Agency	Other Agency	Other Agency	Same Umbrella
Arkansas	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Other Agency
California	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Colorado	Part of SMHA	Same Umbrella	Other Agency	Other Agency	No Response
Connecticut	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Delaware	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
District of Columbia	Same Umbrella	No Response	No Response	No Response	No Response
Florida	Same Umbrella	Other Agency	Other Agency	Same Umbrella	Other Agency
Georgia	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
Hawaii	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Part of SMHA
Idaho	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Illinois	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Other Agency
Indiana	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Other Agency
Iowa	Other Agency	Part of SMHA	Same Umbrella	Other Agency	Other Agency
Kansas	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Other Agency
Kentucky	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
Louisiana	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Maine	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Maryland	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Massachusetts	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Michigan	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
Minnesota	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Other Agency
Mississippi	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
Missouri	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Other Agency
Montana	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Nebraska	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Nevada	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
New Hampshire	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella

Table 2: SMHA Relationship to Other State Agencies (Continued)

State	SMHA Relationship to Other State Agencies				
	Substance Abuse	Intellectual Disabilities (MR/DD)	Medicaid	Housing	Public Health
New Jersey	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Other Agency
New Mexico	Part of SMHA	Part of SMHA	Part of SMHA	Part of SMHA	Part of SMHA
New York	Other Agency	Other Agency	Other Agency	Other Agency	Other Agency
North Carolina	Part of SMHA	Part of SMHA	Same Umbrella	Same Umbrella	Same Umbrella
North Dakota	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Other Agency
Ohio	Other Agency	Other Agency	Other Agency	Other Agency	Other Agency
Oklahoma	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Oregon	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Pennsylvania	Other Agency	Same Umbrella	Part of SMHA	Other Agency	Other Agency
Rhode Island	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
South Carolina	Other Agency	Other Agency	Other Agency	Other Agency	Other Agency
South Dakota	Same Umbrella	Same Umbrella	Other Agency	Other Agency	Other Agency
Tennessee	Part of SMHA	Other Agency	Other Agency	Other Agency	Other Agency
Texas	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Utah	Part of SMHA	Same Umbrella	Other Agency	Other Agency	Other Agency
Vermont	Same Umbrella	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Virginia	Part of SMHA	Part of SMHA	Other Agency	Other Agency	Other Agency
Washington	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Other Agency
West Virginia	Part of SMHA	Part of SMHA	Same Umbrella	Other Agency	Same Umbrella
Wisconsin	Part of SMHA	Same Umbrella	Same Umbrella	Other Agency	Same Umbrella
Wyoming	Part of SMHA	Same Umbrella	Same Umbrella	*	Same Umbrella
	Part of SMHA=31	Part of SMHA=12	Part of SMHA=2	Part of SMHA=1	Part of SMHA=2
	Same Umbrella=15	Same Umbrella=30	Same Umbrella=29	Same Umbrella=2	Same Umbrella=23
	Other Agency=5	Other Agency=8	Other Agency=19	Other Agency=46	Other Agency=24
	No Response=0	No Response=1	No Response=1	No Response=1	No Response=2

*There is no State Housing Authority in Wyoming.

2.3 SMHA Mental Health Responsibilities

SMHAs varied widely regarding the specific types of mental health services they provided or funded and the populations they served. In most states, the SMHA was responsible for both state psychiatric hospital services and community services for both children and adults; however, in some states, responsibilities for delivering some of these mental health services were vested outside of the SMHA. Table 3 lists the SMHA responsibilities for specific mental health services.

2.3.1 Forensic Mental Health Services

Forensic mental health services were provided to persons sent to the mental health system by a criminal court for evaluation or treatment. Examples of forensic services provided by SMHAs included the determination of competency to stand trial and the provision of mental health services to persons found incompetent to stand trial or those found guilty but mentally ill. Forensic services were a rapidly expanding portion of many states' psychiatric hospital populations.

Thirty-six SMHAs were responsible for adult forensic mental health services. An additional 13 SMHAs shared this responsibility with the departments of correction. Of the reporting SMHAs, only Connecticut (DCF) and Wyoming had no responsibility for providing adult forensic mental health services.

The SMHA was responsible for providing court evaluations of mental health status in 30 states; 15 SMHAs shared this responsibility with another agency. Five SMHAs had no responsibility to provide these evaluations. Twenty-seven SMHAs shared responsibility with the departments of correction to provide services to persons with mental illness in prisons and jails; only two SMHAs were solely responsible for providing such services. Twenty-one SMHAs were not responsible for administering these services.

2.3.2 Mental Health Services for Children and Adolescents

Thirty-five SMHAs were responsible for providing mental health services to both children and adolescents; however, in 11 states, the responsibility for children's services was shared between the SMHA and a separate state agency. Three states (Connecticut, Delaware, and Rhode Island) had a separate children's department that was responsible for services including child welfare, juvenile justice, mental health, substance abuse, and other social services for children and adolescents.

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

Eighteen SMHAs shared the responsibility of providing services for people with brain impairment with another agency, whereas the SMHAs in Maryland and North Carolina had the sole responsibility for providing these services. Twenty-nine additional SMHAs had no responsibility for these services.

Table 3: SMHA Mental Health-Related Responsibilities

State	Children's Mental Health Services	Alzheimer's Disease/ Organic Brain Syndrome	Brain Impaired Services (including Traumatic Brain Injury)	State Psychiatric Hospitals	Adult Forensic Mental Health Services
Alabama	Responsibility Shared	Responsibility Shared	No Responsibility	Part of SMHA	Part of SMHA
Alaska	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
Arizona	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
Arkansas	Part of SMHA	Part of SMHA	No Responsibility	Part of SMHA	Part of SMHA
California	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
Colorado	Part of SMHA	No Responsibility	No Responsibility	Outside the SMHA	Responsibility Shared
Connecticut (Adults)	No Responsibility	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA
Connecticut (Children)	Part of DCF*	No Responsibility	No Responsibility	Part of DCF*	No Responsibility
Delaware	No Responsibility	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA
District of Columbia	No Response	No Response	No Response	No Response	No Response
Florida	Responsibility Shared	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Georgia	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Hawaii	Part of SMHA	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA
Idaho	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Responsibility Shared
Illinois	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Indiana	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Responsibility Shared
Iowa	No Response	No Responsibility	No Responsibility	Part of SMHA	Responsibility Shared
Kansas	Part of SMHA	No Responsibility	Responsibility Shared	Part of SMHA	Responsibility Shared
Kentucky	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Responsibility Shared
Louisiana	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Maine	Part of SMHA	No Responsibility	No Response	Part of SMHA	Part of SMHA
Maryland	Part of SMHA	No Responsibility	Part of SMHA	Part of SMHA	Part of SMHA

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

State	Children's Mental Health Services	Alzheimer's Disease/ Organic Brain Syndrome	Brain Impaired Services (including Traumatic Brain Injury)	State Psychiatric Hospitals	Adult Forensic Mental Health Services
Massachusetts	Responsibility Shared	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Michigan	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
Minnesota	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Mississippi	Part of SMHA	Responsibility Shared	No Responsibility	Part of SMHA	Part of SMHA
Missouri	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Montana	Responsibility Shared	Responsibility Shared	Responsibility Shared	Part of SMHA	Responsibility Shared
Nebraska	Responsibility Shared	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Nevada	Responsibility Shared	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
New Hampshire	Responsibility Shared	No Responsibility	No Responsibility	Outside the SMHA	Responsibility Shared
New Jersey	Responsibility Shared	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
New Mexico	Part of SMHA	No Responsibility	Responsibility Shared	Outside the SMHA	Part of SMHA
New York	Part of SMHA	No Response	No Responsibility	Part of SMHA	Responsibility Shared
North Carolina	Part of SMHA	Responsibility Shared	Part of SMHA	Outside the SMHA	Part of SMHA
North Dakota	Part of SMHA	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA
Ohio	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Oklahoma	Part of SMHA	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA
Oregon	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Responsibility Shared
Pennsylvania	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Responsibility Shared
Rhode Island	No Responsibility	No Responsibility	Responsibility Shared	**	Part of SMHA
South Carolina	Responsibility Shared	Responsibility Shared	No Responsibility	Part of SMHA	Responsibility Shared
South Dakota	Part of SMHA	Responsibility Shared	No Response	Outside the SMHA	Responsibility Shared
Tennessee	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA

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

State	Children's Mental Health Services	Alzheimer's Disease/ Organic Brain Syndrome	Brain Impaired Services (including Traumatic Brain Injury)	State Psychiatric Hospitals	Adult Forensic Mental Health Services
Texas	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Utah	Responsibility Shared	No Responsibility	Responsibility Shared	Part of SMHA	Part of SMHA
Vermont	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Virginia	Part of SMHA	Responsibility Shared	No Responsibility	Part of SMHA	Part of SMHA
Washington	Part of SMHA	Responsibility Shared	No Responsibility	Part of SMHA	Part of SMHA
West Virginia	Part of SMHA	Responsibility Shared	Responsibility Shared	Part of SMHA	Part of SMHA
Wisconsin	Responsibility Shared	No Responsibility	No Responsibility	Part of SMHA	Part of SMHA
Wyoming	Part of SMHA	No Responsibility	No Responsibility	Part of SMHA	No Responsibility
	Part of SMHA=35	Part of SMHA=1	Part of SMHA=2	Part of SMHA=44	Part of SMHA=36
	Shared=11	Shared=16	Shared=18	Outside SMHA=5	Shared=13
	No Responsibility=3	No Responsibility=33	No Responsibility=29	Part of DCF=1	No Responsibility=2
	Part of DCF*=1	Part of DCF*=0	Part of DCF*=0	No Response=1	Part of DCF*=0
	No Response=2	No Response=2	No Response=3		No Response=1

*Department of Children and Families.
** Rhode Island does not have a state psychiatric hospital.

In 33 states, the SMHA had no responsibility for the provision of services for people with organic brain syndromes or Alzheimer's disease. Sixteen SMHAs shared this responsibility with another state agency. Arkansas's SMHA had the sole responsibility for the provision of these services.

2.3.4 Operation of State Psychiatric Hospitals

Forty-nine states had stand-alone state psychiatric hospitals, but not all states assigned the responsibility for operating the psychiatric hospitals to the SMHA. In 44 states, the SMHA oversaw state-operated psychiatric hospitals. In five states (Colorado, New Hampshire, New Mexico, North Carolina, and South Dakota), agencies other than the SMHA were responsible for operating state psychiatric hospitals. In these states, the SMHA worked with the state hospitals to coordinate care between the hospitals and community systems. For example, in South Dakota, social workers employed by the Human Services Center worked with community mental health center staff, Division of Mental Health staff, and other community agencies to coordinate services for consumers being discharged back into the community. Rhode Island is the only state without a stand-alone state psychiatric hospital. Rhode Island operates a general hospital that provides psychiatric inpatient services.

2.3.5 Housing Services

Helping mental health consumers live outside of institutions in their desired living situations was a critical support service provided by SMHAs. Thirty-six states had a housing coordinator or specialist within the SMHA who was responsible for increasing affordable housing opportunities for persons with serious mental illnesses (SMI). In 75 percent of these states, the housing coordinators or specialists were full-time employees.

SMHAs in 33 states developed a housing plan—a delineated set of strategies—to address the housing needs of persons with SMI. In 39 states, the SMHA and/or local mental health authorities collaborated with or supported community development corporations or housing authorities. SMHAs had working interagency relationships on housing issues with the State Housing Authority (32), State Department of Housing/Community Development (31), Local Housing Authority (36), State Housing Finance Agency (33), and Other Agencies (18).

Most SMHAs (32) funded housing support services, of which 26 used Medicaid funds to do so. Colorado's SMHA did not provide housing support services, but provided funding for a small number of group homes. Among the housing support services provided by SMHAs were transitional and permanent housing, as well as a variety of housing supports, including rental assistance, home-based rehabilitative services, Shelter Plus Care, case management, supported employment, Assertive Community Treatment, and the Project for Assistance in Transition from Homelessness (PATH).

SMHAs used a variety of Department of Housing and Urban Development (HUD), other federal, and state government funding to develop housing for persons with mental illnesses and to provide consumer/tenant subsidies. Table 4 shows some of the major funding sources used by SMHAs and the number of units of housing provided in 2009 that relied on these funding sources.

Table 4: Housing Resources Used by SMHAs To Provide Housing in 2009

Housing Support Program Funding Sourcess	States Using Funding Sources	Housing Units Provided	States Reporting Number of Housing Units Provided
Federal Housing Development Sources			
HUD Section 811/202	37	71,060	15
HUD Home Funds	35	3,456	9
Continuum of Care Homeless Funds	39	5,986	13
Community Development Block Grant	35	5,046	11
Rural Development	22	4,043	4
Low-Income Housing Tax Credits	36	6,618	8
Housing Opportunities for People With AIDS	25	265	5
SAMHSA Mental Health Block Grant	13	79	4
State Housing Development Sources			
State Housing Trust Funds	19	5,356	9
State General Obligation Bond Financing	12	471	3
State General Revenue Bond Financing	14	108	1
State Mental Health Capital Funds	11	5,513	7
State Housing Tax Credits	16	2,243	5
Federal Tenant Subsidies			
HUD Section 8 Certificates/Vouchers	38	66,246	8
Shelter Plus Care	36	7,676	9
HOME Tenant-Based Rental Subsidies	26	1,866	5
Housing Opportunities for People With AIDS	25	2,363	3
PATH Homeless Funds	29	461	3
State Tenant Subsidies			
State Housing Agency Rent Subsidies	22	11,104	3
State Mental Health Section 8 Bridge Funds	18	1,158	1

Many SMHAs identified barriers that limited their provision of housing for mental health consumers. Among the three fundamental components of housing—capital, services, and housing subsidies—the largest identified needs were housing subsidies (29 SMHAs), capital (18), services (14), and coordination across capital, services, and subsidies (10).

2.4 Reorganization of SMHAs

From 2008 to 2010, five states reorganized their SMHAs. Georgia, Louisiana, and Washington relocated their SMHAs into another department. On July 1, 2009, Georgia reorganized its SMHA from a division within an umbrella agency into the Department of Mental Health. Louisiana folded substance abuse services into the SMHA. In addition, in Alaska, the responsibility for traumatic brain injury and organic brain syndrome services was moved to a separate state agency. In California, the responsibility for traumatic brain injury services was moved out of the SMHA.

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

In 2010, SMHAs funded and/or operated 18,793 organizations to provide mental health services (see table 5). SMHAs directly operated (SMHA employees provide services at facilities owned by the SMHA) 425 mental health organizations. Of these, 201 were state psychiatric hospitals (46 SMHAs reporting), and 209 were community mental health organizations (14 SMHAs reporting). In addition, several states privatized the operation of their state psychiatric hospitals and reported these hospitals as being state funded instead of state operated.

A total of 17,894* community mental health providers were the core of the SMHA mental health system. The vast majority (17,685*) of the community mental health providers were funded, but not operated by the SMHA. Besides community mental health providers and state psychiatric hospitals, SMHAs also operated and funded an array of additional mental health providers. Eighteen SMHAs funded or operated 401 general hospital psychiatric units to provide inpatient psychiatric treatment. Seventeen SMHAs funded 120 private psychiatric hospitals to provide inpatient and other mental health services.

Thirteen SMHAs funded or operated 163 nursing homes and intermediate care facilities for persons with mental illness (ICF-MI). ICF-MI facilities are mental health facilities that provide 24-hour residential treatment to persons with mental illnesses in a less intensive environment than hospitals.

*This number includes a duplicated count of children and adult providers in Georgia.

Table 5: Number of Mental Health Organizations Operated and/or Funded by SMHAs

	State Psychiatric Hospitals	Community Mental Health Providers	Private Psychiatric Hospitals	General Hospitals With Separate Psych Units	Nursing Homes & Other ICF-MI & SNF Providers	Total Mental Health Providers
State Operated	201	209	NA	1	14	425
State Funded	14	17,685*	120	400	149	18,368
Total	215	17,894*	120	401	163	18,793

SNF = skilled nursing facility.
NA = not applicable.
*This number includes a duplicated count of child and adult providers in Georgia.

2.6 Characteristics of Mental Health Consumers Served by SMHA Systems (2009)

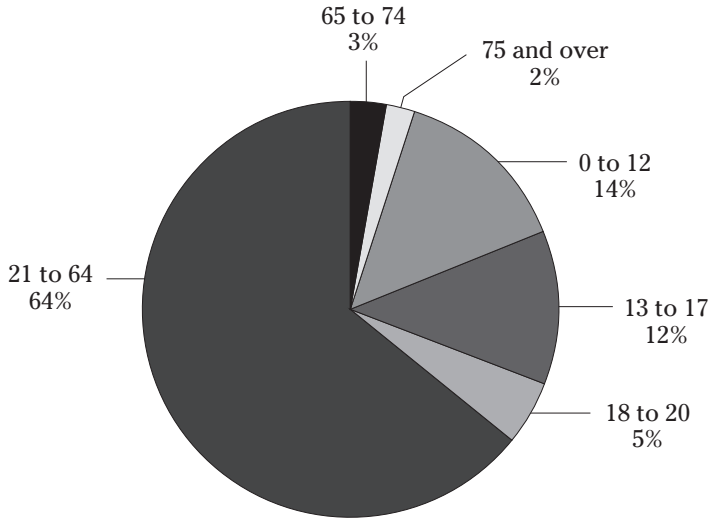
In 2009, the 50 states, the District of Columbia, and 7 U.S. territories served a total of 6,430,546 consumers (just over 2 percent of the U.S. population). The number of consumers served by each SMHA ranged from a high of 687,867 in New York to a low of 9,756 in Delaware. Slightly under half (48 percent) of the consumers served were male (with a utilization rate** of 17.7 per 1,000 population), whereas 51 percent were female (with a utilization rate of 18.6 per 1,000 population). Of all SMHAs reporting data, consumers served in Kansas had the highest utilization rate (40.96 per 1,000), whereas consumers in Massachusetts had the lowest (4.27 per 1,000).

2.6.1 Consumers Served, by Age and Gender

Adults ages 21 to 64 made up the majority (64 percent) of the total number of persons served, whereas young adults (18 to 20) made up 5 percent and older adults (65 and older) made up only 3 percent. See figure 1 for the percent distribution of consumers served, by age group, and table 6 for utilization rate per 1,000 population, by age, gender, and race/ethnicity.

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

Figure 1: Percent Distribution of Consumers Served, by Age



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

Children and adolescents had an average utilization rate of 23.1 per 1,000 U.S. resident population. Children had an average utilization rate of 17.3, with higher male rates (21.7) than female rates (12.6 per 1,000). Although adolescents accounted for only 12 percent of the total population served, they averaged the highest utilization rate (37.6 per 1,000) of all age groups (see figure 2). As in the children rates, male adolescent consumers had higher utilization rates (40.4) than female consumers (34.3).

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

Young adults and adults had an average utilization rate of 23 per 1,000. Young adults had an average utilization rate of 24 per 1,000, with no gender differences. Male adults ages 21 to 64 had lower average utilization rates (20.2) than their female counterparts (25.4).

2.6.1.3 Older Adults (65 and Above)

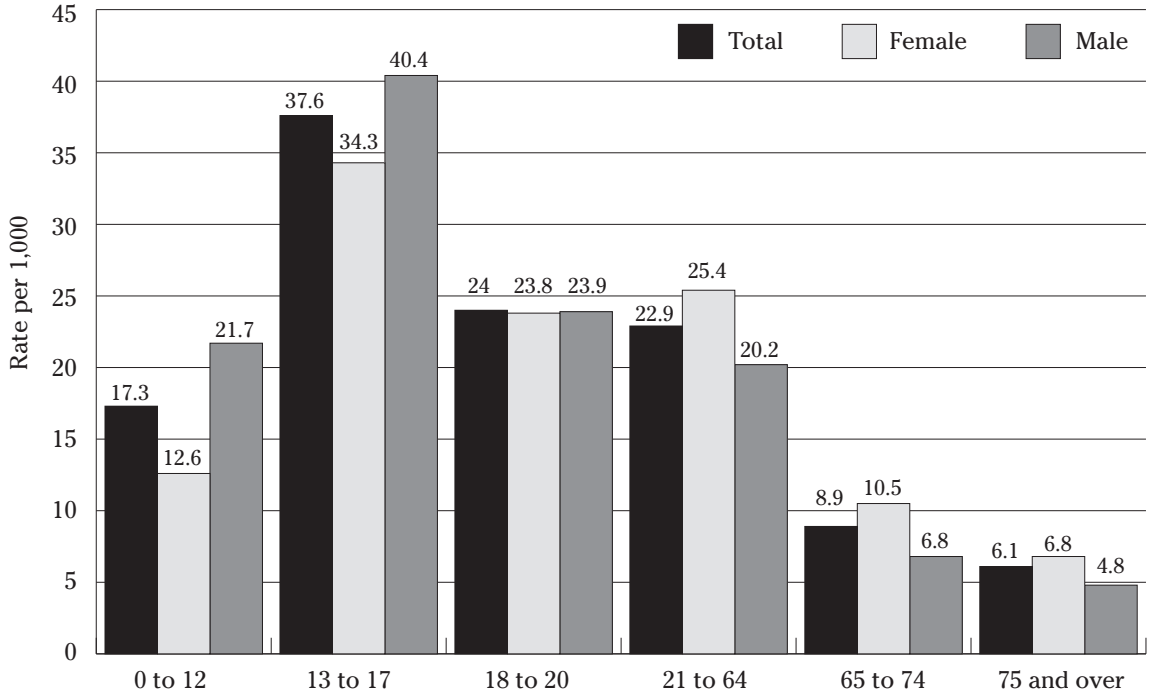
Older adults had an average utilization rate of 9.9 per 1,000. Older adults from 65 to 74 had an average utilization rate of 8.9 per 1,000, with higher rates for females (10.5) than males (6.8). Consumers who were 75 and older had the lowest average utilization rates (6.1) of all age groups, with lower male rates (4.8) than female rates (6.8).

Table 6: Utilization Rate of SMHA Mental Health Services, by Age, Gender, and Race/Ethnicity, 2009

Age	Rate per 1,000 Population								
	Gender	Total	American Indian/ Alaskan Native	Asian American	Black/ African American	Native Hawaiian/ Pacific Islander	White	Hispanic or Latino	Multiracial
Age 0 to 12	Total	17.3	17.3	2.4	25.8	13.9	13.3	9.0	16.6
	Female	12.6	13.6	1.8	17.8	10.2	9.9	6.2	12.5
	Male	21.7	20.8	3.0	33.5	17.5	16.5	11.7	20.5
Age 13 to 17	Total	37.6	43.3	7.6	54.8	35.1	28.4	22.1	43.7
	Female	34.3	42.3	6.8	46.6	30.2	26.5	20.7	42.1
	Male	40.4	44.3	8.4	62.7	39.7	30.1	23.5	45.1
Children & Adolescents		23.1	24.5	3.8	34.4	19.7	17.6	12.2	22.6
Age 18 to 20	Total	24.0	24.7	6.4	32.1	26.1	19.4	12.8	23.7
	Female	23.8	25.2	5.9	29.2	25.5	19.9	12.6	24.3
	Male	23.9	24.2	6.9	34.9	26.7	19.0	12.8	23.1
Age 21 to 64	Total	22.9	24.4	6.4	35.3	30.0	18.9	13.2	30.7
	Female	25.4	28.8	7.0	35.2	32.0	21.6	15.9	33.3
	Male	20.2	20.0	5.8	35.4	28.0	16.3	10.8	27.9
Young Adults & Adults		23.0	24.4	6.4	35.1	29.7	19.0	13.2	29.9
65 to 74	Total	8.9	9.2	5.0	14.4	19.9	7.2	11.6	11.4
	Female	10.5	10.4	5.8	15.7	22.4	8.7	14.7	13.6
	Male	6.8	7.8	4.0	12.7	17.0	5.5	7.8	8.8
75 and over	Total	6.1	7.9	3.4	8.6	12.2	5.2	6.6	6.8
	Female	6.8	8.6	3.6	9.4	14.5	5.9	7.5	7.2
	Male	4.8	6.9	3.1	7.2	8.7	4.1	5.3	6.3
Older Adults		9.9	8.7	4.3	11.9	16.8	6.2	9.4	9.5
TOTAL ALL AGES	Total	20.7	23.3	5.6	32.9	25.9	16.9	12.7	25.5
	Female	18.6	24.9	5.9	30.3	25.9	17.7	13.3	25.1
	Male	17.7	21.7	5.4	35.7	25.8	16.0	12.0	25.8

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

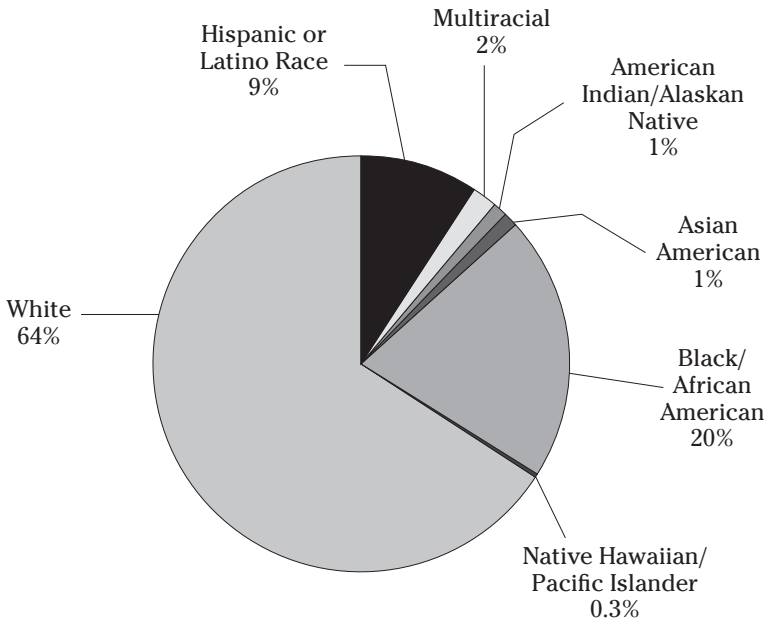
Figure 2: Utilization Rates of Persons Served, by Age and Gender (rate per 1,000)



2.6.2 Consumers Served, by Race/ Ethnicity and Gender

Sixty-four percent of all consumers served by the SMHAs were white; African Americans represented 20 percent of consumers. Native Hawaiians/Pacific Islanders represented the smallest percentage (0.3) of consumers served (see figure 3 for the race/ethnicity breakdown of all consumers served).

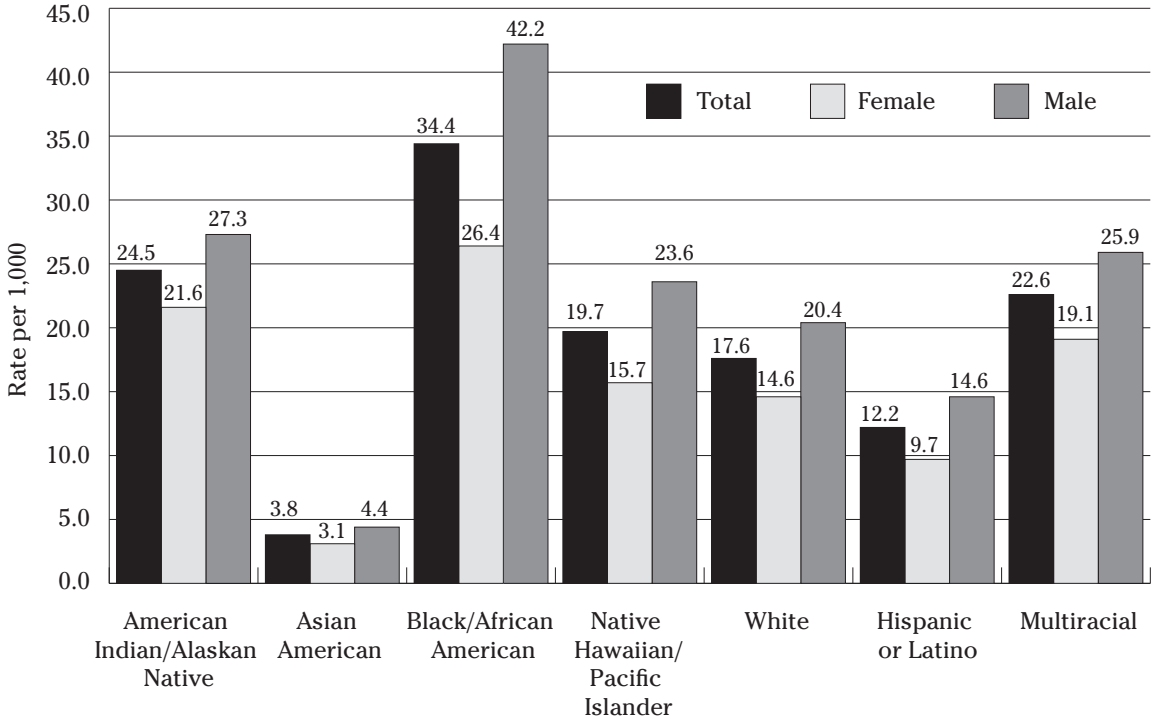
Figure 3: Percentage of Consumers Served, by Race/Ethnicity



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

African American children and adolescents ages 0 to 17 had the highest average utilization rates (34.4 per 1,000) of all groups, whereas Asian Americans averaged the lowest (3.8) utilization rate (see figure 4 for the average utilization rates of children and adolescents, by race/ethnicity and gender). For children (ages 0 to 12), African American males had the highest utilization rate (33.5 per 1,000), whereas Asian American females had the lowest utilization rate (1.8 per 1,000). Similar to the rates for young children, male African American adolescents (ages 13 to 17) had the highest utilization rate (62.7 per 1,000), whereas Asian American females also had the lowest (6.8) utilization rate. Overall, among children, males had higher utilization rates than did females among all racial groups.

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



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

African American adults (ages 21 to 64) had the highest utilization rates (35.1), with slightly higher rates for males (35.4) than females (34.8), whereas Asian Americans in the same age group had the lowest rates (6.4), with slightly higher rates for females (6.9) than males (5.9). Native Hawaiians/ Pacific Islanders and multiracial consumers in this age group had high utilization rates (when compared with other groups) averaging 29.7 and 29.9, respectively (see figure 5).

2.6.2.3 Older Adults (65 and Above)

Unlike all other age groups, Native Hawaiian/Pacific Islanders who were 65 and older had the highest utilization rates (16.8 per 1,000); however, similar to other age groups, Asian Americans averaged the lowest (4.3) utilization rates (see figure 6). Native Hawaiian/ Pacific Islander consumers ages 65 to 74 averaged the highest utilization rates (19.9); males had lower rates (17) than did female consumers (22.4). Asian American consumers who were 65 and older had the lowest utilization rate (4.3), with slightly higher rates for female (4.8) than male (3.7) consumers. Much like Asian Americans within this age group, white Americans also

had lower utilization rates (6.2 per 1,000), with males averaging much lower rates (4.9) than females (7.2).

2.6.3 Adults With SMI and Children With Serious Emotional Disturbances Served

SAMHSA defines SMI as "persons age 18 and over, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities" (Federal Register, 1993, p. 29425). In 32 SMHAs, the state definition of SMI matched that of the federal government; however, in 23 SMHAs, the state had its own definition of SMI.

SAMHSA defines serious emotional disturbances (SED) as "persons from birth up to age 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-III-R, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities"

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

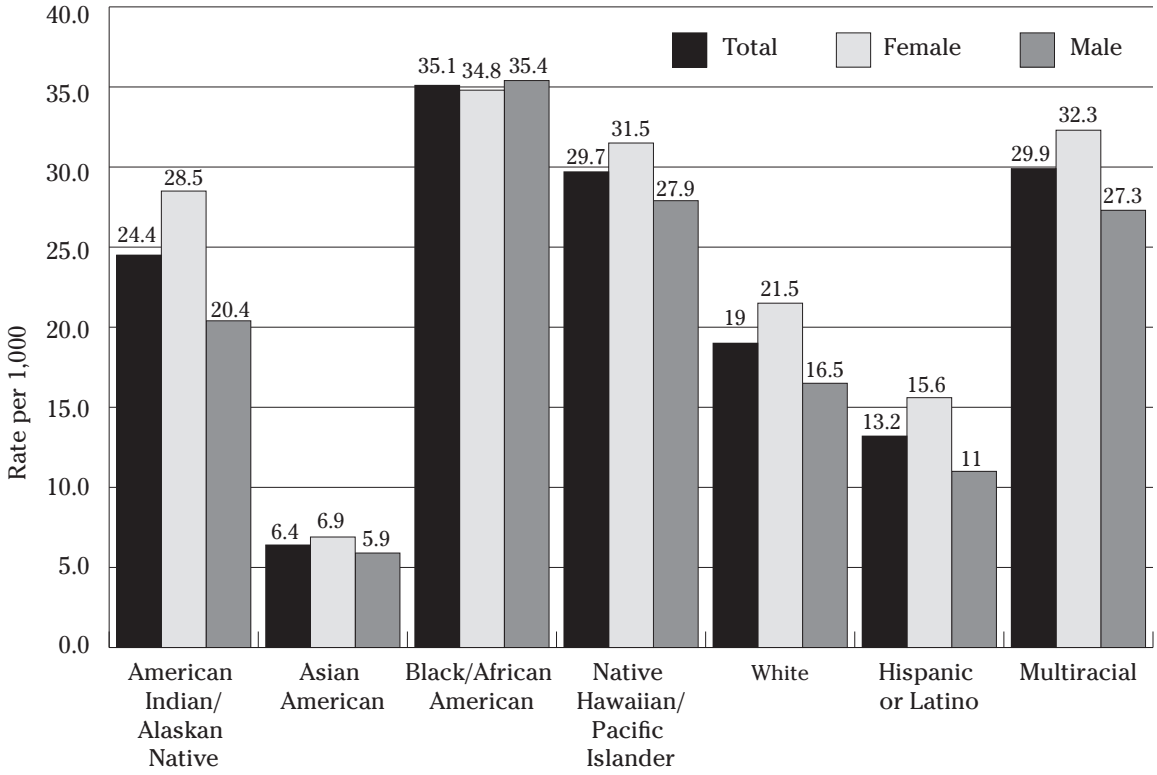
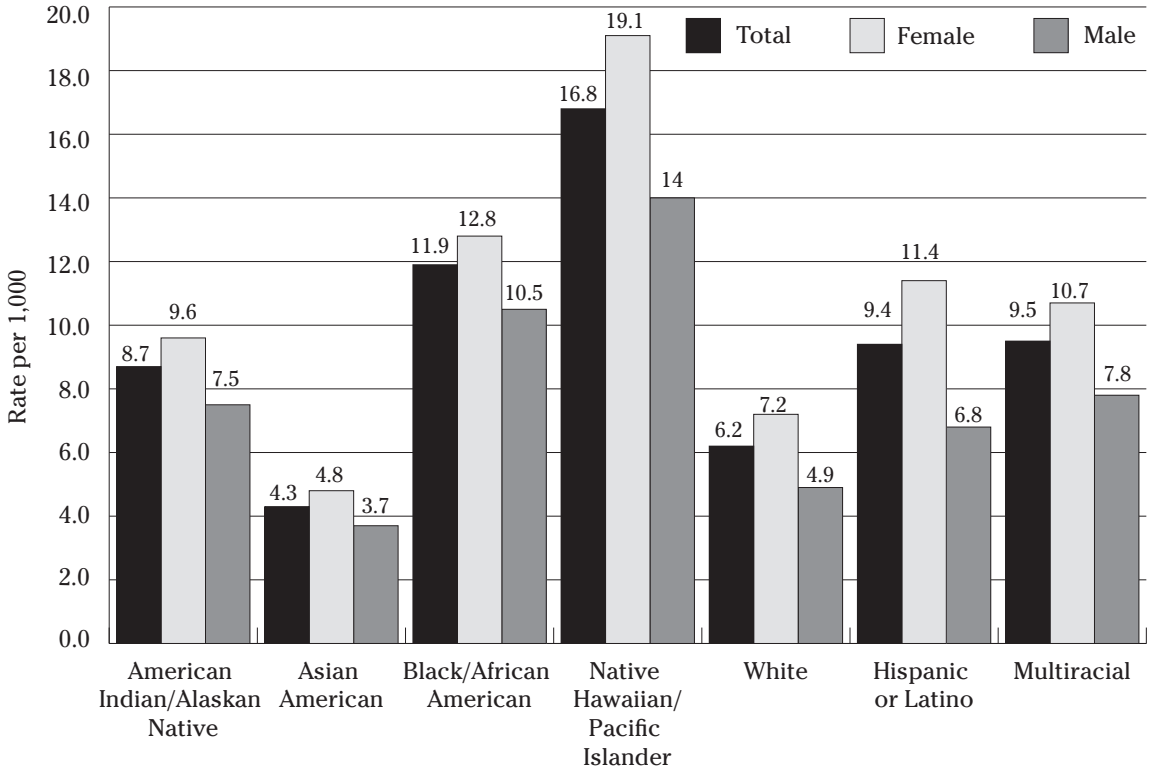


Figure 6: Utilization Rates of Older Adults, by Race and Gender (rate per 1,000)



(Federal Register, 1993, p. 29425). In 35 SMHAs, the state definition of SED matched that of the federal government, whereas in 20 SMHAs, the state had its own definition of SED.

Thirty-two SMHAs adopted the federal definition of SMI, whereas 35 adopted the federal definition of SED. The majority of all adult consumers (65 percent) served by the SMHAs had SMI, whereas 68 percent of all children served had SED. In six SMHAs, 100 percent of adults and children served were diagnosed with SMI or SED. These SMHAs had strict mental health services eligibility requirements where only consumers with SMI or SED were served by the SMHA system.

2.7 Financing of State Mental Health Services

2.7.1 Impact of State Budget Shortages on Mental Health

The recession that hit America beginning in 2008 reduced state government finances and impacted SMHAs. According to the National Governors Association (NGA), "States are facing a protracted budget crisis like none seen in the last 30 years, and perhaps not seen since the Great Depression. State balance sheets face a long, slow climb toward fiscal health and may not reach pre-recession revenue levels for years to come. As a result, many states

have launched urgent efforts to redesign and downsize government" (NGA, n.d.).

A study by NGA and the National Association of State Budget Officers (NASBO) found that "in response to the decline in revenue, 39 states cut their enacted fiscal 2010 budgets by $18.3 billion. Additionally, 14 states have enacted $4.0 billion in budget cuts for fiscal 2011. In fiscal 2009, 43 states cut $31.3 billion and in fiscal 2008, 13 states cut $3.6 billion. The amount of the cuts are considerably larger than the last downturn when in 2002 and 2003, 37 states made midyear budget reductions totaling $14 billion and $12 billion, respectively" (NGA & NASBO, 2010, p. 3).

A study conducted by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc./NASMHPD found that 78 percent (35 out of 45 SMHAs) and 80 percent (36 out of 45) of responding SMHAs had cuts to their mental health budget during FY 2010 and FY 2011, respectively. In FY 2009 and FY 2010, SMHAs received reductions of $1.5 billion ($664 million in reductions during FY 2009 and an additional $817 million in FY 2010). States were in FY 2011 in the fall of 2010, and SMHAs had to make an additional $645 million in reductions (36 states reporting) and expected to make further reductions before the fiscal year was completed.

Because state revenues continued to lag behind budget expectations, SMHAs repeatedly needed to make reductions during the year in order to help balance state budgets. During FY 2009, SMHAs averaged 1.24 different reductions (with a range from one budget reduction to five different reductions throughout the year) and that increased to an average of two reductions per state during FY 2010 (ranging from one budget reduction to four different reductions during the year).

SMHAs addressed these reductions through a variety of strategies. Table 7 shows that in FY 2011, most SMHAs started by making administrative reductions, such as hiring freezes, but the level of cuts required in many states required cutting direct services to consumers. Over half of the states had to reduce funds to community mental health providers, and almost half of the states made reductions to state psychiatric hospital services. Collectively, SMHAs reported having closed 2,198 state psychiatric hospital beds in 25 states over the last 2 years, and 17 SMHAs were considering an additional 1,732 beds for closure in FY 2011 because of continuing budget shortages. In addition, five states (Connecticut, Florida, Maryland, Massachusetts, and Missouri) closed state psychiatric hospitals.

Table 7: Strategies SMHAs Are Using To Reduce Budgets in FY 2011

Strategies Used To Reduce Budgets*	Number of States	States (percent)
Reduce administrative expenses	35	100%
Freeze hiring	31	89%
Reduce funds to community providers	21	60%
Close state hospital units/wards	18	51%
Reduce community mental health services	16	46%
Furlough employees	15	43%
Reduce number served in community	14	40%
Restructure SMHA	12	34%
Implement other community reductions	10	29%
Implement early retirement for workers	9	26%
Contract with family/consumer advocacy organizations	7	20%
Restrict populations served in community system	7	20%
Reduce staff	5	14%
Reduce salaries	5	14%
Reduce consumer-run programs	5	14%
Implement other SMHA reductions	5	14%
Close state hospitals	3	9%
Privatize state-operated services	5	14%
Reduce prevention services	4	11%
Reduce staff ratios at state hospitals	3	9%
Increase use of managed care	1	3%

*These strategies are based on 35 SMHAs experiencing budget reductions in FY 2011.

2.7.2 SMHA Financing Approaches

SMHAs used a variety of mechanisms and funding sources—federal, state, and local sources—to fund the mental health services they provided. Although state general funds and Medicaid were used by all state mental health agencies, states combined and allocated these and other funds using a variety of approaches and mechanisms.

In nine states (Connecticut, Florida, Indiana, New York, North Carolina, Ohio, Oregon, Pennsylvania, and Washington), the SMHA had a portable benefit that followed a client from a state psychiatric hospital to the community. For example, in Connecticut, the SMHA had multiple loan funds available to assist many patients with reentry. In addition, the Connecticut Department of Mental Health and Addiction Services managed a limited discretionary

discharge fund to assist client reentry into community life. This fund provided community-based care and recovery supports that were intended to alleviate gridlock. In Pennsylvania, the Community Hospital Integration Program Project allowed money previously used for state hospital psychiatric treatment to be used for persons discharged to the community.

2.7.3 SMHA Use of Medicaid To Finance Mental Health Services

Every state used Medicaid to reimburse some of their mental health services, and nationally Medicaid had surpassed state general revenue funds as the largest single funding stream of SMHA systems. However, as a joint state-federal program, Medicaid was configured differently in each state. As a result, how Medicaid was used to pay for mental health services had major variations from state to state, with states using differing combinations of Medicaid options, waivers, managed care, and fee-for-service (FFS) approaches.

Table 8 shows that over half the states used managed care approaches with Medicaid, but most states used a combination of managed care and FFS approaches to distribute Medicaid funds for mental health services.

Table 8: Funding Approaches for Medicaid-Funded Mental Health Services

Medicaid Mental Health	Number of States	States (percent)
FFS Approach Only	19	37%
Managed Care Only	2	4%
Combination of FFS and Managed Care	25	49%
No Response	5	10%

2.7.3.1 SMHA Role in Setting Medicaid Rates

The SMHA was responsible for setting Medicaid rates for mental health services in 21 states. The SMHA was responsible for setting Medicaid rates for mental health services in state-operated programs in 15 states, for state-funded programs in 20 states, and for mental health programs that did not receive any SMHA funding in 3 states. The SMHA was designated as the single state agency responsible for setting Medicaid rates for mental health services and for Medicaid options in 13 states (Arizona, Delaware, Kansas, Maryland, Maine, Minnesota, Montana, New Hampshire, New Mexico, New York, Oregon, Virginia, and Washington).

2.7.3.2 SMHAs' Responsibility for Paying Medicaid Match

Medicaid is a joint state-federal program that requires a state match of federal dollars. In 27 states, the SMHA was responsible for paying the state match for Medicaid mental health services in state-operated programs. In 27 states, the SMHA was responsible for the Medicaid

match payments for state-funded mental health programs. For example, the Ohio Department of Mental Health (ODMH) and local boards were jointly responsible for the nonfederal share of any Medicaid payments to providers of community mental health services. Sources of funding for community mental health included state fund allocation from ODMH to county mental health boards and other funds administered at the local level (such as local levy funds). For hospital services, ODMH was responsible for the state match for Medicaid inpatient psychiatric hospital payments to freestanding psychiatric hospitals.

The SMHA was permitted to retain Medicaid revenues of SMHA-operated state psychiatric hospitals in 18 states and of state-operated community mental health programs in 17 states. In 13 states, Medicaid revenues were retained for use for both state psychiatric hospitals and state-operated community mental health programs. The Medicaid revenues of state psychiatric hospitals and state-operated community programs reverted to the state treasury in 15 and 8 states, respectively. In 13 states, either a combination (some funds were retained but others were reverted) or other arrangements were used in state psychiatric hospitals and 17 states for state-operated community mental health programs.

2.7.3.3 Medicaid Coverage

Each state was responsible for establishing the criteria for who is eligible for its Medicaid program. In most states (43), optional Medicaid populations were included in the state's Medicaid plan. Table 9 shows that the Medicaid buy-in group of working individuals with disabilities, children ages 6 to 19 over 100 percent of the Federal Poverty Level (FPL), and pregnant women over 133 percent of FPL were the most common optional populations who were included in state Medicaid plans.

In 2010, 12 SMHAs reported that Medicaid coverage of special populations was expanding, whereas 35 SMHAs reported no changes were being made to the covered populations. No states (0) reported decreasing the special populations covered under Medicaid. Five states (Connecticut, Georgia, Iowa, South Carolina, and Wisconsin) modified their rules regarding who was eligible for Medicaid over the past year (all expanded eligibility criteria).

2.7.3.4 Medicaid Options Used To Fund Mental Health Services

Medicaid services are different in each state because Medicaid includes a set of required services and allows states to select from a variety of options and waivers for additional types of services. States use a variety of Medicaid options and waivers to pay for both inpatient and community-based services for persons with mental illnesses. Table 10 shows the mixture of Medicaid options and waivers that were used to fund mental health services. The most commonly used options were Under Age 21 Inpatient Services, Rehabilitation Services, Targeted Case Management, and Prescription Drug Plan.

Table 9: Expansion of Medicaid To Cover Optional Populations for Mental Health

State	Working Individuals With Disabilities—Medicaid "Buy-In"	Low-Income Parents Above TANF Income Level	Children Ages 6–19 Over 100% FPL	Pregnant Women Over 133% FPL	Disabled & Elderly Above SSI Income Levels (74% FPL), but Below 100% FPL	Disabled & Elderly SSI Recipients Who ReceiveState Supplemental Payments	Institutionalized Persons (including in IMDs) Above SSI Income Level, but Below 300% of SSI	Individuals in 1915(c) Waiver Programs Above SSI Level but Below 300% of SSI Income	Medically Needy	Aged & Disabled Included in Medically Needy Population	Other
Alabama	No	No	No	No	No	No	No	No	No	No	No
Alaska	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	No	No	No	No	Yes	No	No	No	No	No	No
Arkansas	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No
California	Yes	No	No	Yes	Yes	Yes	No	No	Yes	No	Yes
Colorado	No	No	No	No	No	No	No	No	No	No	No
Connecticut	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Delaware	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes
District of Columbia	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Florida	Yes	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No
Georgia	Yes	No	No	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Hawaii	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Idaho	No	No	Yes	No	No	No	No	No	No	No	No
Illinois	Yes	No	No	No	No	No	No	No	No	No	No
Indiana	No	No	No	No	No	No	Yes	No	No	No	No

Table 9: Expansion of Medicaid To Cover Optional Populations for Mental Health (Continued)

State	Working Individuals With Disabilities—Medicaid "Buy-In"	Low-Income Parents Above TANF Income Level	Children Ages 6–19 Over 100% FPL	Pregnant Women Over 133% FPL	Disabled & Elderly Above SSI Income Levels (74% FPL), but Below 100% FPL	Disabled & Elderly SSI Recipients Who ReceiveState Supplemental Payments	Institutionalized Persons (including in IMDs) Above SSI Income Level, but Below 300% of SSI	Individuals in 1915(c) Waiver Programs Above SSI Level but Below 300% of SSI Income	Medically Needy	Aged & Disabled Included in Medically Needy Population	Other
Iowa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kansas	No	No	No	Yes	Yes	No	No	Yes	Yes	No	No
Kentucky	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Louisiana	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No
Maine	No	Yes	Yes	No	Yes	No	No	No	No	No	Yes
Maryland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Massachusetts	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Michigan	Yes	No	No	No	No	No	No	No	Yes	Yes	No
Minnesota	No	No	No	No	No	No	No	No	No	No	No
Mississippi	No	No	No	No	No	No	No	No	No	No	No
Missouri	No	No	Yes	Yes	Yes	No	No	No	No	No	No
Montana	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Nebraska	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No
Nevada	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	Yes
New Hampshire	No	No	No	No	No	No	No	No	No	No	No

Table 9: Expansion of Medicaid To Cover Optional Populations for Mental Health (Continued)

State	Working Individuals With Disabilities—Medicaid "Buy-In"	Low-Income Parents Above TANF Income Level	Children Ages 6–19 Over 100% FPL	Pregnant Women Over 133% FPL	Disabled & Elderly Above SSI Income Levels (74% FPL), but Below 100% FPL	Disabled & Elderly SSI Recipients Who ReceiveState Supplemental Payments	Institutionalized Persons (including in IMDs) Above SSI Income Level, but Below 300% of SSI	Individuals in 1915(c) Waiver Programs Above SSI Level but Below 300% of SSI Income	Medically Needy	Aged & Disabled Included in Medically Needy Population	Other
New Jersey	No	No	No	No	No	No	No	No	No	No	No
New Mexico	No	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
New York	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
North Carolina	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No
North Dakota	Yes	No	No	No	No	No	No	No	No	Yes	No
Ohio	Yes	Yes	Yes	Yes	No	No	No	No	No	No	Yes
Oklahoma	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	Yes
Oregon	Yes	Yes	Yes	No	No	No	No	No	Yes	Yes	No
Pennsylvania	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Rhode Island	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
South Carolina	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	No	No
South Dakota	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	No	No
Tennessee	No	No	Yes	Yes	No	No	No	No	Yes	No	Yes
Texas	Yes	No	No	Yes	No	No	Yes	Yes	Yes	No	No
Utah	No	No	No	No	No	No	No	No	No	No	No

Table 9: Expansion of Medicaid To Cover Optional Populations for Mental Health (Continued)

State	Working Individuals With Disabilities—Medicaid "Buy-In"	Low-Income Parents Above TANF Income Level	Children Ages 6–19 Over 100% FPL	Pregnant Women Over 133% FPL	Disabled & Elderly Above SSI Income Levels (74% FPL), but Below 100% FPL	Disabled & Elderly SSI Recipients Who ReceiveState Supplemental Payments	Institutionalized Persons (including in IMDs) Above SSI Income Level, but Below 300% of SSI	Individuals in 1915(c) Waiver Programs Above SSI Level but Below 300% of SSI Income	Medically Needy	Aged & Disabled Included in Medically Needy Population	Other
Vermont	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Virginia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Washington	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
West Virginia	Yes	Yes	No	Yes	No	No	Yes	No	No	No	No
Wisconsin	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Wyoming	Yes	No	No	No	No	Yes	Yes	No	No	No	No
Yes	29	20	26	28	20	18	24	20	23	15	11
No	17	26	20	18	26	28	22	26	23	31	35
NR (not reported)	5	5	5	5	5	5	5	5	5	5	5

TANF = Temporary Assistance for Needy Families.
SSI = Supplemental Security Income.
IMD = Institution for Mental Disease.

Table 10: Medicaid Options Used To Fund Mental Health Services

State	Targeted Case Management	Clinic Option	Rehabilitation Option	Under Age 21 Inpatient	Over Age 65 Inpatient	Personal Care	Medicaid Buy-In	Prescription Drug Plans	1915(i)	1915(a) Waiver	1915(c) Waiver for Children	1915(c) for Other MH Populations	Other
Alabama	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No	No	No
Alaska	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No
Arizona	No	No	No	No	No	No	No	No	No	No	No	No	No
Arkansas	No	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
California	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No	No	Yes
Colorado	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	Yes
Connecticut	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No	No	No
Delaware	No	Yes	Yes	No	Yes	No	No	Yes	No	No	No	No	Yes
District of Columbia	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Florida	Yes	No	No	Yes	No	Yes	Yes	Yes	No	No	No	No	No
Georgia	No	No	Yes	Yes	No	No	No	No	No	No	No	Yes	No
Hawaii	Yes	No	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
Idaho	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
Illinois	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	No	No
Indiana	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
Iowa	Yes	Yes	Yes	No	No	No	Yes	Yes	Yes	No	No	No	No
Kansas	Yes	No	Yes	No	No	Yes	Yes	Yes	No	No	Yes	No	Yes
Kentucky	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	No	No	No	No

Table 10: Medicaid Options Used To Fund Mental Health Services (Continued)

State	Targeted Case Management	Clinic Option	Rehabilitation Option	Under Age 21 Inpatient	Over Age 65 Inpatient	Personal Care	Medicaid Buy-In	Prescription Drug Plans	1915(i)	1915(a) Waiver	1915(c) Waiver for Children	1915(c) for Other MH Populations	Other
Louisiana	No	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
Maine	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
Maryland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	No
Massachusetts	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No
Michigan	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes
Minnesota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
Mississippi	Yes	No	Yes	Yes	No	No	No	Yes	No	No	Yes	No	No
Missouri	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No	No	No
Montana	No	Yes	Yes	No	No	No	No	No	No	No	No	No	No
Nebraska	No	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
Nevada	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	No
New Hampshire	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No	No	No
New Jersey	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	No
New Mexico	No	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
New York	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	No	No
North Carolina	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	Yes	Yes	No
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
Ohio	Yes	No	Yes	Yes	No	No	Yes	Yes	No	No	No	No	No
Oklahoma	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	No	No	No	No

Table 10: Medicaid Options Used To Fund Mental Health Services (Continued)

State	Targeted Case Management	Clinic Option	Rehabilitation Option	Under Age 21 Inpatient	Over Age 65 Inpatient	Personal Care	Medicaid Buy-In	Prescription Drug Plans	1915(i)	1915(a) Waiver	1915(c) Waiver for Children	1915(c) for Other MH Populations	Other
Oregon	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	No	No	No	No
Pennsylvania	Yes	Yes	No	Yes	Yes	No	No	Yes	No	No	No	No	Yes
Rhode Island	No	No	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	Yes
South Carolina	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	Yes
South Dakota	No	Yes	Yes	No	No	No	No	Yes	No	No	No	No	Yes
Tennessee	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	No	No	No	No
Texas	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No
Utah	Yes	No	Yes	Yes	No	No	No	Yes	No	No	No	No	No
Vermont	No	Yes	Yes	Yes	Yes	No	Yes	No	No	No	Yes	No	Yes
Virginia	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	No	No
Washington	No	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No
West Virginia	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No	No	No	No
Wisconsin	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No
Wyoming	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	No	No
Yes	38	35	46	44	38	15	20	38	3	3	11	4	10
No	12	15	4	6	12	35	30	12	47	47	39	46	40
NR (not reported)	1	1	1	1	1	1	1	1	1	1	1	1	1

2.7.3.5 Using the 1915(i) Option To Pay for Mental Health Services

The Deficit Reduction Act of 2005 established a new Medicaid option, 1915(i) Home and Community-Based Services (HCBS), which allowed for the provision of home and community-based services. The 1915(i) option puts an emphasis on "person centered" and "self-directed" care and allows states to provide a range of services, including specialized services such as day treatment, psychosocial rehabilitation, and clinic services for individuals with severe and persistent mental illness. In 2010, 10 SMHAs (Arkansas, Georgia, Iowa, Indiana, Louisiana, Missouri, North Carolina, North Dakota, Oregon, and Wisconsin) reported their state was working on using the 1915(i) option to provide mental health services, and four (Georgia, Iowa, Oregon, and Wisconsin) had applied to use the option. Iowa's and Wisconsin's applications to use the 1915(i) option were approved.

2.7.4 Use of Medicaid Managed Care To Provide Mental Health Services

Managed care practices, including contracting with managed care organizations (MCOs), administrative services organizations (ASOs), and health maintenance organizations (HMOs), were used in mental health to help control costs while ensuring consumers had full access to a broad array of needed mental health services. In 35 states, managed care practices were used to provide mental health services. In 28 of these states, both mental health and substance abuse services were provided through managed care practices, whereas in 7 states, only mental health services were provided through managed care practices.

In 2010, 14 SMHAs changed their use of managed care to finance/deliver mental health services. These changes included preparing for the expanded Medicaid-eligible population under the Patient Protection and Affordable Care Act, moving to risk-based managed care, extending managed care to additional regions of a state, and implementing Medicaid 1915(i) Home and Community-Based Services. In three states (Maine, New York, and South Carolina), these changes in the use of managed care were in response to the state budget shortages.

Managed care was most often used for Medicaid-funded services (34 states). As depicted in table 11, the Medicaid 1915(b) waiver was the most frequently used waiver (19 states), followed by the 1115 waiver (14 states), and the 1915(c) HCBS waiver (9 states).

Table 11: State Use of Managed Care To Provide Behavioral Health Services

State	Type of Medicaid Waiver Used			
	Is your state using managed care practices to provide behavioral health services?	Medicaid Research and Demonstration (1115) waiver?	Medicaid 1915(b) waiver?	Medicaid 1915(c) HCBS waiver for mental health?
Alabama	No Managed Care	NA	NA	NA
Alaska	MH Only	No	No	Yes
Arizona	Both MH&SA	Yes	No	No
Arkansas	No Managed Care	NA	NA	NA
California	MH Only	Yes	Yes	No
Colorado	MH Only	No	Yes	No
Connecticut (Adults)	Both MH&SA	No	Yes	Yes
Delaware	Both MH&SA	Yes	No	No
District of Columbia	NR	NR	NR	NR
Florida	Both MH&SA	Yes	Yes	No
Georgia	Both MH&SA	*	No	No
Hawaii	Both MH&SA	Yes	No	No
Idaho	No Managed Care	NA	NA	NA
Illinois	No Managed Care	NA	NA	NA
Indiana	Both MH&SA	Yes	Yes	No
Iowa	Both MH&SA	No	Yes	No
Kansas	Both MH&SA	No	Yes	Yes
Kentucky	No Managed Care	NA	NA	NA
Louisiana	MH Only	NR	NR	NR
Maine	No Managed Care	NA	NA	NA
Maryland	Both MH&SA	Yes	No	Yes

Table 11: State Use of Managed Care To Provide Behavioral Health Services (Continued)

State	Type of Medicaid Waiver Used			
	Is your state using managed care practices to provide behavioral health services?	Medicaid Research and Demonstration (1115) waiver?	Medicaid 1915(b) waiver?	Medicaid 1915(c) HCBS waiver for mental health?
Massachusetts	Both MH&SA	Yes	No	No
Michigan	Both MH&SA	Yes	Yes	Yes
Minnesota	Both MH&SA	Yes	No	No
Mississippi	No Managed Care	NA	NA	NA
Missouri	MH Only	Yes	Yes	No
Montana	No Managed Care	NA	NA	NA
Nebraska	Both MH&SA	No	Yes	No
Nevada	Both MH&SA	No	Yes	Yes
New Hampshire	No Managed Care	NA	NA	NA
New Jersey	No Managed Care	NA	NA	NA
New Mexico	Both MH&SA	No	Yes	No
New York	No Managed Care	NA	NA	NA
North Carolina	Both MH&SA	No	Yes	Yes
North Dakota	No Managed Care	NA	NA	NA
Ohio	No Managed Care	NA	NA	NA
Oklahoma	No Managed Care	NA	NA	NA
Oregon	Both MH&SA	Yes	No	No
Pennsylvania	Both MH&SA	No	Yes	No
Rhode Island	Both MH&SA	Yes	No	No
South Carolina	Both MH&SA	No	No	No
South Dakota	No Managed Care	NA	NA	NA

Table 11: State Use of Managed Care To Provide Behavioral Health Services (Continued)

State	Type of Medicaid Waiver Used			
	Is your state using managed care practices to provide behavioral health services?	Medicaid Research and Demonstration (1115) waiver?	Medicaid 1915(b) waiver?	Medicaid 1915(c) HCBS waiver for mental health?
Tennessee	Both MH&SA	Yes	No	No
Texas	Both MH&SA	No	Yes	Yes
Utah	MH Only	No	Yes	No
Vermont	Both MH&SA	Yes	No	No
Virginia	Both MH&SA	No	Yes	No
Washington	MH Only	No	Yes	No
West Virginia	Both MH&SA	No	No	No
Wisconsin	Both MH&SA	No	Yes	Yes
Wyoming	Both MH&SA	Yes	NA	NA
	27 = Both MH & SA	16 = Yes	19 = Yes	9 = Yes
	7 = MH Only	18 = No	14 = No	24 = No
	16 = No MC	16 = NA	16 = NA	16 = NA
	1 = NR	2 = NR	2 = NR	2 = NR

MH = mental health.
SA = substance abuse.
MC = managed care.
NA = not applicable.
NR = no response.
*Georgia had an application pending.

2.7.4.1 Medicaid 1915(b) Waivers

The most frequent type of Medicaid waiver used to pay for mental health services was the 1915(b) managed care waiver in which states have options to restrict the types of providers that people can use to get Medicaid benefits through a managed care system, use local government to help people choose a managed care plan, use savings generated from a managed care delivery system to provide additional services, or restrict the provision of specific Medicaid services to a particular type of providers. In 2010, 1915(b) waivers were used in 19 states. In 16 states, there was 1 1915(b) waiver being used for behavioral health, whereas in 3 states, there were multiple 1915(b) waivers (North Carolina and Pennsylvania had 2 1915(b) waivers and Texas had 3 1915(b) waivers). In 11 states, behavioral health services for 1,413,118 consumers were covered by a 1915(b) waiver. States using 1915(b) waivers varied from a low of 11,875 persons included in their waiver in North Carolina to a high of 435,133 persons in California.

In 12 states, the mental health benefits of the 1915(b) waiver were carved out with responsibilities for mental health services contracted to a specialty behavioral healthcare network or managed behavioral healthcare provider. In five states, the mental health benefits of the 1915(b) waiver were carved in with responsibilities for mental health services retained with behavioral health benefits provided by the primary healthcare provider networks or an HMO. In Texas, which had multiple 1915(b) waivers, carve-out and carve-in approaches were used.

2.7.4.2 Medicaid 1115 Waivers

The second most frequent type of Medicaid waiver used to pay for mental health services was the 1115 Research and Demonstration waiver, in which states can apply for program flexibility in order to test new innovative or existing approaches to finance and deliver Medicaid services. The 1115 waiver was used in 16 states. In 5 states, 369,195 consumers received behavioral health services under an 1115 waiver. States using 1115 waivers varied from a low of 2,300 consumers in Missouri to a high of 183,695 consumers in Tennessee.

In nine states, the mental health benefits of an 1115 waiver were carved out to a specialty behavioral healthcare network or managed behavioral healthcare provider. In eight states, the mental health benefits of an 1115 waiver were carved in, with behavioral health benefits provided by the primary healthcare provider networks or HMO.

2.7.4.3 Medicaid 1915(c) HCBS Waivers

The 1915(c) HCBS waiver was less commonly used for mental health services. This waiver program allows states to offer traditional medical services (i.e., dental services and skilled nursing services) as well as nonmedical services (i.e., respite, case management, and environmental modifications). States may put a cap on the number of consumers served and request waivers of statewideness; comparability

of services; and income and resource rules that allow them to cover those who would otherwise be eligible only in an institutional setting. The 1915(c) waiver was used to provide mental health services in nine states. Four states reported having one 1915(c) waiver used for behavioral health. In 6 states, 2,400 consumers received behavioral health services from a 1915(c) waiver. States using 1915(c) waivers varied from a low of 40 to 50 persons in Connecticut to a high of 2,157 consumers in Nevada.

2.7.4.4 Services Provided Under Managed Care

SMHAs reported a variety of mental health services were available under the various waivers used to provide mental health services. Table 12 shows that outpatient therapy, acute hospitalization, assessment and diagnosis, and emergency/crisis services were the most frequently covered services under both 1115 and 1915(b) waivers.

Table 12: Number of States Covering Specific Mental Health Services Under 115 and 1915(b) Waivers

Mental Health Services Available Under Waiver	Number of States Covering Service, by Type of Medicaid Waivers Used	
	1115 Waivers	1915(b) Waivers
Outpatient Therapy	15	19
Acute Hospitalization	15	18
Assessment and Diagnosis	15	18
Emergency/Crisis Services	14	18
Treatment Planning	14	17
Medication Administration and Monitoring	13	16
Psychosocial Rehabilitation	10	16
Day Treatment/Partial Hospitalization	12	15
Residential Treatment Centers	9	12
Intensive In-Home Services	9	12
Prescription Medications for Mental Health	13	11
Peer Support	5	9
Crisis Residential	8	8
Wraparound Services	4	8
Consumer-Run Services	3	7
Inpatient Care in State Psychiatric Hospitals	5	6
Long-Term Hospitalization	7	5
Other Services	3	2

2.7.4.5 Inclusion of Adults With SMI and Children With SED in Medicaid Waivers

States had different rules regarding which mental health consumers were included in waivers and whether persons with SMI or SED were required to participate in the plan (*mandatory*), were allowed an option of joining a managed care plan (*voluntary*), or were excluded from the managed care system (*excluded*). Table 13 shows the different mental health consumer groups that were included in the waivers and identifies whether the consumers of each group could voluntarily elect to participate in the waiver, whether their participation was mandatory, or whether that group was excluded from participating in the waiver. For states with 1115 waivers, inclusion of adults with SMI was mandatory in six states and was voluntary in two states. For states with 1915(b) waivers, the participation of adults with SMI was mandatory in 13 states and was voluntary in 3 states.

Table 13: Mental Health Population Covered Under 1115 and 1915(b) Waivers

Population	Number of States					
	1115			1915(b)		
	Voluntary	Mandatory	Excluded	Voluntary	Mandatory	Excluded
Adults With SMI	**2**	**6**	**0**	**3**	**13**	**2**
SSI	1	6	3	2	12	2
Non-SSI	2	5	1	1	12	0
Children With SED	**1**	**8**	**1**	**1**	**12**	**3**
SSI	1	8	4	1	12	3
Non-SSI	2	8	1	0	13	1
All Other Consumers	**0**	**6**	**0**	**1**	**11**	**3**
SSI	0	6	2	0	9	3
Non-SSI	0	6	0	1	11	0

2.7.4.6 SMHA Role in Monitoring and Managing Mental Health Managed Care Benefits

The SMHA often worked with its state Medicaid agency in the development, writing, and monitoring of managed care benefits for mental health. Table 14 shows the roles for which the SMHA and state Medicaid agency were responsible in managing and monitoring the mental health/behavioral health managed care benefits. SMHAs either had the lead role (7 states) or were jointly responsible (15 states) for the development of the managed care benefit, followed by monitoring and evaluating the managed care system. In six states, the SMHA served as the managed care agent responsible for mental health services. SMHAs were least likely to be involved in the actual writing of waivers and in the managed care contracting process.

Table 14: SMHA Role in Managing and Monitoring Managed Care

Role	SMHA Has Lead Responsibility	SMHA Jointly Responsible With Medicaid	SMHA Has No Responsibility
Designing Mental Health Benefit System	7	15	8
Writing the Waiver	6	6	17
Contracting	8	7	15
Monitoring	8	11	11
Evaluating	7	11	12
Serving as the Managed Care Agent	6	2	16
Acting in Other Role	3	0	1

2.8 SMHA-Controlled Revenues and Expenditures for Mental Health Services in FY 2008

SMHAs administered and oversaw funds from a variety of sources, including federal, state, and local sources, to finance public mental health services. In FY 2008, SMHAs directed the expenditure of $36.7 billion (2.1 percent of total state government expenditures) for mental health services in state psychiatric hospitals; community mental health agencies; and the SMHA's research, training, and administration operations. SMHAs averaged per capita expenditures of $121, with a median of $109. SMHA per capita expenditures varied from over $300 in the District of Columbia and Maine to less than $50 per capita in Arkansas, Florida, Georgia, Idaho, and Texas (see figure 7 and table 15).

2.8.1 SMHA Expenditures Vary by SMHA Responsibilities

On average, SMHAs that were responsible for administering some Medicaid benefits for mental health had higher expenditures than states where the SMHA was not responsible for setting Medicaid rates for mental health or for managing Medicaid mental health benefits (see figure 8).

The 19 SMHAs that were responsible for setting some of the Medicaid rates for mental health services averaged $151.12 in per capita expenditures, whereas the 30 SMHAs that were not responsible for setting Medicaid rates averaged $103.11. States where the SMHA was involved in setting Medicaid rates had higher per capita expenditures for community mental health services ($110.59 versus $71.53), whereas per capita expenditures for state psychiatric hospitals were much more similar ($37.20 to $28.93).

The states where the SMHA was involved in setting Medicaid rates for mental health services reported much greater SMHA-controlled revenues from Medicaid (on average, 52 percent of SMHA revenues were from Medicaid) than states that were not involved in setting Medicaid rates (on average, 36 percent of revenues were from Medicaid).

Figure 7: Total SMHA-Controlled per Capita Expenditures for Mental Health Services, FY 2008

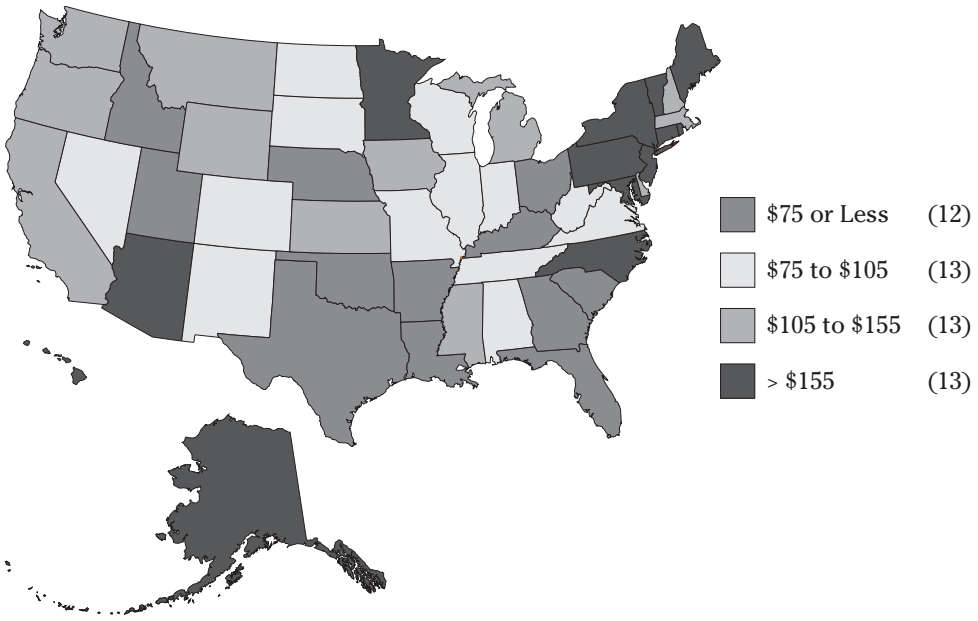


Table 15: SMHA Total Expenditures, per Capita Expenditures, and Expenditures per Population Under 135 Percent of FPL for Mental Health Services, FY 2008

State	Total Expenditure	Total Rank	State Civilian Population	Per Capita	Per Capita Rank	Per Capita Population <135% of Poverty	<135% Poverty per Capita Rank
Alabama	$369,100,000	27	4,649,367	$79.39	37	$383.28	39
Alaska	$184,099,600	38	664,546	$277.03	3	$2,068.53	1
Arizona	$1,126,700,000	7	6,480,767	$173.85	11	$707.28	20
Arkansas (a)	$115,460,531	46	2,848,432	$40.53	50	$178.46	50
California (b)	$5,503,873,606	1	36,609,002	$150.34	15	$693.01	21
Colorado	$401,414,502	25	4,912,947	$81.71	35	$491.33	29
Connecticut (ac)	$659,400,000	17	3,493,783	$188.74	10	$1,427.27	6
Delaware (ac)	$96,545,836	47	869,221	$111.07	25	$647.96	24
District of Columbia	$224,903,447	34	588,910	$381.90	1	$1,618.01	4
Florida	$768,903,101	14	18,257,662	$42.11	49	$210.95	49
Georgia (a)	$472,015,033	23	9,622,508	$49.05	47	$232.63	46

Table 15: SMHA Total Expenditures, per Capita Expenditures, and Expenditures per Population Under 135 Percent of FPL for Mental Health Services, FY 2008 (Continued)

State	Total Expenditure	Total Rank	State Civilian Population	Per Capita	Per Capita Rank	Per Capita Population <135% of Poverty	<135% Poverty per Capita Rank
Hawaii (c)	$259,614,519	32	1,250,676	$207.58	7	$1,366.39	8
Idaho	$72,962,700	49	1,518,914	$48.04	48	$225.89	48
Illinois	$1,110,300,000	8	12,867,077	$86.29	32	$488.90	31
Indiana	$568,964,398	20	6,373,299	$89.27	31	$448.00	33
Iowa	$373,575,000	26	3,000,490	$124.50	20	$824.67	15
Kansas	$321,700,000	29	2,782,245	$115.63	23	$552.75	27
Kentucky	$230,300,000	33	4,254,964	$54.13	46	$227.12	47
Louisiana	$325,491,816	28	4,395,797	$74.05	41	$283.28	44
Maine (b)	$448,173,086	24	1,312,972	$341.34	2	$1,923.49	2
Maryland	$898,906,000	9	5,604,174	$160.40	12	$1,195.35	10
Massachusetts (a)	$792,200,000	13	6,492,024	$122.03	21	$785.13	16
Michigan (b)	$1,358,300,000	6	9,998,854	$135.85	17	$740.22	19
Minnesota	$833,276,226	12	5,215,815	$159.76	13	$1,099.31	12
Mississippi	$319,700,000	30	2,922,355	$109.40	26	$390.35	38
Missouri	$482,143,187	21	5,891,974	$81.83	34	$416.00	35
Montana	$147,371,924	41	963,802	$152.91	14	$759.65	17
Nebraska (b)	$118,638,632	44	1,776,757	$66.77	42	$407.69	37
Nevada	$210,765,076	35	2,589,934	$81.38	36	$491.29	30
New Hampshire	$177,652,442	40	1,314,533	$135.14	18	$1,225.19	9
New Jersey (b)	$1,706,776,011	5	8,670,204	$196.86	9	$1,421.13	7
New Mexico (ac)	$189,562,021	37	1,974,993	$95.98	29	$334.32	42
New York (b)	$4,492,600,000	2	19,465,159	$230.80	5	$1,124.27	11
North Carolina	$1,808,253,118	4	9,121,606	$198.24	8	$920.70	14
North Dakota	$47,834,889	51	634,282	$75.42	39	$447.06	34
Ohio	$856,298,838	11	11,476,782	$74.61	40	$378.06	40
Oklahoma (b)	$199,100,000	36	3,620,620	$54.99	45	$270.52	45
Oregon	$473,203,156	22	3,786,824	$124.96	19	$681.85	23
Pennsylvania (ac)	$3,396,321,504	3	12,440,129	$273.01	4	$1,780.04	3
Rhode Island (c)	$116,922,840	45	1,046,535	$111.72	24	$612.16	25

Table 15: SMHA Total Expenditures, per Capita Expenditures, and Expenditures per Population Under 135 Percent of FPL for Mental Health Services, FY 2008 (Continued)

State	Total Expenditure	Total Rank	State Civilian Population	Per Capita	Per Capita Rank	Per Capita Population <135% of Poverty	<135% Poverty per Capita Rank
South Carolina	$288,200,000	31	4,438,870	$64.93	44	$299.90	43
South Dakota	$68,308,552	50	800,997	$85.28	33	$461.54	32
Tennessee	$608,600,000	18	6,202,407	$98.12	28	$409.28	36
Texas (b)	$874,000,000	10	24,214,127	$36.09	51	$148.14	51
Utah (b)	$178,238,145	39	2,730,919	$65.27	43	$535.25	28
Vermont	$138,600,000	43	620,602	$223.33	6	$1,557.30	5
Virginia	$709,900,000	16	7,648,902	$92.81	30	$595.05	26
Washington	$754,600,000	15	6,502,019	$116.06	22	$757.63	18
West Virginia (b)	$143,500,000	42	1,812,879	$79.16	38	$356.97	41
Wisconsin	$589,044,635	19	5,625,013	$104.72	27	$684.14	22
Wyoming (b)	$75,432,325	48	529,490	$142.46	16	$967.08	13
Total	$36,687,746,696		302,887,160	$121.13		$617.35	
Average (Mean)	$719,367,582		5,938,964	$126.80		$730.43	
Median	$373,575,000		4,254,964	$109.40		$595.05	
Number of States Reporting	51		51	51		51	

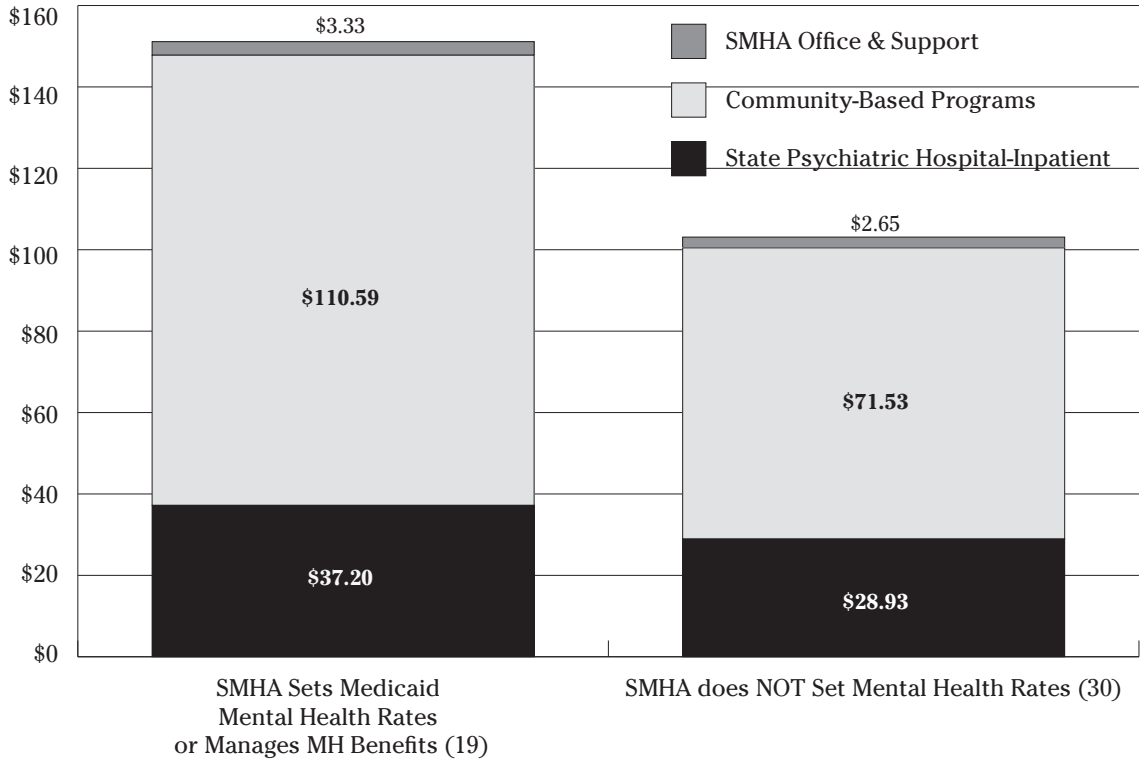
a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.
c = Children's mental health expenditures are not included in SMHA-controlled expenditures.

2.8.2 SMHA Expenditures, by How SMHAs Fund Community Mental Health Services

SMHAs organized and funded community mental health services using several methods. The three primary methods used were as follows: (1) SMHAs directly operated community mental health services with state employees; (2) SMHAs funded county/city governments or boards to organize and deliver community mental health services; and (3) SMHAs directly contracted with community mental health providers, which were typically not-for-profit organizations.

Seven SMHAs primarily directly operated community mental health services, and these SMHAs reported the lowest level of SMHA per capita expenditures ($94.54). States that directly operated their community mental health services also tended to rely more heavily on state

Figure 8: SMHA-Controlled per Capita Expenditures for Mental Health, by SMHA Responsibility for Setting Medicaid Rates, FY 2008

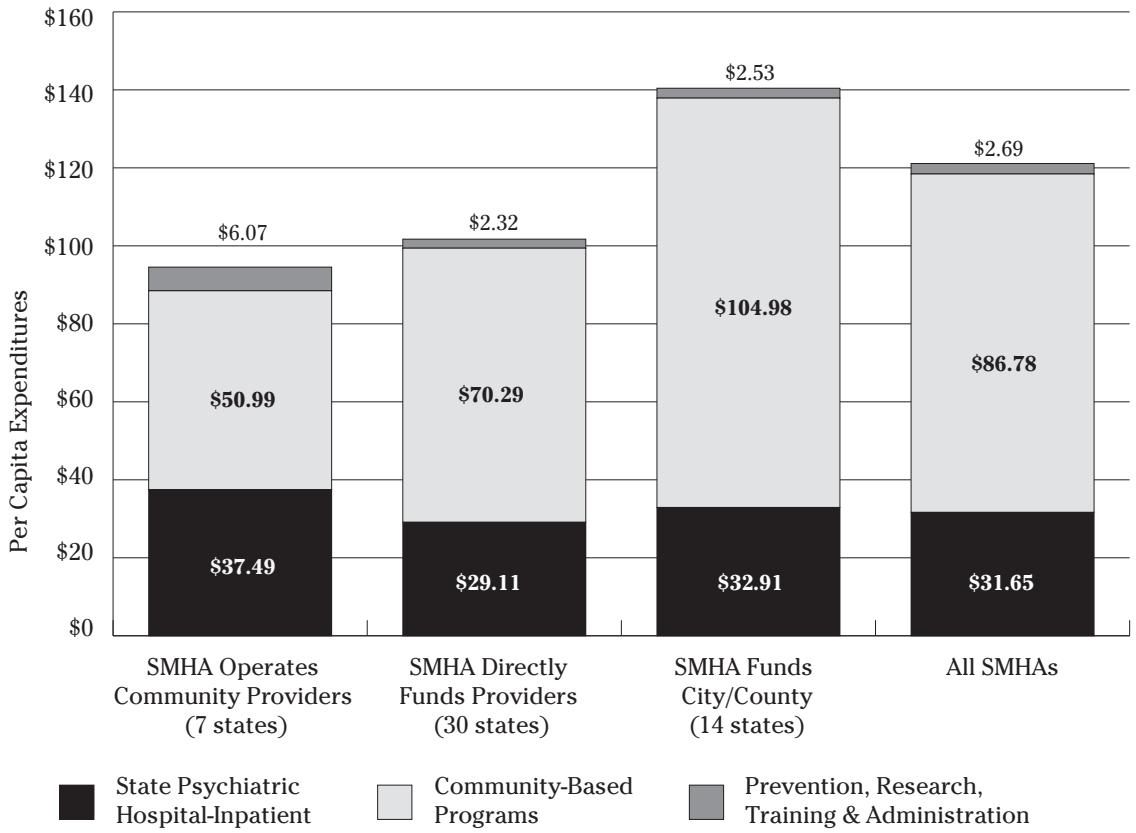


general fund dollars and less on Medicaid and other reimbursements for services than states where the community mental health providers were private not-for-profits or county based. The SMHAs that operated community services also had the highest reported average administration operations costs (averaging $7.61 per capita). Such costs may have been due to SMHAs having to pay directly for the administration operations and personnel expenses of state-operated community providers that were included in the services expenditures in states that do not directly operate community providers. The seven states (Connecticut, District of Columbia, Idaho, Kentucky, Louisiana, Nevada, and South Carolina) that directly operated community providers tended to be smaller states and collectively represented 7 percent of the total U.S. population.

The 14 SMHAs that organized their community mental health systems by primarily funding city/county governments to provide services had the highest per capita expenditures for community mental health ($104.98) and for overall SMHA expenditures ($140.42). These 14 states tended to be larger population states and collectively represented 51 percent of the U.S. population.

The majority of SMHAs (30) primarily directly funded community providers, and these states averaged the lowest per capita expenditures for state psychiatric hospitals ($29.11) and for SMHA administration operations expenses ($2.32). Overall, states that directly funded community providers had the second highest total per capita expenditures ($101.72) and represented 41 percent of the total U.S. population (see figure 9).

Figure 9: SMHA-Controlled per Capita Expenditures for Mental Health, by Primary Method Used To Fund Community Services, FY 2008



2.8.3 Major Funding Sources of SMHAs, FY 2008

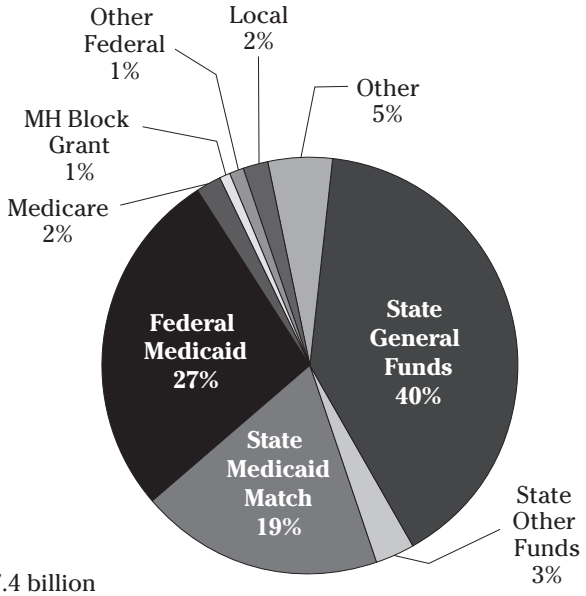
In FY 2008, 62 percent of SMHA-controlled revenues came from state government sources. The largest shares of state government funding of mental health were state general revenue funds (40 percent); the state Medicaid match (19 percent); and state special funds such as special funding sources dedicated to mental health, or interdepartmental funds received by the SMHA from other state government agencies or entities through fund transfer, contract, or memorandum of agreement (3 percent).

The federal government was the second largest (31 percent) source of funding. The federal share of Medicaid (27 percent) was the largest single federal source, followed by Medicare (2 percent), the MHBG (1 percent), and other federal funds (1 percent). Local county and city government contributed 2 percent. Cities and counties, in some states, spent their own tax dollars to provide mental health services that were not counted as part of the SMHA-controlled system. SMHAs also received 4.6 percent of revenues from other sources, which included private health insurance reimbursement and consumer copays, as well as donations and all other funding sources. Total Medicaid expenditures, combining the state and federal shares, totaled $17.1 billion and were the largest single funding source (46 percent) for the SMHAs.

See figure 10 for a breakdown of total revenues, by funding sources, and table 16 for a breakdown of total revenues, by funding sources and state.

As depicted in table 16, states varied in their reliance on the state general funds versus Medicaid, with Connecticut, Hawaii, District of Columbia, Georgia, Wyoming, and Massachusetts reporting over 80 percent of SMHA-controlled revenues were from state general funds. In Maine, Rhode Island, Vermont, New Hampshire, and Arizona, the majority of the SMHA-controlled revenues came from Medicaid. Three states that organized their community mental health systems through county governments reported the highest use of local government funds (Ohio (32 percent), Wisconsin (21 percent), and Iowa (10 percent)).

Figure 10: Percentage of SMHA-Controlled Revenues for Mental Health Services, by Funding Sources, FY 2008



Total SMHA Revenues = $37.4 billion

Table 16: SMHA-Controlled Mental Health Revenues, by Funding Sources and State, FY 2008 (in millions)

State	State General and Other Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd-Party and Other Funds		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Alabama	$199.10	53%	$130.70	35%	$17.20	5%	$6.90	2%	$1.40	0%	$0.00	0%	$21.50	6%	$376.80
Alaska	$39.10	21%	$139.20	76%	$2.70	1%	$0.70	0%	$1.10	1%	$0.00	0%	$1.40	1%	$184.10
Arizona	$188.20	17%	$879.50	78%	$0.50	0%	$8.50	1%	$6.60	1%	$0.00	0%	$42.70	4%	$1,126.00
Arkansas (a)	$69.30	60%	$31.10	27%	$3.40	3%	$3.70	3%	$3.10	3%	$0.00	0%	$4.90	4%	$115.50
California (b)	$2,386.40	43%	$2,115.30	38%	$34.70	1%	$59.30	1%	$7.20	0%	$0.00	0%	$901.00	16%	$5,503.90
Colorado	$133.80	33%	$246.00	61%	$7.50	2%	$6.10	2%	$4.00	1%	$1.10	0%	$3.00	1%	$401.40
Connecticut (ac)	$632.80	93%	$14.40	2%	$7.50	1%	$5.00	1%	$13.80	2%	$0.00	0%	$6.60	1%	$680.10
Delaware (ac)	$77.00	78%	$16.00	16%	$0.70	1%	$0.40	0%	$3.00	3%	$0.00	0%	$1.20	1%	$98.30
District of Columbia	$199.80	89%	$18.80	8%	$3.70	2%	$0.80	0%	$1.90	1%	$0.00	0%	$0.00	0%	$224.90
Florida	$594.40	77%	$128.60	17%	$0.00	0%	$25.70	3%	$20.10	3%	$0.00	0%	$0.00	0%	$768.90
Georgia (a)	$394.60	84%	NA	NA	$11.60	2%	$15.00	3%	$5.80	1%	NA	0%	$45.00	10%	$472.00
Hawaii (c)	$213.50	89%	$19.90	8%	$0.20	0%	$1.90	1%	$4.30	2%	$0.00	0%	$0.30	0%	$240.10
Idaho	$54.10	74%	$7.90	11%	$1.40	2%	$1.80	2%	$6.50	9%	$0.00	0%	$1.20	2%	$73.00
Illinois	$630.50	57%	$443.70	40%	$10.20	1%	$16.10	1%	$7.70	1%	$0.00	0%	$2.10	0%	$1,110.30
Indiana	$184.20	32%	$363.30	64%	$5.60	1%	$7.80	1%	$6.70	1%	$0.00	0%	$1.30	0%	$569.00
Iowa	$58.20	15%	$206.90	54%	$3.20	1%	$3.30	1%	$14.20	4%	$37.70	10%	$57.10	15%	$380.60
Kansas	$117.40	36%	$201.30	63%	NA	NA	$2.70	1%	$0.30	0%	NA	0%	NA	0%	$321.70
Kentucky	$136.00	59%	$69.00	30%	$11.90	5%	$5.40	2%	$3.70	2%	$0.00	0%	$4.30	2%	$230.30
Louisiana	$151.40	46%	$100.90	31%	$0.70	0%	$5.20	2%	$42.40	13%	$0.00	0%	$24.90	8%	$325.50
Maine (b)	$51.70	12%	$393.40	88%	$0.00	0%	$1.70	0%	$1.40	0%	$0.00	0%	$0.00	0%	$448.20
Maryland	$613.70	68%	$266.80	30%	$0.00	0%	$10.50	1%	$8.00	1%	$0.00	0%	$0.00	0%	$898.90
Massachusetts (a)	$778.50	82%	$146.00	15%	$8.70	1%	$8.00	1%	$5.70	1%	$0.00	0%	$7.10	1%	$954.00
Michigan (b)	$379.70	28%	$871.60	64%	$0.80	0%	$15.00	1%	$32.20	2%	$30.50	2%	$28.50	2%	$1,358.30
Minnesota	$375.50	45%	$370.80	45%	$5.40	1%	$7.10	1%	$13.60	2%	$35.20	4%	$25.70	3%	$833.30

Table 16: SMHA-Controlled Mental Health Revenues, by Funding Sources and State, FY 2008 (in millions) (Continued)

State	State General and Other Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd-Party and Other Funds		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Mississippi	$150.80	47%	$137.80	43%	$8.40	3%	$4.10	1%	$5.20	2%	$0.00	0%	$13.40	4%	$319.70
Missouri	$333.00	52%	$267.80	42%	$14.50	2%	$6.80	1%	$13.20	2%	$0.00	0%	$3.70	1%	$638.90
Montana	$50.70	34%	$93.30	63%	$0.00	0%	$1.20	1%	$2.20	1%	$0.00	0%	$0.00	0%	$147.40
Nebraska (b)	$85.10	72%	$17.00	14%	$0.50	0%	$2.70	2%	$2.10	2%	$0.00	0%	$11.20	9%	$118.60
Nevada	$153.80	73%	$29.30	14%	$9.40	4%	$1.60	1%	$9.30	4%	$0.00	0%	$7.20	3%	$210.80
New Hampshire	$13.40	8%	$140.80	79%	$10.80	6%	$1.50	1%	$5.50	3%	$0.00	0%	$5.50	3%	$177.70
New Jersey (b)	$1,032.80	61%	$456.10	27%	$52.30	3%	$12.00	1%	$6.30	0%	$70.80	4%	$76.40	4%	$1,706.80
New Mexico (ac)	$67.50	36%	$117.80	62%	$0.30	0%	$2.00	1%	$0.10	0%	$0.00	0%	$1.90	1%	$189.60
New York (b)	$1,223.40	28%	$2,388.90	54%	$302.60	7%	$27.80	1%	$84.40	2%	$76.60	2%	$296.20	7%	$4,399.90
North Carolina	$367.90	20%	$1,320.40	73%	$26.90	1%	$9.80	1%	$1.90	0%	$58.80	3%	$22.60	1%	$1,808.30
North Dakota	$21.90	46%	$9.70	20%	$3.00	6%	$0.80	2%	$5.50	11%	$0.00	0%	$7.00	15%	$47.80
Ohio	$493.00	37%	$358.40	27%	$20.10	2%	$14.00	1%	$14.20	1%	$418.70	32%	$1.60	0%	$1,320.00
Oklahoma (b)	$155.20	78%	$25.80	13%	$4.90	2%	$4.20	2%	$2.60	1%	$0.00	0%	$6.40	3%	$199.10
Oregon	$164.00	35%	$296.60	63%	$0.00	0%	$3.90	1%	$1.00	0%	$0.00	0%	$7.70	2%	$473.20
Pennsylvania (ac)	$953.60	28%	$2,282.00	67%	$32.80	1%	$14.40	0%	$71.70	2%	$18.80	1%	$11.30	0%	$3,384.60
Rhode Island (c)	$14.50	12%	$100.50	86%	NA	NA	$1.10	1%	$0.80	1%	$0.00	0%	NA	0%	$116.90
South Carolina	$154.30	52%	$111.00	37%	$0.80	0%	$5.60	2%	$8.50	3%	$3.10	1%	$14.60	5%	$297.90
South Dakota	$36.30	56%	$22.20	34%	$2.90	4%	$0.90	1%	$1.50	2%	$0.00	0%	$0.70	1%	$64.50
Tennessee	$165.50	27%	$420.80	69%	$6.30	1%	$7.90	1%	$5.20	1%	$0.00	0%	$2.90	0%	$608.60
Texas (b)	$604.00	69%	$150.80	17%	$22.80	3%	$32.30	4%	$28.20	3%	$19.70	2%	$16.20	2%	$874.00
Utah (b)	$40.60	23%	$129.20	72%	$1.60	1%	$2.80	2%	$2.20	1%	NA	0%	$1.80	1%	$178.20

Table 16: SMHA-Controlled Mental Health Revenues, by Funding Sources and State, FY 2008 (in millions) (Continued)

State	State General and Other Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd-Party and Other Funds		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Vermont	$22.30	16%	$113.00	82%	$0.10	0%	$0.80	1%	$2.20	2%	$0.00	0%	$0.20	0%	$138.60
Virginia	$426.00	61%	$231.40	33%	$18.10	3%	$9.90	1%	$0.60	0%	$0.00	0%	$15.10	2%	$701.10
Washington	$239.30	32%	$466.60	62%	$21.00	3%	$8.70	1%	$1.40	0%	$0.00	0%	$17.60	2%	$754.60
West Virginia (b)	$66.60	46%	$68.70	48%	$3.50	2%	$2.10	1%	$0.30	0%	$0.00	0%	$2.30	2%	$143.50
Wisconsin	$275.60	47%	$158.80	27%	$6.50	1%	$7.40	1%	$4.90	1%	$124.50	21%	$11.40	2%	$589.00
Wyoming (b)	$63.00	83%	$9.60	13%	$0.00	0%	$0.50	1%	$2.50	3%	$0.00	0%	$0.00	0%	$75.50
Total	$16,033.0	42.9%	$17,105.5	45.8%	$707.7	1.9%	$405.5	1.1%	$498.0	1.3%	$895.4	2.4%	$1,734.6	4.6%	$37,379.7
Average (Mean)	$314.4		$335.4		$13.9		$8.0		$9.8		$17.6		$34.0		$732.9
Median	$164.0		$140.0		$6.3		$5.2		$5.2		$36.4		$7.1		$380.6

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

2.8.4 SMHA Revenue Trends for Mental Health Services

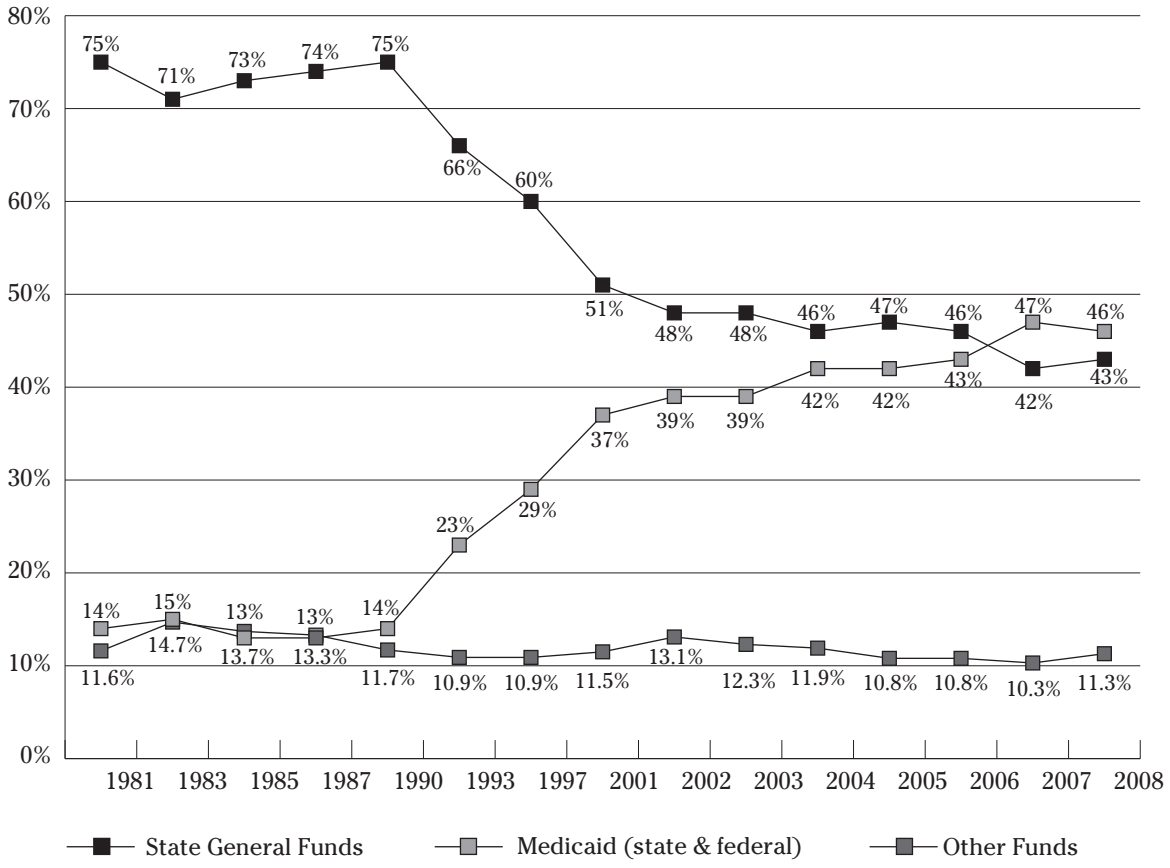
The funding sources that SMHAs rely on to pay for their mental health systems have shifted over time. In FY 2007, for the first time, Medicaid funding became the largest single source of funding, replacing state general revenue funds. Historically, state government tax dollars appropriated to the SMHA as general or special funds were the largest single funding source. In FY 1981, 75 percent of funding came from state general and special funds, and as recently as FY 2001, state general and special funds represented over half (51 percent) of SMHA revenues. Medicaid has grown from representing only 14 percent of SMHA funding in 1981 to 46 percent in FY 2008 (see figure 11). Most of the increase in Medicaid occurred after 1990, when states began using the rehabilitation services and targeted case management Medicaid options, as well as Medicaid 1915(b) and 1115(c) waivers, to expand community mental health services eligible for Medicaid reimbursement.

Although state general funds have dropped as a share of SMHA revenues, the actual amount of state general fund dollars has increased over the last 27 years. Figure 12 shows that state general funds grew from $4.6 billion in FY 1981 to $16 billion in FY 2008, an annual average increase of 4.7 percent per year. Medicaid (state and federal), however, increased at a much faster rate, an annual average rate of 11.7 percent per year, from $0.9 billion in FY 1981 to $17.1 billion in FY 2008.

During the 1980s, 75 percent of new funds for SMHAs came from state general funds, whereas Medicaid accounted for only 13 percent of new funds and other federal funds (including the MHBG) accounted for 9 percent. Since the 1990s and during the first 8 years of the 2000s, most of SMHA funding increases were from Medicaid. During the 1990s, Medicaid was 64 percent of the increased SMHA funding, whereas state general funds were 25 percent. From FY 2001 to FY 2008, the trends were similar, with Medicaid accounting for 60 percent of increased funding, whereas state general funds accounted for 29 percent. All other funds provided only about 7 percent of increased funding from FY 1981 to FY 2008 (see figure 13).

The growth in Medicaid revenues was mostly due to an increased use of Medicaid to pay for community mental health services. From FY 1981 to FY 2008, Medicaid funding for community mental health systems increased by 24 percent per year. Meanwhile, state general funds for community mental health increased 6.7 percent per year. All other funds for community mental health increased by 9 percent per year.

Figure 11: Percentage of SMHA-Controlled Revenues From Major Funding Sources, FY 1981 to FY 2008



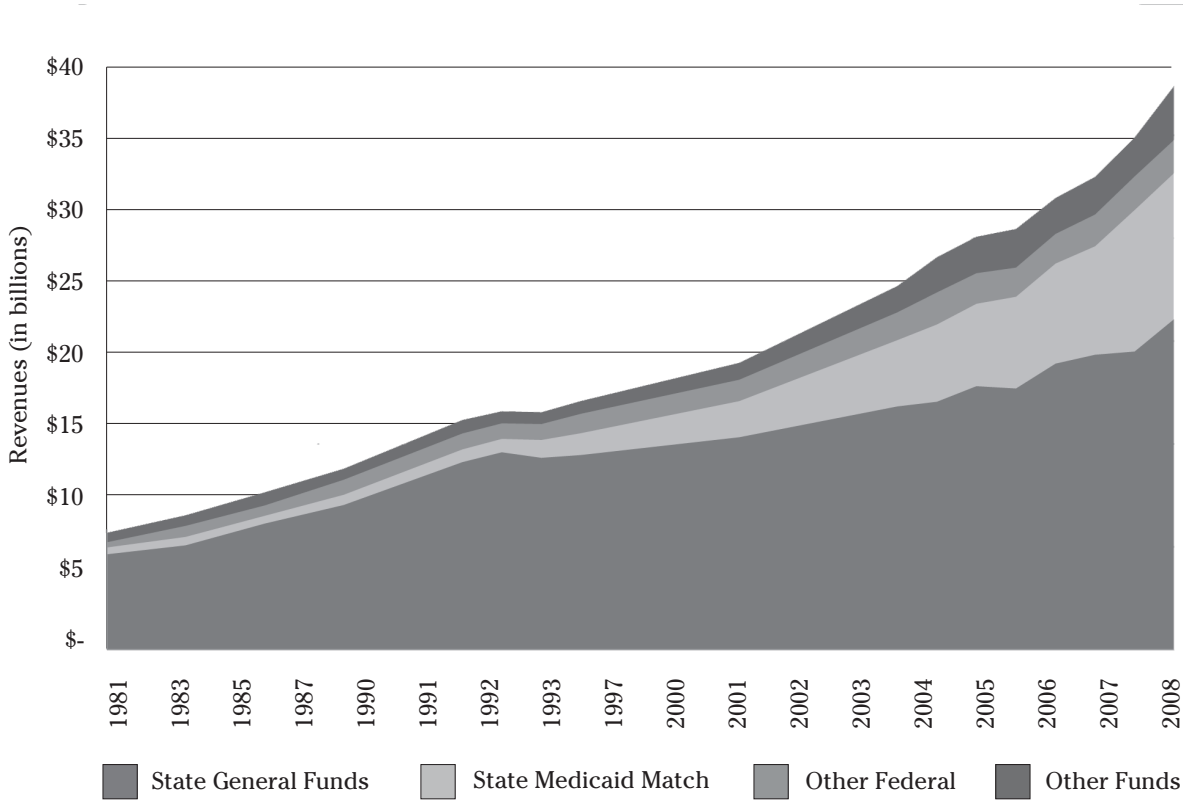
2.8.5 SMHA Revenues From Medicaid

Since 1990, Medicaid revenues devoted to the provision of SMHA services have grown faster than the overall growth rate of Medicaid. State government total Medicaid expenditures have grown at an annual rate of 9.2 percent per year since FY 1981 (NASBO, 2009). During this same period, SMHA-controlled Medicaid revenues for mental health services increased at an annual rate of 11.7 percent per year. As a result of the increases in Medicaid funding going into SMHA systems, Medicaid devoted to SMHA services as a share of total Medicaid grew from 2.3 percent of all Medicaid spending in FY 1990 to 5.5 percent in FY 2008 (see figure 14).

2.8.6 SMHA Mental Health Expenditures Over Time

From FY 2001 to FY 2008, SMHA expenditures increased at an average annual rate of 6.9 percent, from $23 billion in 2001 to $36.7 billion in 2008. When constant inflation-adjusted dollars were looked at (using the medical care component of the Consumer Price Index for each fiscal year), SMHA expenditures

Figure 12: SMHA-Controlled Revenues for Mental Health Services, FY 1981 to FY 2008



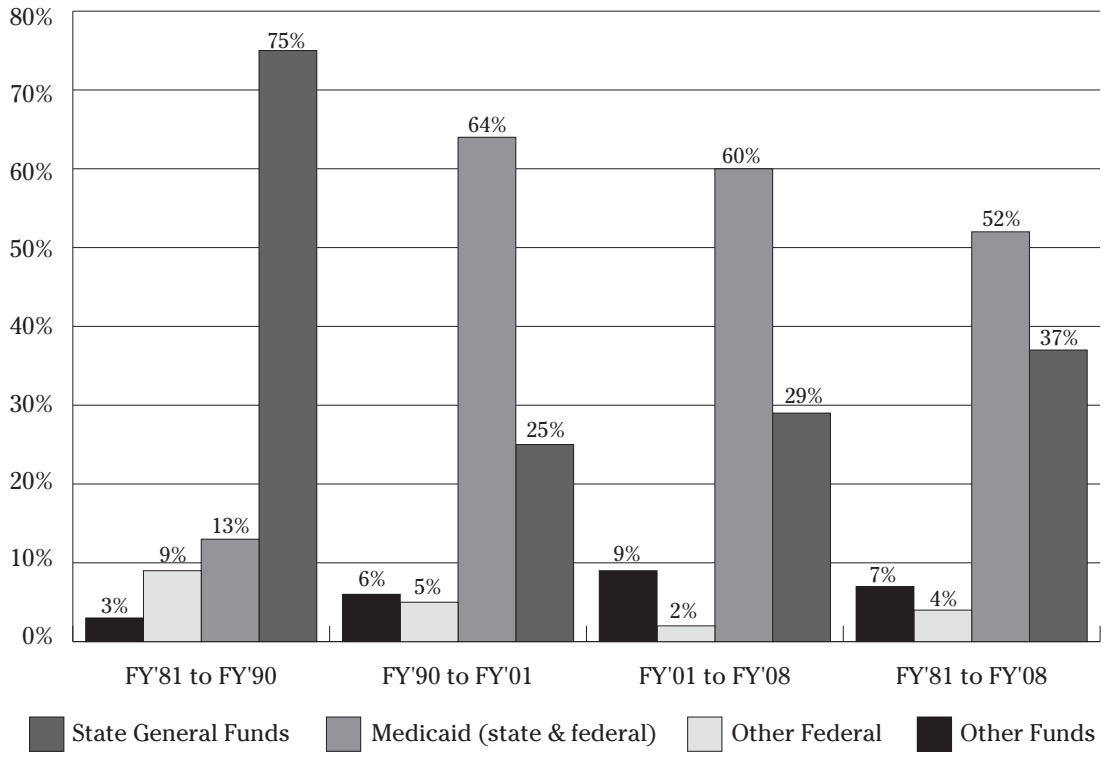
have increased by only 2.6 percent per year since 2001 (see figure 15).

When adjusted for the growth in population and inflation, SMHA-controlled expenditures were flat, with an increase of only 0.1 percent per year since FY 1981. Not all SMHAs experienced equal growth in expenditures. From FY 2007 to FY 2008, 44 SMHAs increased expenditures, whereas 6 states (Alaska, District of Columbia, Maine, Mississippi, New Mexico, and North Dakota) experienced declines. When expenditures were adjusted for inflation, 33 SMHAs experienced a growth in expenditures from 2001, and 18 SMHAs experienced a decline in total expenditures (see table 17).

2.8.7 Trends in Community Mental Health and State Psychiatric Hospital Expenditures

From FY 2001 to FY 2008, expenditures for community mental health services increased by 8.2 percent per year, whereas state psychiatric hospital-inpatient expenditures increased by 4 percent per year (see figure 16). When adjusted for inflation and population growth, community mental health expenditures increased by 2.9 percent per year, whereas state psychiatric hospital-inpatient expenditures declined by 1.1 percent per year.

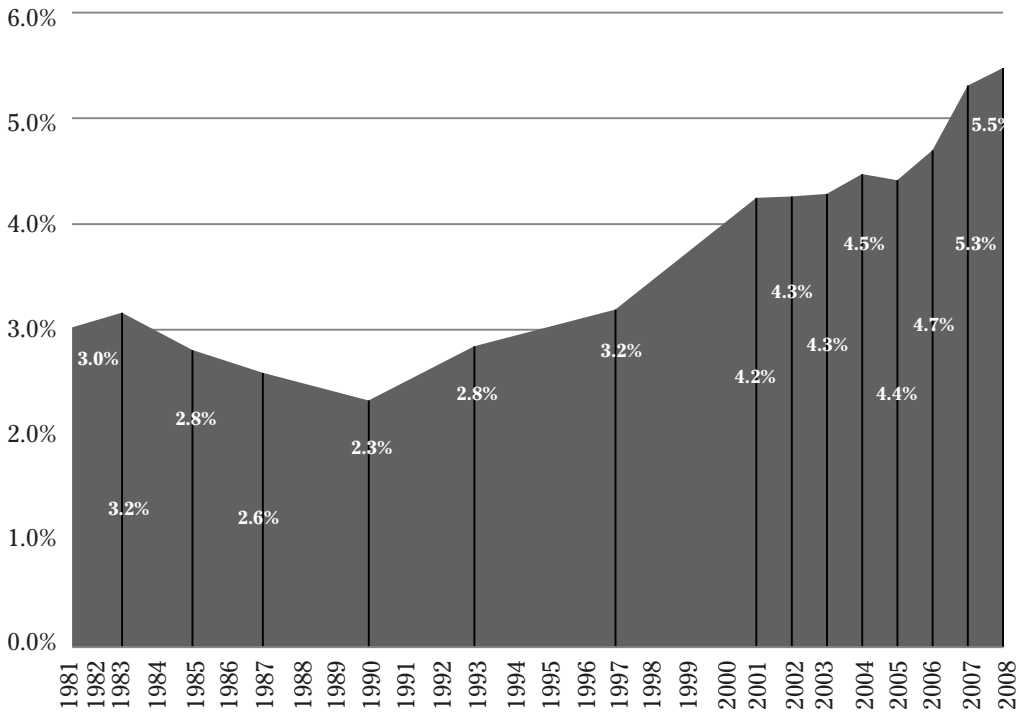
Figure 13: Percentage of New SMHA-Controlled Revenues, by Major Funding Sources, FY 1981 to FY 2008



From FY 2001 to FY 2008, 49 SMHAs increased their expenditures for community mental health services, whereas 2 decreased their expenditures. Forty-three SMHAs increased state psychiatric hospital expenditures, whereas eight expended less in state hospitals in 2008 than in 2001. Since 2001, expenditures for community mental health, adjusted for inflation and population growth, increased in 35 states and decreased in 16 states. Inflation- and population-adjusted expenditures for state hospitals show that more states have had a decrease in expenditures (29) than have had an increase (21).

Over the 27-year period from FY 1981 to FY 2008, SMHA-controlled expenditures increased from $6.1 billion to $36.7 billion, an increase of 501 percent (an average annual increase of 6.9 percent). When total SMHA mental health expenditures were adjusted for inflation, expenditures increased by 37.7 percent—an annualized increase of 1.2 percent over the 27-year period. When mental health expenditures were adjusted for inflation and population growth, SMHA expenditures grew only 3.6 percent over the 27-year period (an annualized increase of only 0.1 percent).

Figure 14: SMHA-Controlled Medicaid Funds as a Percentage of Total State Medicaid Spending, FY 1981 to FY 2008



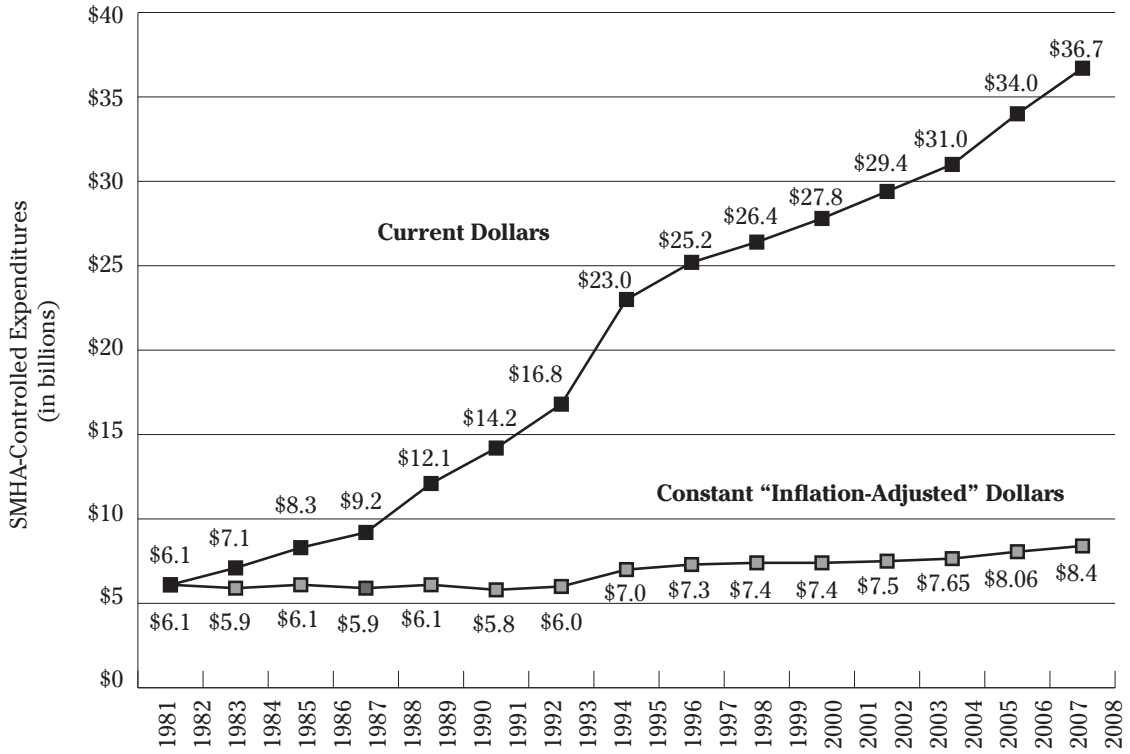
Most of the increases in SMHA expenditures were devoted to community mental health and state hospital ambulatory services, which increased from $2 billion in FY 1981 to $26.3 billion in FY 2008 (an average annual increase of 10 percent). When community mental health expenditures were adjusted for population growth and inflation, they increased by 126 percent (an average increase of 3.1 percent per year over the last 27 years). State psychiatric hospital -inpatient expenditures for inpatient services grew at a much slower rate than those for community mental health services, increasing from $3.8 billion in FY 1981 to $9.5 billion in FY 2008, an increase of 148 percent (an average increase of 3.4 percent per year).

When state psychiatric hospital-inpatient expenditures were adjusted for population growth and inflation, expenditures decreased by 57.3 percent (an average decrease of 3.1 percent per year).

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

The trend of SMHAs increasing their mental health expenditures for community mental health services at a much faster rate than state psychiatric hospitals has resulted in a historic shift in emphasis of where SMHAs devote their resources. In FY 2008, SMHAs spent 72 percent of their funding on community mental health services, whereas state psychiatric hospital-inpatient services represented only 26

Figure 15: Trends in SMHA-Controlled Mental Health Spending, FY 1981 to FY 2008



percent of SMHA resources. This is a major reversal from the 1980s, when SMHAs expended 63 percent of their funds in state psychiatric hospitals and only 33 percent for community mental health services (see figure 17).

2.9 Summary

The majority of SMHAs operated as a division within a larger state umbrella agency, most often within the Department of Human Services. Most SMHA commissioners reported to a cabinet secretary; however, 14 reported to an independent mental health council or board. Almost all SMHAs were responsible for both state psychiatric hospital and community mental health services for both children and adults. Many SMHAs also administered other disability services, including substance abuse treatment, intellectual disability services, and brain-impaired and organic brain syndrome services.

Over 6.4 million consumers were served by the SMHAs in 2009. Forty-eight percent of these consumers were male, whereas 51 percent were female. The majority of consumers (64 percent) were ages 21 to 64, were white (64 percent), and were diagnosed with SMI (65 percent) or SED (68 percent).

Table 17: Total SMHA-Controlled Expenditures, in Current and Constant Inflation-Adjusted Dollars, FY 2001 to FY 2008 (in millions)

State	Total SMHA-Controlled MH Expenditures (in millions)						Average Annual Change*			
	Current Expenditures			Constant Inflation-Adjusted 2001 Expenditures			Current Dollars		Constant Dollars	
	FY'01	FY'07	FY'08	FY'01	FY'07	FY'08	FY'07 to '08	FY'01 to '08	FY'07 to '08	FY'01 to '08
Alabama	$253.30	$341.50	$369.10	$253.30	$264.90	$276.60	8.10%	5.50%	4.40%	1.30%
Alaska	$51.40	$193.90	$184.10	$51.40	$150.40	$137.90	-5.00%	20.00%	-8.30%	15.10%
Arizona	$472.30	$1,001.00	$1,126.70	$472.30	$776.50	$844.20	12.60%	13.20%	8.70%	8.70%
Arkansas (a)	$75.70	$112.20	$115.50	$75.70	$87.00	$86.50	2.90%	6.20%	-0.60%	1.90%
California (b)	$3,147.80	$4,888.70	$5,503.90	$3,147.80	$3,792.10	$4,124.10	12.60%	8.30%	8.80%	3.90%
Colorado	$282.60	$367.70	$401.40	$282.60	$285.20	$300.80	9.20%	5.10%	5.40%	0.90%
Connecticut (ac)	$439.50	$609.20	$659.40	$439.50	$472.60	$494.10	8.20%	6.00%	4.60%	1.70%
Delaware (ac)	$73.50	$90.70	$96.50	$73.50	$70.40	$72.30	6.40%	4.00%	2.80%	-0.20%
District of Columbia	$226.60	$229.50	$224.90	$226.60	$178.00	$168.50	-2.00%	-0.10%	-5.30%	-4.10%
Florida	$578.30	$722.70	$768.90	$578.30	$560.60	$576.10	6.40%	4.20%	2.80%	-0.10%
Georgia (a)	$380.60	$448.10	$472.00	$380.60	$347.60	$353.70	5.30%	3.10%	1.80%	-1.00%
Hawaii (c)	$213.60	$0.00	$259.60	$213.60	NR	$194.50	**	2.80%	**	-1.30%
Idaho	$60.50	$71.40	$73.00	$60.50	$55.40	$54.70	2.10%	2.70%	-1.40%	-1.40%
Illinois	$789.90	$1,088.00	$1,110.30	$789.90	$844.00	$832.00	2.00%	5.00%	-1.40%	0.70%
Indiana	$411.90	$552.80	$569.00	$411.90	$428.80	$426.30	2.90%	4.70%	-0.60%	0.50%
Iowa	$152.40	$310.70	$373.60	$152.40	$241.00	$279.90	20.20%	13.70%	16.20%	9.10%
Kansas	$161.80	$258.60	$321.70	$161.80	$200.60	$241.10	24.40%	10.30%	20.20%	5.90%
Kentucky	$196.90	$227.40	$230.30	$196.90	$176.40	$172.60	1.30%	2.30%	-2.20%	-1.90%
Louisiana	$200.90	$271.20	$325.50	$200.90	$210.30	$243.90	20.00%	7.10%	15.90%	2.80%

Table 17: Total SMHA-Controlled Expenditures, in Current and Constant Inflation-Adjusted Dollars, FY 2001 to FY 2008 (in millions) (Continued)

State	Total SMHA-Controlled MH Expenditures (in millions)						Average Annual Change*			
	Current Expenditures			Constant Inflation-Adjusted 2001 Expenditures			Current Dollars		Constant Dollars	
	FY'01	FY'07	FY'08	FY'01	FY'07	FY'08	FY'07 to '08	FY'01 to '08	FY'07 to '08	FY'01 to '08
Maine (b)***	$137.50	$451.30	$448.20	$137.50	$350.10	$335.80	-0.70%	18.40%	-4.10%	13.60%
Maryland	$677.80	$858.30	$898.90	$677.80	$665.80	$673.60	4.70%	4.10%	1.20%	-0.10%
Massachusetts (a)	$682.20	$753.90	$792.20	$682.20	$584.80	$593.60	5.10%	2.20%	1.50%	-2.00%
Michigan (b)	$844.40	$1,065.10	$1,358.30	$844.40	$826.20	$1,017.80	27.50%	7.00%	23.20%	2.70%
Minnesota	$518.00	$773.20	$833.30	$518.00	$599.80	$624.40	7.80%	7.00%	4.10%	2.70%
Mississippi	$246.80	$351.90	$319.70	$246.80	$273.00	$239.60	-9.20%	3.80%	-12.20%	-0.40%
Missouri	$336.20	$451.80	$482.10	$336.20	$350.50	$361.30	6.70%	5.30%	3.10%	1.00%
Montana	$111.70	$138.90	$147.40	$111.70	$107.80	$110.40	6.10%	4.00%	2.50%	-0.20%
Nebraska (b)	$86.60	$116.20	$118.60	$86.60	$90.10	$88.90	2.10%	4.60%	-1.40%	0.40%
Nevada	$120.20	$200.80	$210.80	$120.20	$155.80	$157.90	4.90%	8.40%	1.40%	4.00%
New Hampshire	$140.50	$170.80	$177.70	$140.50	$132.50	$133.10	4.00%	3.40%	0.50%	-0.80%
New Jersey (b)	$763.10	$1,632.70	$1,706.80	$763.10	$1,266.50	$1,278.90	4.50%	12.20%	1.00%	7.70%
New Mexico (ac)	$59.00	$190.70	$189.60	$59.00	$147.90	$142.00	-0.60%	18.10%	-4.00%	13.40%
New York (b)	$3,331.70	$4,319.40	$4,492.60	$3,331.70	$3,350.50	$3,366.30	4.00%	4.40%	0.50%	0.10%
North Carolina	$442.70	$1,724.70	$1,808.30	$442.70	$1,337.80	$1,354.90	4.80%	22.30%	1.30%	17.30%
North Dakota	$49.90	$50.20	$47.80	$49.90	$39.00	$35.80	-4.80%	-0.60%	-8.00%	-4.60%
Ohio	$692.30	$839.00	$856.30	$692.30	$650.80	$641.60	2.10%	3.10%	-1.40%	-1.10%
Oklahoma (b)	$136.10	$190.00	$199.10	$136.10	$147.40	$149.20	4.80%	5.60%	1.20%	1.30%
Oregon	$201.90	$430.60	$473.20	$201.90	$334.00	$354.60	9.90%	12.90%	6.20%	8.40%

Table 17: Total SMHA-Controlled Expenditures, in Current and Constant Inflation-Adjusted Dollars, FY 2001 to FY 2008 (in millions) (Continued)

State	Total SMHA-Controlled MH Expenditures (in millions)						Average Annual Change*			
	Current Expenditures			Constant Inflation-Adjusted 2001 Expenditures			Current Dollars		Constant Dollars	
	FY'01	FY'07	FY'08	FY'01	FY'07	FY'08	FY'07 to '08	FY'01 to '08	FY'07 to '08	FY'01 to '08
Pennsylvania (ac)	$1,859.80	$3,222.40	$3,396.30	$1,859.80	$2,499.60	$2,544.90	5.40%	9.00%	1.80%	4.60%
Rhode Island (c)	$92.50	$111.70	$116.90	$92.50	$86.70	$87.60	4.70%	3.40%	1.10%	-0.80%
South Carolina	$299.40	$284.00	$288.20	$299.40	$220.30	$215.90	1.50%	-0.50%	-2.00%	-4.60%
South Dakota	$45.70	$61.30	$68.30	$45.70	$47.60	$51.20	11.40%	5.90%	7.60%	1.60%
Tennessee	$395.20	$598.20	$608.60	$395.20	$464.00	$456.00	1.70%	6.40%	-1.70%	2.10%
Texas (b)	$797.00	$817.10	$874.00	$797.00	$633.80	$654.90	7.00%	1.30%	3.30%	-2.80%
Utah (b)	$159.30	$172.80	$178.20	$159.30	$134.10	$133.60	3.10%	1.60%	-0.40%	-2.50%
Vermont	$79.70	$132.60	$138.60	$79.70	$102.90	$103.90	4.50%	8.20%	1.00%	3.90%
Virginia	$466.60	$647.80	$709.90	$466.60	$502.50	$531.90	9.60%	6.20%	5.90%	1.90%
Washington	$525.60	$681.40	$754.60	$525.60	$528.60	$565.40	10.70%	5.30%	7.00%	1.00%
West Virginia (b)	$87.10	$133.20	$143.50	$87.10	$103.30	$107.50	7.70%	7.40%	4.10%	3.10%
Wisconsin	$405.40	$585.80	$589.00	$405.40	$454.40	$441.40	0.60%	5.50%	-2.90%	1.20%
Wyoming (b)	$30.10	$51.80	$75.40	$30.10	$40.10	$56.50	45.80%	14.00%	40.80%	9.40%

Table 17: Total SMHA-Controlled Expenditures, in Current and Constant Inflation-Adjusted Dollars, FY 2001 to FY 2008 (in millions) (Continued)

State	Total SMHA-Controlled MH Expenditures (in millions)						Average Annual Change*			
	Current Expenditures			Constant Inflation-Adjusted 2001 Expenditures			Current Dollars		Constant Dollars	
	FY'01	FY'07	FY'08	FY'01	FY'07	FY'08	FY'07 to '08	FY'01 to '08	FY'07 to '08	FY'01 to '08
Total	$22,991	$33,995	$36,688	$22,991	$26,370	$27,490	7.90%	6.90%	4.20%	2.60%
Median	$247	$352	$374	$247	$273	$280	4.90%	5.50%	1.30%	1.20%
Average	$451	$667	$719	$451	$517	$539	6.70%	6.70%	3.10%	2.40%
States Reporting	51	50	51	51	50	51	50	51	50	51
States Increasing							44	48	33	33
States Decreasing							6	3	17	18

a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.
c = Children's mental health expenditures are not included in SMHA-controlled expenditures.
*Average annual changes are calculated based only on states reporting data for both years being compared.
**Change could not be calculated because Hawaii did not report FY 2007 data.
***In FY'01, Maine was using a different methodology to calculate expenditures, which accounts for the large increase from FY 2001 to FY 2008.

States relied on a variety of funding sources to finance the delivery of mental health services. The state-federal Medicaid program has become the largest single payer source for SMHA services, but states used a broad array of Medicaid options and waivers to develop their state Medicaid plans. Managed care, often provided through a Medicaid waiver, was used by many states to finance the delivery of mental health services. However, states differed regarding which Medicaid waivers were used and which patient populations were included in the waiver. States also differed in whether mental health services within the waivers were carved in with general healthcare or carved out to a specialty behavioral health MCO.

In FY 2008, SMHAs spent $36.7 billion for mental health services. The majority of SMHA-controlled revenues originated from state government sources, including state general funds, Medicaid match funds, and other special funds. A third of SMHA funds came from the federal government through Medicaid, Medicare, and the MHBG.

Figure 16: Average Annual Percent Change in SMHA-Controlled Mental Health Expenditures, by Decade and Type of Program, FY 1981 to FY 2008

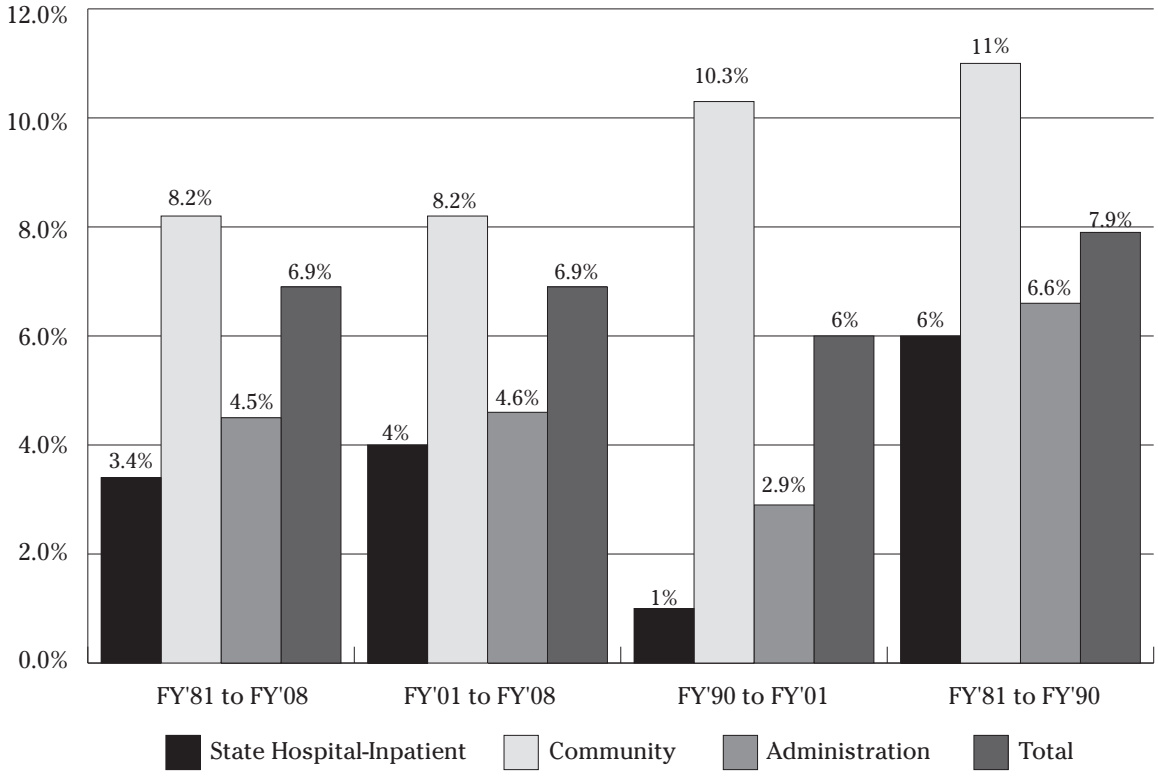
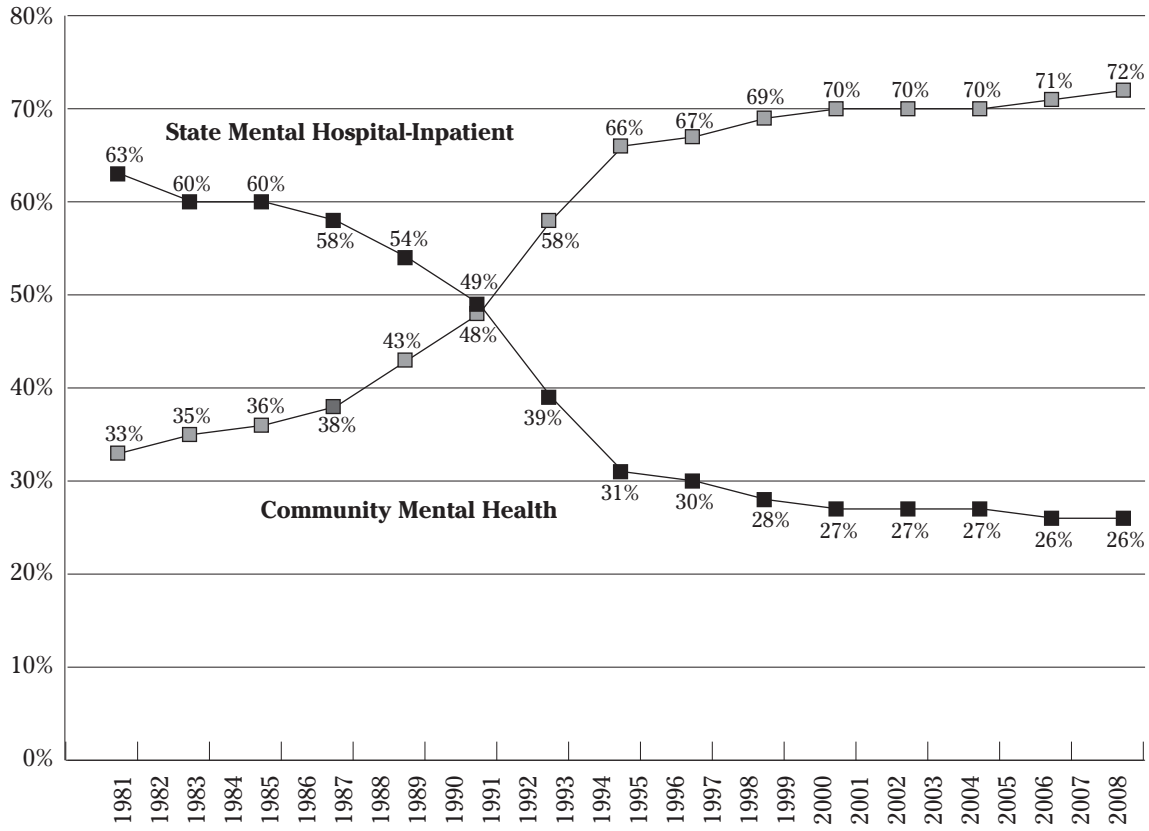


Figure 17: SMHA Expenditures for State Psychiatric Hospital-Inpatient and Community-Based Mental Health Services, FY 1981 to FY 2008



III. SMHA Policies

State Mental Health Agencies (SMHAs) have a set of policies regarding the clients they serve, the services they provide, the priority initiatives they undertake, and the approaches they use to ensure the inclusion of mental health services in the new Patient Protection and Affordable Care Act (ACA) that is reforming health insurance coverage. This section reviews some major SMHA policies and initiatives.

3.1 Eligibility for Mental Health Services

Each state determined the eligibility criteria a person must meet to receive services from the SMHA. The criteria could have been inclusive or restrictive, based upon decisions made largely by each state's Governor and legislature. Table 18 shows which patient groups were eligible to receive mental health services provided by state dollars or by other funds, including Medicaid. The majority (27 SMHAs for adults and 27 SMHAs for children/adolescents) did not have strict eligibility requirements, meaning adults or children with any mental illness were eligible for services funded through state general funds. Some SMHAs (18 for adults and 12 for children/adolescents) had stricter eligibility requirements; that is, only adults with serious mental illnesses (SMI) or children with serious emotional disturbances (SED) were eligible for services. Nebraska reported that although adults with any mental illness were eligible for some services, certain mental health services (such as Assertive Community Treatment (ACT)) were limited to adults disabled by serious and persistent mental illness.

SMHAs varied in the factors used to determine whether a client met the state's criteria for SMI and SED. Table 19 shows the major elements that were in each state's definition of adults with SMI and children with SED. Most states (41 for adults and 35 for children) used specific diagnoses as part of their SMI and SED determinations. Functional impairment levels were used by 33 states for adults with SMI determination and by 34 states for children with SED determination. Other factors cited by states included duration of illness, chronicity, need for specific intensive services, and risk of out-of-home placements for children.

Most states used estimated prevalence rates for adults with SMI that were similar to the federal prevalence estimate of 5.4 percent (30 states) or reported using a range of estimates. State estimates of the prevalence for children with SED were higher than rates for adults, with the median state estimate of 8 percent and the mode (most frequent rate) of 11 percent (in four states).

Table 18: SMHA-Eligible Groups for State, Medicaid, and Other Funded Mental Health Services

State	State General Funds		Medicaid		Other Funds	
	Adults	Children	Adults	Children	Adults	Children
Alabama	SMI Only	SED Only	NA	NA	NA	NA
Alaska	SMI Only	SED Only	NA	NA	NA	NA
Arizona	SMI Only	All Children	All Adults	All Children	All Adults	All Children
Arkansas	All Adults	All Children	All Adults	All Children	All Adults	All Children
California	SMI Only	SED Only	SMI Only	SED Only	All Adults	All Children
Colorado	SMI Only	SED Only	SMI Only	SED Only	NA	NA
Connecticut	SMI Only	All Children	SMI Only	All Children	SMI Only	All Children
Delaware	All Adults	All Children	SMI Only	SED Only	NA	NA
District of Columbia	NR	NR	NR	NR	NR	NR
Florida	SMI Only	All Children	SMI Only	All Children	NA	All Children
Georgia	All Adults	All Children	All Adults	All Children	All Adults	All Children
Hawaii	SMI Only	NA	All Adults	NA	NA	NA
Idaho	SMI Only	NA	SMI Only	NA	NA	NA
Illinois	All Adults	All Children	All Adults	All Children	All Adults	All Children
Indiana	SMI Only	SED Only	All Adults	All Children	All Adults	All Children
Iowa	All Adults	All Children	All Adults	All Children	All Adults	All Children
Kansas	All Adults	All Children	All Adults	All Children	All Adults	All Children
Kentucky	All Adults	All Children	All Adults	All Children	SMI Only	All Children
Louisiana	SMI Only	SED Only	SMI Only	SED Only	SMI Only	SED Only
Maine	All Adults	All Children	All Adults	All Children	All Adults	All Children
Maryland	All Adults	All Children	All Adults	All Children	NA	NA
Massachusetts	SMI Only	SED Only	SMI Only	SED Only	NA	NA

Table 18: SMHA-Eligible Groups for State, Medicaid, and Other Funded Mental Health Services (Continued)

State	State General Funds		Medicaid		Other Funds	
	Adults	Children	Adults	Children	Adults	Children
Michigan	SMI Only	SED Only	SMI Only	SED Only	All Adults	All Children
Minnesota	SMI Only	SED Only	All Adults	All Children	NA	NA
Mississippi	All Adults	All Children	All Adults	All Children	All Adults	All Children
Missouri	All Adults	NA	SMI Only	All Children	NA	NA
Montana	SMI Only	SED Only	All Adults	SED Only	NA	NA
Nebraska	Some Restrictions	SED Only	Some Restrictions	NA	NA	NA
Nevada	All Adults	All Children	SMI Only	All Children	NA	All Children
New Hampshire	SMI Only	NA	SMI Only	NA	NA	NA
New Jersey	All Adults	NA	All Adults	NA	All Adults	NA
New Mexico	All Adults	NA	All Adults	All Children	NA	NA
New York	All Adults	All Children	All Adults	All Children	All Adults	All Children
North Carolina	All Adults	All Children	All Adults	All Children	All Adults	All Children
North Dakota	All Adults	NA	All Adults	All Children	All Adults	NA
Ohio	NA	NA	All Adults	All Children	NA	NA
Oklahoma	All Adults	All Children	All Adults	All Children	All Adults	All Children
Oregon	All Adults	All Children	All Adults	All Children	All Adults	All Children
Pennsylvania	All Adults	All Children	All Adults	All Children	All Adults	All Children
Rhode Island	SMI Only	SED Only	All Adults	All Children	NA	NA
South Carolina	SMI Only	All Children	SMI Only	All Children	SMI Only	All Children
South Dakota	All Adults	All Children	All Adults	All Children	NA	NA
Tennessee	All Adults	All Children	All Adults	All Children	All Adults	All Children
Texas	SMI Only	SED Only	SMI Only	SED Only	SMI Only	SED Only

Table 18: SMHA-Eligible Groups for State, Medicaid, and Other Funded Mental Health Services (Continued)

State	State General Funds		Medicaid		Other Funds	
	Adults	Children	Adults	Children	Adults	Children
Utah	NA	NA	All Adults	All Children	All Adults	All Children
Vermont	All Adults	All Children	All Adults	All Children	All Adults	All Children
Virginia	All Adults	All Children	SMI Only	SED Only	SMI Only	SED Only
Washington	NA	NA	SMI Only	SED Only	NA	NA
West Virginia	All Adults	All Children	All Adults	All Children	All Adults	All Children
Wisconsin	All Adults	All Children	All Adults	All Children	All Adults	All Children
Wyoming	All Adults	All Children	SMI Only	All Children	All Adults	All Children
All Clients	27	27	30	33	24	27
SMI/SED Clients	19	13	17	10	6	3
Some Restrictions	1	0	1	0	0	0
Not Applicable (NA)	3	10	2	7	20	20
No Response (NR)	1	1	1	1	1	1

Table 19: Number of States With Adults With SMI and Children With SED Definitions Using Specific Diagnoses, Functional Levels, and Other Factors

Population	Specific Diagnoses	Functional Levels	Other Factors
Adults With SMI	41	33	3
Children With SED	35	34	4

3.2 Long-Term Care

SMHAs provided long-term care services for persons with mental illness in a variety of settings within the SMHAs' service care model. In the majority of states, state psychiatric hospitals were used to provide long-term care services, followed by nursing homes and SMHA-funded group homes (see table 20). Among the other settings described by SMHAs were assisted living facilities, transitional living homes, personal care homes, permanent supported housing, and county-owned group homes.

Table 20: Settings Used To Provide Long-Term Care Services

Setting	Number of States
State Psychiatric Hospitals	41
Nursing Homes	29
SMHA-Funded Group Homes	25
Nursing Home Special Care Units	14
Nursing Home IMDs	9
Private Psychiatric Hospitals	8
Geriatric Nursing Home IMDs	7
SMHA-Owned Group Homes	7
Other	20

IMD = Institution for Mental Disease.

3.3 Nursing Homes

In 11 states, the SMHA had a policy regarding the use of nursing homes by persons leaving state psychiatric hospitals. Several of these states described policies that discouraged discharging consumers from state psychiatric hospitals to nursing homes unless the consumer had physical health needs that required a nursing home level of care and additional psychiatric screening before the transfer.

The most common method of paying for mental health services in nursing homes was through Medicaid, paid either under a per diem rate or as an ancillary service. Only six SMHAs reported that they paid for nursing home services (see table 21).

Table 21: Payment Sources for Mental Health Services in Nursing Homes, 2010

Payment Source	Number of States
Medicaid per diem rate	25
Medicaid as an ancillary service	21
Services for non-Medicaid residents limited to private pay or third-party reimbursements (including Medicare)	20
Coverage by the facility for persons in Medicare (SNF benefit) covered stays	13
Other payment sources	12
Inclusion in the daily rate charged to non-Medicaid-covered residents	10
The SMHA	6

SNF = skilled nursing facility.

SMHAs related to nursing homes that provided mental health services in several ways. In 24 states, the SMHA provided training to staff of nursing homes for services to persons with mental illnesses. In 17 states, the SMHA received data about mental health services in nursing homes provided to residents identified through the Medicaid Preadmission Screening and Resident Review. In 12 states, the SMHA operated specialized nursing homes/ intermediate care facilities (ICF) that serve persons with mental illnesses. In seven states, the SMHA funded specialized ICF that serve persons with mental illnesses, and in six states, the SMHA funded nursing homes (not specialized to treat mental illness). Of the reporting SMHAs, none were responsible for the licensing or certification of nursing homes.

3.4 Health-Mental Health Integration

Over the last decade, SMHAs have increasingly focused attention on the physical health needs of mental health consumers. The finding that mental health consumers often die prematurely up to 25 years earlier than persons without mental illnesses living in their communities (Colton & Manderscheid, 2006) has led to much of the renewed focus on the health-mental health needs of mental health consumers. In 2008, the National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council issued a report, *Measurement of Health Status for People with Serious Mental Illnesses* (Parks et al., 2008), recommending routine health screenings for a core set of health concerns for all consumers receiving SMHA funded or operated services.

There were initiatives to improve the integration of mental health with primary healthcare in 44 SMHAs. For example, in Iowa, some mental health providers used Mental Health Block Grant (MHBG) funds to support mental health-primary healthcare integration, whereas the SMHA worked with Medicaid on the development of an integrated medical and mental health

home model. In California, the SMHA used the Mental Health Services Act to support and improve an effective approach. This approach integrated mental health and primary healthcare and, at the same time, encouraged counties to develop and implement a full range of integrated programs to treat the whole person. Forty-five SMHAs supported the colocation of mental health providers in primary care, and in 46 states, community mental health centers (CMHCs) partnered with federally qualified health centers (FQHCs).

3.4.1 Collaborations With Other State Agencies To Increase Screening for Mental Health Among Primary Care Providers

The SMHA collaborated with other state government agencies, including Medicaid (30 states), state health departments (23 states), and other state agencies (such as Social Services, Education, State Insurance Administration, and Substance Abuse), to increase the screening and treatment of mental illness by primary care providers. The SMHAs in 19 states collaborated with private healthcare providers to increase the screening and treatment of mental illnesses.

3.4.2 Collaborations With Health Providers To Screen for Physical Health Needs of Mental Health Consumers

In almost two-thirds of the states (62 percent), the SMHA worked with public health providers, including community health clinics and state health agencies, to increase the recognition and treatment of the physical health needs of persons with mental illnesses. In 47 percent (21) of the responding states, the SMHA worked with private healthcare providers, such as local hospitals and physician groups, to increase the recognition and treatment of mental health needs.

3.4.3 Screening for the Physical Health Needs of SMHA Consumers in SMHA Programs

The NASMHPD Medical Directors Council report, *Measurement of Health Status for People with Serious Mental Illnesses* (Parks et al., 2008), reviewed the high level of comorbid health conditions among mental health consumers and recommended a set of 10 health indicators (1. personal history of diabetes, hypertension, cardiovascular disease (CVD); 2. family history of diabetes, hypertension, cardiovascular disease; 3. weight/height/Body Mass Index (BMI); 4. blood pressure; 5. blood glucose or HbA1C; 6. lipid profile; 7. tobacco use/history; 8. substance use/history; 9. medication history/current medication list, with dosages; and 10. social supports) and two process indicators (1. screening and monitoring of health risk and conditions in mental health settings and 2. access to and utilization of primary care services (medical and dental)) for use by SMHAs.

Since the development of the NASMHPD-recommended health indicators, many SMHAs have begun to use these as a set of standard health screens for new consumers. These SMHAs use the health indicators at intake into public mental health services and often at a followup

point after intake. Table 22 shows that the most frequently conducted health screens were medication history; personal history of diabetes, hypertension, and CVD; and tobacco use history. Health screens were much more common at intake into a state psychiatric hospital or community mental health program than after intake, but over half the states conducted several of the screens after intake (BMI, family history, and blood pressure).

In 2010, all 49 responding SMHAs were screened or assessed mental health consumers for physical health issues in state hospitals (see table 23). These screens were most often conducted at all state psychiatric hospitals for all patients. SMHA-funded community mental health providers frequently conducted health screens for only some patients or at only some community mental health providers.

Fewer states conducted health assessments at community mental health programs, and often the assessments were either not performed for all clients or not conducted by all community mental health providers. Fourteen SMHAs directly operated some community mental health providers, and in these states, the SMHA was more likely to report that it screened all clients and in all providers. SMHA-funded community mental health providers appeared more likely to screen only some patients or limit screening to certain providers. Table 24 shows that in most states (41), health assessments and screens were required to be conducted by state psychiatric hospitals and state-operated community mental health providers (11 states), but were often encouraged instead of required in SMHA-funded community providers.

As depicted in table 25, not all SMHAs received information about health assessments for inclusion in state client data systems. In 21 states, state psychiatric hospitals reported information about health status measures to the SMHA central office, and in only 15 states, information about client health assessments from state hospitals was included in SMHA client databases. Fewer states included health assessment results from either SMHA-operated or SMHA-funded community mental health providers in SMHA client databases.

Table 26 shows that state general funds were the funding source used most frequently to pay for health assessments in state psychiatric hospitals, followed by Medicaid and Medicare. In SMHA-funded community mental health programs, Medicaid was the most frequent source of funding used to pay for health assessments, followed by state general funds.

3.4.4 Health Promotion Activities

Health promotion activities are organized activities designed to help mental health consumers improve and maintain good physical health. In 2010, 72 percent of SMHAs (36 states) had health education or ongoing promotion initiatives. Smoking cessation initiatives were the most common health promotion activity (35 states), followed by physical fitness (31 states) and nutrition programs (31 states).

Table 22: Number of SMHAs Conducting Health Screening, by Setting

Health Screen/Assessment Conducted	State Psychiatric Hospitals			State-Operated Community			State-Funded Community		
	At Intake	After Intake	Not Measured	At Intake	After Intake	Not Measured	At Intake	After Intake	Not Measured
Personal history of diabetes, hypertension, CVD*	48	18	3	15	8	7	25	17	1
Family history of diabetes, hypertension, CVD*	48	31	0	14	5	1	22	11	3
BMI*	42	36	0	5	11	4	13	9	10
Blood pressure*	48	31	0	12	6	3	20	15	2
Blood glucose or HbA1C*	42	30	0	7	8	1	15	14	6
Lipid profile*	42	18	0	8	12	0	17	16	6
Tobacco use history*	48	18	0	14	12	0	24	13	2
Substance use history*	47	22	0	17	12	0	28	15	0
Medication history*	48	0	0	17	0	0	27	14	1
Current list of behavioral health medications with dosages	46	21	0	16	14	0	26	17	2
Current list of physical health medications (including over-the-counter)	43	25	2	15	13	2	23	15	2
Social supports*	44	10	0	16	5	0	24	16	1
HIV	18	4	0	8	0	0	13	7	2
Other	5	0	0	3	0	0	8	6	1

*Health screen recommended by the NASMHPD Medical Directors Council.

Table 23: Screening for Physical Health Needs in SMHA Systems

	State Psychiatric Hospitals		State-Operated Community		State-Funded Community	
	All Patients	Some Patients	All Patients	Some Patients	All Patients	Some Patients
All Mental Health Service Providers	49	2	13	4	13	9
Some Mental Health Service Providers	3	0	4	0	7	13

Table 24: Health Screens Required or Encouraged by SMHAs

	State Psychiatric Hospitals	State-Operated Community	State-Funded Community
Screening is required	41	11	19
Screening is encouraged, not required	4	6	15

Table 25: Information About Health Status Measures Reported to the SMHA Central Office and Included in SMHA Databases

	State Psychiatric Hospitals	State-Operated Community	State-Funded Community
Information about health status measures is reported to SMHA	21	8	8
SMHA client databases	15	5	5
Special health screen database (client level)	9	3	3
Aggregate data about screens (not client level)	6	3	3
Other	6	1	0

Table 26: Funding Sources SMHAs Used To Pay for Health Screens

	State Psychiatric Hospitals	State-Operated Community	State-Funded Community
State General Funds	41	12	17
Medicaid	28	13	24
Medicare	28	9	13
Other	6	4	5

Table 27 shows the specific types of health promotion activities that SMHAs supported in 2010. Among physical health activities, group-based physical fitness education, exercise programs including nutrition programs, and group physical fitness exercise programs led by mental health professionals were the three most common activities. Nutrition programs were most frequently led by mental health professionals.

Table 28 shows that health promotion activities were most often available to selected groups of consumers instead of all mental health consumers. In addition,

Table 27: Health Promotion Areas Addressed by SMHAs

Health Promotion Activity	Number of States
Physical Health	
Physical Fitness Exercise Education Programs	
Group-Based Fitness Education	28
Individual Fitness Counseling/Education	16
Group Physical Exercise Programs	
Led by Fitness Instructor	7
Led by Mental Health Professional	18
Led by Peer	12
Individual Physical Exercise Programs	
Led by Fitness Instructor	6
Led by Mental Health Professional	12
Led by Peer	8
Exercise Program Includes Nutrition Component	22
Fitness Club Memberships (including YMCA/YWCA)	
Paid in Full	6
Discounted (Copayment Required)	5
Nutrition	
Group-Based Education	
Led by Dietitians	16
Led by Mental Health Professionals	24
Led by Peers	17

Table 27: Health Promotion Areas Addressed by SMHAs (Continued)

Health Promotion Activity	Number of States
Individual Education/Counseling	
Led by Dietitians	11
Led by Mental Health Professionals	18
Led by Peers	12
Smoking Cessation	
Education (Group Based)	30
Education (Individual)	28
Treatment (Group Based)	16
Treatment (Individual)	23
Links to State-Run Tobacco Quit Lines	23

physical health and nutrition programs were often available in only portions of a state, whereas smoking cessation programs were most often available statewide. State general funds were the most frequently used source of payment for all three types of health promotion activities, followed by Medicaid.

3.4.5 Smoking Policies

Most SMHAs (45) made a statewide requirement that their hospitals be tobacco free both in the buildings and on their grounds. In three states that did not have a smoking policy, the SMHA was considering adopting a policy about smoking or tobacco use.

Table 28: Coverage and Payment for Health Promotion Activities

	Physical Health	Nutrition	Smoking Cessation
Population Covered			
All Clients	7	6	9
Some Clients	21	23	21
Availability of Health Promotion Activity			
Parts of State	9	16	13
Statewide	23	12	17
Funding Sources			
General Funds	20	20	22
Medicaid	12	13	14
Medicare	4	5	7
Other	3	4	6

3.5 Social Inclusion Initiatives

Most SMHAs (42) engaged in activities to reduce stigma or discrimination about mental illnesses. There were 39 SMHAs with universal initiatives (designed to address all groups within a state). Examples of universal stigma initiatives included a public television show with a mental health theme in Arkansas; mental health "first aid" initiatives in Colorado, Georgia, Iowa, and Missouri; public service announcements in Maine; a public service announcement in Spanish, Navajo, and English, called *Talk About it New Mexico*, on social inclusion for persons with mental health and substance abuse disorders in New Mexico; and Palmetto Media Watch, which was designed to ally the media with the South Carolina Department of Mental Health in the fight against stigma in South Carolina.

Twenty-four SMHAs reported targeted stigma initiatives that focused on specific population groups. Examples of targeted initiatives included mental health first aid training aimed at the general public, with special initiatives for aging populations, in Georgia; a women's health initiative with a focus on integrating behavioral and physical health in Maine; and a statewide public awareness campaign to reduce stigma around depression in seniors in Minnesota. Three initiatives were as follows: (1) education on psychiatric service dogs; (2) a media campaign; and (3) parents with mental health conditions, and their sons and daughters, in Nebraska, and *Community Champions*©, a workforce campaign through local civic entities and businesses to educate employers and encourage the employment of individuals with mental illness in Oklahoma.

Many SMHAs (23) had public information initiatives to promote a better understanding of the role of mental health in overall health and/or had initiatives to raise awareness of mental illness as a public health or social issue. These initiatives were focused on children and adolescents in 21 SMHAs and on adults in 21 SMHAs.

3.6 Mental Health Prevention and Early Intervention Initiatives

More than half (55 percent) of the SMHAs (28 of 51 states) had early intervention programs for adults or children with mental illness. Examples of early intervention programs for children included an early childhood mental health consultation paradigm for childcare facilities in Colorado; outreach to those deemed "at risk" as part of the children's system of care in Arkansas; early mental health consultation for Head Start and daycare providers, early screening for emotional/behavioral disorders, and Child FIRST—an intensive in-home early intervention/treatment program—in Connecticut; and school-based mental health programs in Tennessee. Examples of early intervention programs for young adults and adults with early signs of psychoses included the Portland Identification and Early Referral Program developed in Maine, and the Recovery After an Initial Schizophrenia Episode project funded by the National Institute of Mental Health.

3.6.1 Early Identification and Treatment for Depression

In 24 states, the SMHA had a partnership to increase the early identification and treatment of depression. The partners with which the SMHAs were working on depression included Medicaid (3), Public Health (3), Education (3), and the SAMHSA Screening, Brief Intervention, and Referral to Treatment program (2). In 20 states, the SMHA worked with public health to increase awareness of depression and its role in increased health risk and chronic disease. In 10 states, the SMHA promoted screening for depression in public health programs aimed at preventing diabetes.

3.6.2 Screening for Histories of Trauma Among Mental Health Consumers

Forty-two SMHAs required or worked with mental health providers to screen for histories of trauma in the individuals they served. For example, the Arizona Department of Health Services (ADHS)/ Division of Behavioral Health Services (DBHS) required its mental health providers to complete an initial clinical assessment for everyone entering the behavioral health system. ADHS/DBHS required its mental health providers to complete an initial clinical assessment for everyone entering the behavioral health system, and the providers completed these initial assessments every 12 months thereafter or when significant changes occurred. As part of these assessments, mental health providers asked questions relevant to multiple risk areas that included current and historical trauma information. The division implemented a separate assessment for infants and toddlers aged birth to 5 years, which contained several questions related to determining potential risks the young child may have experienced or was currently experiencing with the caregiver or in the environment.

In 29 states, the SMHA provided or made referrals for specialized trauma treatment or services. Twenty-six SMHAs funded or operated special trauma treatment services for individuals with trauma. Sixteen SMHAs compiled information on the number of persons receiving mental health services who had a history of trauma.

3.6.3 Screening for Mental Health-Substance Abuse Dual Diagnoses

Every responding SMHA (49) required or worked with providers to screen for co-occurring mental health and substance abuse disorders. For example, in Iowa, the SMHA used a portion of its MHBG funds for co-occurring capability training for substance abuse and mental health professionals, whereas many of the community mental health providers that received MHBG funding used those funds for co-occurring programs. Among those SMHAs that required screening, most SMHAs (34) compiled information on the numbers of persons needing co-occurring services.

3.7 Suicide Prevention

Most SMHAs (80 percent, or 39 out of 49 SMHAs) implemented some of the recommendations set forth in *Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority* (Litts, Radke, & Silverman, 2008), a technical report released by the NASMHPD Medical Directors Council. Table 29 shows that almost all SMHAs supported or collaborated with crisis hotlines to ensure individuals at risk for suicide, including those who had made a suicide attempt, could readily access high-quality support services. Most SMHAs also worked with other principals on the state suicide prevention advisory council to ensure suicide prevention programs and practices were in place for persons with SMI.

Table 29: Suicide Report Recommendations Implemented by SMHAs

NASMHPD Medical Directors' Recommendations	Number of States	State (percent)
2.1 Works closely with other principals on the state suicide prevention advisory council to ensure suicide prevention programs and practices are in place for persons with SMI	38	86%
3.1 Supports or collaborates with crisis hotlines to ensure individuals at risk for suicide, including those who have made a suicide attempt, can readily access high-quality crisis support services	46	96%
4.1 Works with the State Health Authority (SHA) to improve collaboration and information sharing and surveillance between and among systems of care for all persons, especially for persons with SMI	33	72%
5.1 In collaboration with the SHA, has initiated policies and practices that promote improved continuity of care for individuals at heightened risk of suicide following discharge from emergency departments for suicide attempts and inpatient psychiatric hospitalization	23	50%
6.1 in collaboration with the SHA, requires screening for suicide risk at all primary care appointments for those individuals who exhibit risk factors such as depression or substance abuse	3	6%
7.1 in collaboration with the SHA, developed and implemented strategies to reduce access to lethal means for suicide	22	46%
8.1 in collaboration with the SHA, initiated programs to strengthen psychoeducational programs in communities and for at-risk populations (e.g., addressing stigma, care-seeking, and recovery from a suicide attempt)	35	74%
9.1 in collaboration with the SHA, developed and/or promoted new models for providing evidence-based services over the life course for those who have attempted suicide, particularly for those who have made multiple or medically serious attempts	16	33%
9.2 implemented strategies to improve training of mental health professionals in evidence-based treatments that reduce rates of suicidal behaviors among persons with mental illnesses	29	64%

Most SMHAs funded or operated suicide prevention programs. Table 30 shows that suicide prevention programs for adolescents and children were the most frequent type of initiative SMHAs funded. Seventy-four percent of SMHAs funded or operated suicide prevention programs for veterans or military personnel, and two-thirds (69 percent) had a plan to reduce these suicide attempts or to initiate a suicide prevention program for them. Seventy-one percent of SMHAs operated, funded, or participated in programs providing postsuicide support and treatment.

Table 30: SMHA Suicide Prevention Initiatives, by Age Group and Veterans

Population Covered	Percentage and Number of States With a Plan To Reduce Suicide Attempts or Initiate Suicide Prevention Initiatives	Percentage and Number of SMHAs That Fund or Operate Suicide Prevention Programs
Children	69% (33 states)	77% (37 states)
Adolescents	68% (32 states)	80% (39 states)
Adults	63% (29 states)	74% (34 states)
Older Adults	60% (27 states)	67% (30 states)
Veterans	69% (31 states)	74% (34 states)

3.8 Healthcare Reform and SMHAs

The passage of the ACA of 2010 portended major changes for the role of SMHAs in providing safety net services to individuals with mental illnesses. Traditionally, SMHAs have played a major role in providing mental health services to individuals with the most severe mental illnesses who often lacked private health insurance and who therefore relied on state government funding and Medicaid to pay for their services. With the phased implementation of ACA over the next several years, many of the individuals traditionally served by SMHAs may gain new insurance benefits (through the expansion of Medicaid eligibility, the elimination of preexisting condition limitations, and the new individual insurance mandate). Although Congress passed ACA in 2010, many of these major changes (expansion of Medicaid, and the implementation of health information exchange (HIE) and individual insurance requirements) were to be phased in by 2014. In the face of this historic shift to expand insurance coverage, SMHAs were actively preparing for their future roles in ensuring the availability of quality mental health services within their states.

Most SMHAs (34) had begun meeting to determine future roles for the SMHA in the implementation of ACA. Some of the roles SMHAs identified included defining the scope of services; expanding prevention services and integrated care programs; meeting the behavioral health needs that extend beyond healthcare reform, such as forensic services, employment supports, and housing supports; promoting and

achieving a quality-focused, culturally responsive, and recovery-oriented system of care; ensuring safety net services are available; providing education and consultation to the state Medicaid and health agencies; providing direction (training, technical assistance, and monitoring) to specialty mental health providers; working to include mental health in healthcare homes; providing training and preparation for the mental health workforce; and working to foster linkages between FQHCs and mental health providers.

Table 31 shows some of the future roles SMHAs identified as health insurance reform is implemented over the next few years. The most common future role identified by SMHAs was to provide a safety net of mental health services for individuals without any insurance, followed by providing an array of support services. Such services included employment, housing, peer supports, and wraparound services that may not be reimbursed by private insurance because of "medical necessity" restrictions. Slightly more than one-third of SMHAs reported they were planning to be a provider of mental health services that would compete with private providers in providing mental health services to be reimbursed by private health insurance.

Table 31: Potential Roles SMHAs Are Taking To Prepare for Health Insurance Reform

SMHA Roles in Preparation for Health Insurance Reform (ACA)	Number of States	States (percent)
Providing a safety net of services to persons with SMI without any health insurance	37	88%
Providing an array of essential support services that may not be covered by private insurance as "medically necessary" to persons with SMI who gain insurance coverage	33	80%
Providing a mental health leadership function in overseeing the system to ensure appropriate services are available	31	79%
Reviewing health plans and mental health benefit packages that will be offered under the new HIEs	16	36%
Being a provider of mental health services that will be reimbursed by private insurance (competing with private providers)	14	35%

3.9 Mental Health Parity

In 2008, Congress passed and the President signed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA guaranteed mental health benefits equal copay and limitation requirements (parity) with other health insurance benefits. SMHAs were working within their states to ensure the implementation of this new parity law. In 60 percent of states, the SMHA was involved in the implementation of the parity statute

along with state partners such as the state insurance commissioner. SMHAs described roles including partnering with their state Medicaid agency, state insurance department, or Department of Health and Human Services, as well as businesses and consumer organizations within the state, about service needs, best practices, and insurance benefit requirements. In 15 states, the SMHA worked with Medicaid to make changes to Medicaid managed care plans to comply with the parity law.

3.10 Comprehensive Mental Health Planning

Every SMHA developed a comprehensive mental health plan as part of its MHBG process. In 38 states, the planning process for the delivery of mental health services spanned multiple state agencies (beyond just the SMHA). In 30 states, the plan addressed the mental health services and essential support services provided by state agencies other than the SMHA. All states included representatives of other state agencies as members of their state's mental health planning council.

In 19 states, the SMHA developed a separate plan to address the Supreme Court's Olmstead ruling. The Olmstead decision was a 1999 Supreme Court case brought under the Americans with Disabilities Act (ADA). This decision found that persons in institutions (such as psychiatric hospitals) have a right to receive care in the most integrated setting appropriate and that unnecessary institutionalization is discriminatory and violates the ADA. In 2010, four states were under an Olmstead lawsuit (Illinois, New Jersey, New York, and North Carolina) related to mental health services.

3.11 Collaboration With Other State Agencies

SMHAs were the lead agency in each state for organizing, funding, and planning for comprehensive mental health services. However, SMHAs were not the only state government agency involved in providing mental health services. Increasingly, SMHAs collaborated with other state government agencies to ensure high-quality mental health services were provided across state government and to reduce fragmentation in services and coordinate services across state government. States adopted the concept of "no wrong door" that promoted the provision of the most appropriate and timely mental health services consumers need, no matter which state agency they first accessed for services.

In 2010, 48 SMHAs collaborated with other state agencies to reduce the fragmentation of services. Forty-one SMHAs had initiatives to transform the way mental health services were delivered across state government agencies. In their efforts to reduce fragmentation, SMHAs were most likely to coordinate with Criminal Justice, Substance Abuse, Medicaid, and Juvenile Justice Agencies (see table 32). The other state agencies in which SMHAs worked most often to coordinate funding streams were Medicaid, Housing, and Substance

Table 32: SMHA Collaboration With Other State Agencies

Agency	Reduce Fragmentation	Determine Client Eligibility	Coordinate Funding Streams	Coordinate Service Delivery
Criminal Justice	40	18	20	35
Substance Abuse	39	22	26	39
Medicaid	38	24	31	37
Housing	37	17	25	29
Juvenile Justice	36	8	17	37
Employment	35	12	21	31
Child Welfare	35	12	20	30
Education	27	9	13	24
National Guard	21	7	9	22

Abuse.

3.12 Working With Native American Tribal Governments

Sixteen states had intergovernmental relationships with Native American Tribal Governments to coordinate mental health services to Native Americans. For example, in Minnesota, 25 percent of the SMHA's MHBG fund was dedicated to services delivered by tribal governments and their affiliates with full-time staff dedicated to Native American services, and in North Carolina, the Secretary of the North Carolina Department of Health and Human Services sat on the North Carolina Commission of Indian Affairs. In six states, the SMHA had an intergovernmental relationship with the federal Indian Health Service to coordinate mental health services to Native Americans. For example, the intergovernmental relationship with the State of Oklahoma and the federal Indian Health Service was woven throughout initiatives such as the Governor's Transformation Advisory Board and the Tribal State Relations Workgroup that both had Indian Health Service representatives and were active in decision making and networking roles.

3.13 Consumer and Family-Driven Care

Forty-four SMHAs had initiatives to ensure every consumer received individualized, person-centered treatment plans that met their unique needs. In most SMHAs, these treatment plans were required by legislation, regulation, or contract. Thirty-six SMHAs provided training and technical assistance to providers in developing individualized person-centered treatment plans. To ensure that every consumer received an individualized treatment plan, SMHAs conducted client record audits, provider site visits, and regulatory/certification requirements. Nine SMHAs (Connecticut, Florida, Louisiana, Michigan, North Carolina, New Mexico, Texas, West Virginia, and Wyoming) had a voucher program or initiative that allowed consumers to purchase services of their own choice.

Thirty-two SMHAs involved consumers and family members in policymaking, quality assurance, and evaluation/research activities. In many states (27), the SMHA had a statutory or regulatory requirement for consumers and family member participation in policymaking. In 17 SMHAs, there was a requirement for their participation in evaluation and quality assurance monitoring. Fewer SMHAs had statutory or regulatory requirements for consumer and family participation in Internal Review Boards for research (9) and licensing/credentialing (8).

Most SMHAs had Offices of Consumer Affairs (35), and some (11) had consumer advisors outside the agency (5 states had both an Office of Consumer Affairs and consumer advisors from outside the SMHA).

3.14 Advanced Directives

Advanced directives are written legal documents that allow consumers to make decisions about how they wish to receive mental health services, including medications, at a future time. Psychiatric advanced directives are used by mental health consumers to specify to mental health providers and family members how they wish to be treated during an episode of illness when they may not be capable of making treatment decisions. In 46 states, either a state statute or policy encouraged the use of advanced directives for mental health consumers. In 20 states, there was a general state statute on advanced directives (not specific to mental health). However, in 22 states, there was a statute specific to mental health (in 13 of these states, there was both a general state advanced directive statute and a mental health specific statute). In four states, there was no state statute on advanced directives, but the SMHA had a policy or rule encouraging their use (see figure 18). The most common forms of psychiatric advanced directives permitted the appointment of healthcare proxies/representatives (30 states), followed by advance directives that expressed consumers' own wishes for treatment in the event they lack the capacity in the future (26 states).

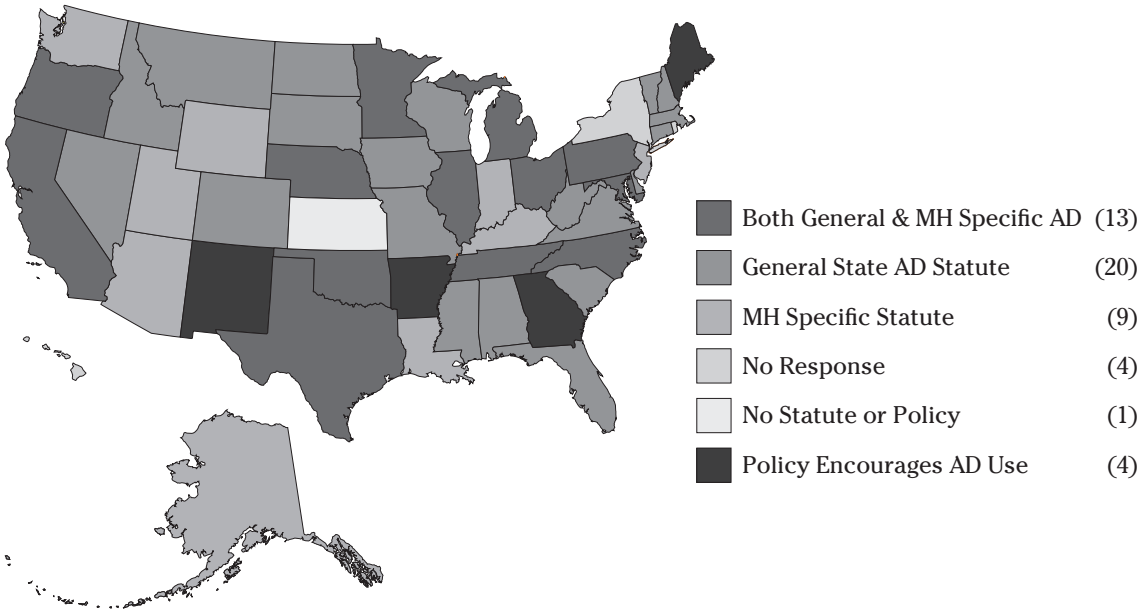
3.15 Outpatient Civil Commitment Statutes

The mental health code of most states (42) allowed outpatient civil commitments. The length of stay for outpatient civil commitments ranged from a high of 5 years in New Hampshire to a low of 21 days in Minnesota. Nine states allowed commitments of 1 year (365 days), whereas 11 states allowed commitments of 180 days. Alabama allowed commitments of 150 days and Kentucky allowed commitments of 120 days. Five states allowed commitments of 90 days.

3.16 Custody Relinquishment

In 28 states, there were laws or policies designed to avoid parents' having to relinquish custody of children (to the mental health, child welfare, or juvenile justice systems) in order for the children to obtain mental health services.

Figure 18: Use of Advanced Directives in Mental Health



For example, in Louisiana, the children's code statutes allowed judges to order children into services without requiring parents to relinquish custody. Seventeen states did not have laws or policies designed to avoid parental custody relinquishment specific to mental health.

3.17 Services for Armed Forces Veterans and National Guard Members

"Since October 2001, approximately 1.64 million U.S. troops have been deployed for Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) in Afghanistan and Iraq" (Tanielian & Jaycox, 2008, p. iii). These deployments resulted in elevated levels of mental illness among the troops and their families. "Early evidence suggests that the psychological toll of these deployments — many involving prolonged exposure to combat-related stress over multiple rotations — may be disproportionately high compared with the physical injuries of combat. Concerns have been most recently centered on two combat-related injuries in particular: posttraumatic stress disorder and traumatic brain injury. With the increasing concern about the incidence of suicide and suicide attempts among returning veterans, concern about depression is also on the rise" (Tanielian & Jaycox, 2008, p. iii).

Most states (45) had specific initiatives to address the mental health service needs of returning veterans and their families. As depicted in table 33, these initiatives focused on members of the state National Guard (40), veterans (39), family members of the military (37), the Reserve (33), and Active Duty military (29). In addition, the SMHAs in Connecticut, Illinois, Maryland, Missouri, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Texas, Vermont, Wisconsin, and Wyoming arranged for specialized treatment services. These services included identifying particular providers as specifically prepared to deal with the mental health service needs of returning veterans or family members and arranging for group counseling for returning veterans and their family members.

SMHAs in 26 states had a plan in place to meet the mental health needs including posttraumatic stress disorder (PTSD) and traumatic brain injuries (TBI) of returning veterans and their families. In 17 states, funds were appropriated specifically to address the mental health service needs of returning veterans and their families. Ten states appropriated a total of $9,720,850, with amounts ranging from $300,000 in New York to $1.9 million in Maryland. Most of these funds were new funds (10 states), whereas 3 states used a combination of new funds and reprogrammed existing funds. These funds were directed to the SMHA to manage in Connecticut, Maryland, Missouri, New Mexico, North Carolina, Ohio, Texas, and Wyoming, whereas the state Veteran's Affairs/services office was responsible for managing these funds in Utah.

SMHAs in 30 states had arrangements in place to refer or pay for the mental health service needs/coordination of care for returning veterans and their families who do not have access to military reimbursed or provided mental health services. Table 34 shows the types of screens and determinations that SMHAs were requiring their funded mental health providers to conduct for veterans and their families. Over half the states required providers to determine whether a mental health client was a veteran, current military member, or family member. Fewer SMHAs required all providers to screen veterans for potential mental illnesses.

In 34 states, the SMHA sponsored, provided, or arranged training in the mental health problems of returning veterans and their families for mental health professionals and other providers. PTSD was the focus of these trainings in 27 states. Other training topics included veterans' benefits and eligibility requirements in Connecticut; suicide prevention among veterans in Delaware; military culture in New York and Vermont; and military family reintegration and substance abuse disorders in North Carolina.

Table 33: Initiatives To Address Mental Health Service Needs of Military Population

State	State has specific initiatives to address mental health service needs?	Target Population				
		Active Duty Military	Veterans	National Guard	The Reserve	Family Members
Alabama	Yes	Yes	Yes	Yes	Yes	Yes
Alaska	Yes	NR	NR	NR	NR	NR
Arizona	Yes	No	Yes	Yes	Yes	Yes
Arkansas	Yes	Yes	Yes	Yes	Yes	Yes
California	Yes	Yes	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	Yes	Yes	Yes	Yes
Connecticut	Yes	No	Yes	Yes	Yes	Yes
Delaware	Yes	NR	NR	Yes	NR	NR
District of Columbia	NR	NR	NR	NR	NR	NR
Florida	Yes	Yes	Yes	Yes	Yes	Yes
Georgia	Yes	Yes	Yes	Yes	Yes	NR
Hawaii	No	NA	NA	NA	NA	NA
Idaho	No	NA	NA	NA	NA	NA
Illinois	Yes	NR	Yes	NR	NR	Yes
Indiana	No	NA	NA	NA	NA	NA
Iowa	Yes	NR	NR	NR	NR	NR
Kansas	Yes	No	Yes	Yes	No	No
Kentucky	Yes	Yes	Yes	Yes	Yes	Yes
Louisiana	No	NA	NA	NA	NA	NA
Maine	Yes	NR	Yes	NR	NR	Yes
Maryland	Yes	NR	Yes	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes	Yes	No
Michigan	Yes	NR	NR	Yes	NR	NR
Minnesota	Yes	No	No	Yes	Yes	Yes
Mississippi	Yes	Yes	Yes	Yes	Yes	Yes
Missouri	Yes	NR	NR	NR	NR	NR
Montana	Yes	Yes	Yes	Yes	Yes	Yes
Nebraska	Yes	No	Yes	Yes	No	Yes
Nevada	No	NA	NA	NA	NA	NA
New Hampshire	Yes	Yes	Yes	Yes	Yes	Yes

Table 33: Initiatives To Address Mental Health Service Needs of Military Population (Continued)

State	State has specific initiatives to address mental health service needs?	Target Population				
		Active Duty Military	Veterans	National Guard	The Reserve	Family Members
New Jersey	Yes	Yes	Yes	Yes	Yes	Yes
New Mexico	Yes	Yes	Yes	Yes	Yes	Yes
New York	Yes	Yes	Yes	Yes	No	Yes
North Carolina	Yes	Yes	Yes	Yes	Yes	Yes
North Dakota	Yes	Yes	Yes	Yes	Yes	Yes
Ohio	Yes	Yes	Yes	Yes	Yes	Yes
Oklahoma	Yes	Yes	Yes	Yes	Yes	Yes
Oregon	Yes	Yes	Yes	Yes	Yes	Yes
Pennsylvania	Yes	Yes	Yes	Yes	Yes	Yes
Rhode Island	Yes	No	Yes	Yes	No	Yes
South Carolina	Yes	No	Yes	Yes	Yes	Yes
South Dakota	Yes	Yes	Yes	Yes	Yes	Yes
Tennessee	Yes	Yes	Yes	Yes	Yes	Yes
Texas	Yes	Yes	Yes	Yes	Yes	Yes
Utah	Yes	Yes	Yes	Yes	Yes	Yes
Vermont	Yes	Yes	Yes	Yes	Yes	Yes
Virginia	Yes	Yes	Yes	Yes	Yes	Yes
Washington	Yes	Yes	Yes	Yes	Yes	Yes
West Virginia	Yes	Yes	Yes	Yes	NR	Yes
Wisconsin	Yes	No	Yes	Yes	Yes	Yes
Wyoming	Yes	Yes	Yes	Yes	Yes	Yes
	Yes = 45	Yes = 29	Yes = 39	Yes = 40	Yes = 33	Yes = 37
	No = 5	No = 8	No = 1	No = 0	No = 4	No = 2
	NR = 1	NR = 9	NR = 6	NR = 6	NR = 9	NR = 7
		NA = 5	NA = 5	NA = 5	NA = 5	NA = 5

NA = not applicable.
NR = no response.

Table 34: Veteran-Related Requirements of SMHA-Funded Mental Health Providers

SMHA Requirements for State-Funded Mental Health Providers	Number of States
Determine whether a client is a veteran, current military member, or family member	27
Refer veteran clients with potential mental health disorders for further services	25
Screen veterans for potential mental health disorders	13
Screen veterans for cognitive disabilities/TBI	6

Many SMHAs (26) either provided outreach to OEF/OIF veterans and family members or assisted mental health providers with its provision. For example, in Alabama the Reintegration Action Plan (RAP) for returning veterans and family members was distributed to all providers of the SMHA's Mental Illness and Substance Abuse divisions. Also distributed was information regarding the accompanying Web site: **http://www.alabamareturningveterans.org**, where RAP can be downloaded. In 13 states, the SMHA arranged specialized treatment services for returning veterans dealing with mental health problems (e.g., identifying particular providers as specifically prepared to deal with returning veterans or family members, or arranging group counseling for veterans).

3.17.1 Coordination With Federal Programs on Veterans Mental Health

Managers from 41 SMHAs met with the health and mental health authorities to discuss the mental health needs and coordination of care for returning veterans and their families. In 38 states, managers met with the Department of Veterans Affairs, in 18 with the Department of Defense, and in 37 with the National Guard. In addition, in 36 states, the SMHA and the state Substance Abuse Agency met to discuss coordination of mental health needs for returning veterans.

3.18 Older Adults

Fifteen SMHAs had specialized plans for the provision of mental health services to older adults, ages 65 and up. For example, the SMHA in Delaware partnered with the Division of Services for Aging and Adults with Physical Disabilities to create programming to address the unique mental health needs of older adults. In Hawaii, the SMHA developed a plan in partnership with the state's Administration on Aging and the counties' Aging Area Administrators along with other aging service partners and consumers. Sixteen SMHAs provided specialized training to providers regarding older adult mental health services and issues of mental illnesses. These plans included practice protocols, collaboration with universities, suicide prevention activities, and enforcement of service requirements for providers. Most SMHAs (33) offered incentives to work with primary care and mental health providers to administer services to older adults with

mental health problems. SMHAs helped primary care and mental health service providers to recognize symptoms and treat older adults served in community mental health settings (24), nursing homes (20), primary care settings (20), inpatient psychiatric care (13), and long-term care settings (17). To do this, SMHAs trained, established practice protocols for, and collaborated with other state agencies.

3.19 Evidence-Based Practices

"In the field of mental health, the term evidence-based practices (EBPs) refers to interventions that have been rigorously tested, have yielded consistent, replicable results, and have proven safe, beneficial and effective for most people diagnosed with mental illness" (Substance Abuse and Mental Health Services Administration [SAMHSA] GAINS Center, n.d.).

In order to assist states in reducing the gap that exists between services that are based on scientific research and the application of these services, the 1999 Surgeon General's report on mental health identified the necessary steps that should be undertaken by states. SAMHSA also undertook several major initiatives to assist SMHAs in addressing the difficulties of implementing EBPs. CMHS supported the development of six toolkits to help states, providers, clinicians, and consumers and their families implement and use EBP services for adults with SMI. Since the publication of the original six toolkits, additional toolkits for supported housing; consumer-operated services; and a variety of child, adolescent, and older adult EBPs have been under development. SMHAs, in return, have responded to the federal leadership by increasing the number and level of EBPs provided. In 2010, every reporting SMHA implemented at least one of the EBPs identified by CMHS. As depicted in table 35 the majority of SMHAs promoted the implementation of integrated treatment for co-occurring disorders (mental health and substance abuse) (48), supported employment (47), and ACT (44).

3.19.1 Assertive Community Treatment

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

Forty-four SMHAs actively promoted ACT services through a variety of methods, including endorsing ACT in state plans, directly providing or funding training, providing incentives for providers to adopt ACT, and funding aspects of training or service delivery. In 31 states, ACT services were available in parts of the state, whereas in 12 states, these services were available statewide. Additionally, 15 states planned to implement ACT services in either parts of the state (6) or statewide (9).

Table 35: Number of SMHAs Implementing or Planning To Implement EBPs

EBP	Promoting Implementation	Implementing Statewide	Implementing Parts of State	Piloting	Planning To Implement
ACT	44	12	31	0	15
Supported Employment	47	17	25	4	10
Medication Algorithms (Schizophrenia)	15	5	6	2	5
Medication Algorithms (Bipolar)	9	5	3	1	2
Family Psychoeducation	31	12	15	0	9
Integrated Treatment for Co-Occurring Disorders (Mental Health/Substance Abuse)	48	17	28	1	16
Illness Self-Management	38	11	26	0	10
Supported Housing	41	18	21	2	12
Multisystemic Therapy (Conduct Disorder)	25	1	22	3	7
Functional Family Therapy	21	1	19	2	6
Incredible Years	12	0	12	0	6
Parent-Child Interaction Therapy	15	2	9	2	5
Parent Management Training	10	2	7	0	2
Brief Strategic Family Therapy	10	1	8	1	3
Problem-Solving Skills Training	8	1	6	0	5
Coping Power	4	1	2	0	4
Cognitive Behavioral Therapy for Depression	23	4	18	0	6
Cognitive Behavioral Therapy for Anxiety	17	3	12	1	4
Trauma-Focused Cognitive Behavioral Therapy	31	9	17	1	7
Interpersonal Therapy for Depression	8	1	5	0	3

Table 35: Number of SMHAs Implementing or Planning To Implement EBPs (Continued)

EBP	Promoting Implementation	Implementing Statewide	Implementing Parts of State	Piloting	Planning To Implement
School-Based Intervention	23	1	13	2	5
Consumer-Operated Services	40	11	28	1	14
Other Adult EBPs	25	9	12	1	11
Other Child EBPs	36	3	19	14	10

Of the 44 states that promoted the implementation of ACT services, 42 implemented these services consistent with published national standards for ACT. The fidelity of ACT programs to standards was being assessed in 32 states. The most frequently used method of assessing fidelity was the Dartmouth Assertive Community Treatment Fidelity Scale (used by 15 states). ACT teams averaged a patient to staff ratio of 10.1 to 1.

SMHAs used a variety of funding sources, including state general funds (36), Medicaid (35), the federal Community Mental Health Services Block Grant (21), local funds (12), and other funds (5), to pay for ACT services. Seventeen states reported a single bundled rate under Medicaid that they used to pay for ACT services. The most frequently used Medicaid options used to pay for ACT services were the Rehabilitation Option (29 states) and Clinic Option (8 states).

3.19.2 Supported Employment

Supported employment programs are designed to help consumers gain competitive employment, within the community. Competitive employment pays at least minimum wage, and any person can apply for it, in accord with consumer choices and capabilities, without requiring extended prevocational training. Unlike other vocational approaches, supported employment programs do not screen people for work readiness, but help all who indicate they want to work. These programs do not provide intermediate work experiences, such as prevocational work units, transitional employment, or sheltered workshops. However, they actively facilitate job acquisition, often sending staff to accompany clients on interviews, and provide ongoing support once the client is employed.

Forty-seven SMHAs promoted supported employment services through a variety of methods, including endorsing supported employment programs in state plans, directly providing or funding training, providing incentives for providers to adopt supported employment, and funding aspects of training or service delivery. In 25 states, supported employment services were available in parts of the state, whereas in 17 states, they were available statewide. Additionally, 10 states planned to implement supported employment services in either parts of the state (3) or statewide (7).

SMHAs used a variety of funding sources, including state general funds (32), Medicaid (17), the federal Community Mental Health Services Block Grant (21), local funds (11), and other funds (11), to pay for supported employment services.

3.19.3 Medication Algorithms

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

3.19.3.1 Schizophrenia

Fifteen SMHAs actively promoted medication algorithms for schizophrenia through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In six states, medication algorithms for schizophrenia were available in parts of the state, whereas in five states, they were available statewide. Additionally, five states planned to implement medication algorithms for schizophrenia statewide.

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

3.19.3.2 Bipolar Disorder

Nine SMHAs actively promoted medication algorithms for bipolar disorders through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In three states, medication algorithms for bipolar disorder were available in parts of the state, whereas in five states, they were available statewide. Additionally, two states planned to implement medication algorithms for bipolar disorders statewide.

For these services, SMHAs used a variety of funding sources, including state general funds (four), Medicaid (four), the federal Community Mental Health Services Block Grant (three), local funds (three), and other funds (two).

3.19.4 Family Psychoeducation

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

Thirty-one SMHAs actively promoted family psychoeducation services through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 15 states, family psychoeducation services were available in parts of the state, whereas in 12 states, they were available statewide. Additionally, nine states planned to implement family psychoeducation services in either parts of the state (five) or statewide (four).

SMHAs used a variety of funding sources for these services, including state general funds (17), Medicaid (11), the federal Community Mental Health Services Block Grant (12), local funds (5), and other funds (2).

3.19.5 Integrated Treatment for Co-Occurring Disorders (Mental Illness and Substance Abuse)

Integrated treatment for co-occurring disorders combine or integrate mental health and substance abuse interventions at the clinical encounter level. Thus, integrated treatment means that the same clinicians or teams of clinicians working in one setting provide appropriate mental health and substance abuse interventions in a coordinated fashion. For individuals with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations. The goal of dual diagnosis interventions is recovery from two serious illnesses.

Forty-eight SMHAs actively promoted integrated mental health and substance abuse treatment services through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 28 states, these services were available in parts of the state, whereas in 17 states they were available statewide. Additionally, 16 states planned to implement integrated mental health and substance abuse services in either parts of the state (4) or statewide (12).

SMHAs used a variety of funding sources for these services, including state general funds (33), Medicaid (30), the federal Community Mental Health Services Block Grant (20), local funds (8), and other funds (8).

3.19.6 Illness Self-Management

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

Thirty-eight SMHAs actively promoted illness self-management services through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 26 states, these services were available in parts of the state, whereas in 11, they were available statewide. Additionally, 10 states planned to implement illness self-management services in either parts of the state (5) or statewide (5).

SMHAs used a variety of funding sources for these services, including state general funds (22), Medicaid (17), the federal Community Mental Health Services Block Grant (11), local funds (8), and other funds (5).

3.19.7 Supported Housing

Supported housing is an EBP that assists individuals in finding and maintaining appropriate housing arrangements. The premise of this activity is the idea that certain consumers are able to live independently in the community only if they have support staff for monitoring and/or assisting with residential responsibilities. Support staff assist clients in selecting, obtaining, and maintaining safe, decent affordable housing and in maintaining a link to other essential services provided within the community. The object of supported housing is to help obtain and maintain independent living.

Forty-one SMHAs actively promoted supported housing services through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 21 states, these services were available in parts of the state, whereas in 18, they were available statewide. Additionally, 12 states planned to implement supported housing services in either parts of the state (4) or statewide (8).

SMHAs used a variety of funding sources for these services, including state general funds (32), Medicaid (8), the federal Community Mental Health Services Block Grant (11), local funds (11), and other funds (18).

3.19.8 Multisystemic Therapy

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

Twenty-five SMHAs actively promoted MST through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In 22 states, MST was available in parts of the state, whereas it was available statewide in 1 state. Additionally, seven states planned to implement MST either in parts of the state (four) or statewide (three).

SMHAs used a variety of funding sources for these services, including state general funds (20), Medicaid (15), the federal Community Mental Health Services Block Grant (6), local funds (6), and other funds (7).

3.19.9 Functional Family Therapy

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

Twenty-one SMHAs actively promoted FFT services through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 19 states, FFT was available in parts of the state, whereas in 1 state, it was available statewide. Additionally, six states planned to implement FFT in either parts of the state (five) or statewide (one).

SMHAs used a variety of funding sources for these services, including state general funds (16), Medicaid (6), the federal Community Mental Health Services Block Grant (4), local funds (3), and other funds (8).

3.19.10 Incredible Years

Incredible Years (IY) is a multilevel home and school-based intervention program with the goal of reducing child aggression by teaching parents and teachers how to manage misbehavior, promote problem-solving strategies, instill emotional regulation, and strengthen social competency. The child-training component targets appropriate classroom behavior, anger management, and problem-solving skills. "Ultimately, the aim of the IY teacher, parent, and child training programs is to prevent and reduce the occurrence of aggressive and oppositional behavior, thus reducing the chance of developing the later delinquent behaviors" (The Incredible Years, Inc., 2010).

Twelve SMHAs actively promoted IY programs through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In all 12 states, IY programs were available in parts of the state. Additionally, six states planned to implement IY programs in either parts of the state (four) or statewide (two).

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

3.19.11 Parent-Child Interaction Therapy

Parent-Child Interaction Therapy (PCIT) was "designed to establish an authoritative parenting style, which includes high parental nurturance, clear parent-child communication, and firm limit-setting with the child" (Funderburk & Eyberg, 2010, p. 1). PCIT is a two-phase parent-training program for families, delivered by trained therapists. In phase 1, parents learn how to

strengthen attachment to their child, and in phase 2, parents learn how to be strong authority figures to their child.

Fifteen SMHAs actively promoted PCIT through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In nine states, PCIT services were available in parts of the state, whereas in two states, these services were available statewide. Additionally, five states planned to implement PCIT in either parts of the state (four) or statewide (one).

SMHAs used a variety of funding sources for these services, including state general funds (five), Medicaid (seven), the federal Community Mental Health Services Block Grant (five), local funds (four), and other funds (four).

3.19.12 Parent Management Training

Parent Management Training (PMT) is a preventive and clinical intervention designed for both parents and youth to enhance effective parenting and to reduce coercive practices. Trained therapists implement PMT in clinic and home-based settings. Skills are taught to increase parents' ability to reward positive behavior, set limits with consequences, and prevent conflict from escalating. PMT modifies PCIT "in ways that are designed to promote prosocial child behavior and to decrease antisocial or oppositional behavior" (Feldman & Kazdin, 1995, p. 3).

Ten SMHAs actively promoted PMT through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In seven states, PMT services were available in parts of the state, whereas these services were available statewide in two states. Additionally, two states planned to implement PMT in either parts of the state (one) or statewide (one).

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

3.19.13 Brief Strategic Family Therapy

Brief Strategic Family Therapy (BSFT) is an intervention delivered by therapists who coach family members to develop a therapeutic alliance, diagnose family strengths and problem relationships, develop a change strategy, and implement those strategies. "By integrating theory, research findings, and clinical practice, BSFT has been continuously refined to improve its effectiveness with youth with behavior problems" (Robbins & Szapocznik, 2000, p. 1).

Ten SMHAs actively promoted BSFT through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service

delivery. In eight states, BSFT services were available in parts of the state, whereas these services were available statewide in one state. Additionally, three states planned to implement BSFT in either parts of the state (two) or statewide (one).

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

3.19.14 Cognitive Problem-Solving Skills Training

Cognitive Problem-Solving Skills Training (CPSST) is an intervention for children, used in conjunction with PMT, to improve a child's interpersonal and problem-solving skills. Children are taught to identify problems, find solutions, evaluate the pros and cons, and make decisions about behaviors, which will yield better outcomes.

Eight SMHAs actively promoted CPSST through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In six states, CPSST services were available in parts of the state, whereas in one state, these services were available statewide. Additionally, five states planned to implement CPSST in either parts of the state (four) or statewide (one).

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

3.19.15 Coping Power

Coping Power is a prevention and intervention program delivered at school in a group format with child and parent components. The child component teaches skills such as affect regulation, self-control, and social problem-solving. The parent component teaches skills to identify prosocial and disruptive behavior targets, appropriate rewards, and effective consequences.

Four SMHAs actively promoted Coping Power through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In two states, Coping Power services were available in parts of the state, whereas in one state, these services were available statewide. Additionally, four states planned to implement Coping Power in either parts of the state (three) or statewide (one).

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

3.19.16 Cognitive Behavioral Therapy for Depression

Based on the adult coping with depression program, Cognitive Behavioral Therapy (CBT) for depression teaches adolescents problem-solving, communication, and negotiation skills. The first half of the program is behavioral therapy to increase the amount of age-appropriate and individually tailored fun activities. The second half involves cognitive therapy. The goal of CBT for depression is for the adolescent to replace unproductive, unexamined beliefs with more positive, productive ones. The therapist works from a manual with scripted sessions while the adolescent follows along in a workbook with corresponding exercises.

Twenty-three SMHAs actively promoted CBT for depression through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In 18 states, CBT for depression programs were available in parts of the state, whereas in four states, these programs were available statewide. Additionally, six states planned to implement CBT for depression in either parts of the state (four) or statewide (two).

SMHAs used a variety of funding sources for these services, including state general funds (eight), Medicaid (six), the federal Community Mental Health Services Block Grant (five), local funds (four), and other funds (one).

3.19.17 CBT for Anxiety

CBT for anxiety teaches the child to recognize signs that lead to anxious arousal and use those as a cue to enact learned strategies that decrease the arousal. The skills taught are awareness of physical symptoms of anxiety, recognition of anxious self-talk, behavior and coping, self-talk and self-evaluation, and administration of self-reward for efforts. Parents are involved as consultants. The program is manualized, but flexibility with the manual is encouraged to tailor the treatment of the child's individual needs.

Seventeen SMHAs actively promoted CBT for anxiety through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In 12 states, CBT for anxiety programs were available in parts of the state, whereas in 3 states, these programs were available statewide. Additionally, four states planned to implement CBT for anxiety in either parts of the state (three) or statewide (one).

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

3.19.18 Trauma-Focused CBT

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Its goal is to help address the unique biopsychosocial needs of both children with PTSD or other problems related to traumatic life experiences and their parents or primary caregivers. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.

Thirty-one SMHAs actively promoted TF-CBT through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In 17 states, TF-CBT programs were available in parts of the state, whereas in 9 states, these programs were available statewide. Additionally, seven states planned to implement TF-CBT in either parts of the state (four) or statewide (three).

SMHAs used a variety of funding sources for these services, including state general funds (15), Medicaid (17), the federal Community Mental Health Services Block Grant (8), local funds (4), and other funds (4).

3.19.19 Interpersonal Psychotherapy for Depression

Interpersonal Psychotherapy (IPT) for depression is psychotherapy in which interpersonal problems are seen as the underlying cause of the depression. The objectives are to identify problem areas, relate symptoms to problem areas, focus on current relationships, and master the interpersonal context of the depression. This therapy is better suited for adolescents who are motivated to be in treatment and who agree that one or more interpersonal problems exist.

Eight SMHAs actively promoted IPT through a variety of methods, including endorsing its use in state plans, directly providing or funding training, providing incentives for providers to adopt its use, and funding aspects of training or service delivery. In five states, IPT programs were available in parts of the state, whereas it was available statewide in one state. Additionally, three states planned to implement IPT in either parts of the state (two) or statewide (one).

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

3.19.20 School-Based Interventions

School-based interventions are evidence-based interventions delivered in school settings, such as IY or Second Step (a violence prevention program that teaches children to change attitudes and behaviors to reduce aggressiveness).

Twenty-three SMHAs actively promote school-based interventions through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 13 states, school-based intervention programs were available in parts of the state. Additionally, five states planned to implement school-based intervention programs in either parts of the state (four) or statewide (one), and one state piloted school-based programs.

SMHAs used a variety of funding sources for these services, including state general funds (nine), Medicaid (four), the federal Community Mental Health Services Block Grant (five), local funds (four), and other funds (seven).

3.19.21 Older Adult EBPs

Of the 49 SMHAs responding, only 15 were implementing EBPs for older adults. Older adult EBPs implemented by SMHAs included Psychogeriatric Assessment and Treatment in City Housing (PATCH), Positive Achievement Change Tool, and CBT for older adults. In addition, eight SMHAs were planning to implement older adult EBPs including outcome-based treatment planning, the Program to Encourage Active and Rewarding Lives for Seniors, and the expansion of certified peer specialists to facilitate screening for older adults.

3.19.22 Training for EBPs

SMHAs used a variety of mechanisms to provide ongoing training to providers related to implementing EBPs. Most SMHAs (42) relied on expert consultants to provide ongoing training to providers, 46 used internal staff, 36 collaborated with universities, 33 used provider-to-provider training, 16 had established research/training institutes, and 8 used outside accreditation organizations.

Most SMHAs organized workforce training for child and adolescent EBPs, whereas some SMHAs provided these trainings for consumers (15) and family members (24). For adult EBPs, the majority of SMHAs (39) provided training for their workforce, whereas a slightly lower number of SMHAs (30) provided such trainings for adult consumers and family members (22).

3.19.23 Barriers to Implementing EBPs

Almost all SMHAs experienced barriers to implementing EBPs. The most prevalent barriers reported included financing programs (47), shortages of appropriately trained workforce (45), attaining or maintaining fidelity to EBP model standards (41), modification of the EBP model to meet local needs (33), and resistance to implementing EBPs from providers (30).

3.19.24 SMHA Initiatives To Promote the Adoption of EBPs

All reporting SMHAs had initiatives to promote the adoption of EBPs. The most frequently used initiatives included education and training (45 SMHAs) and consensus building among stakeholders (42 SMHAs). Other initiatives included monitoring fidelity (36 SMHAs), incorporation of EBPs into contracts (37 SMHAs), modification of information systems and data reports (30 SMHAs), provision of financial incentives (20 SMHAs), and budget requests specific to EBPs (19 SMHAs).

3.19.25 Emerging EBPs

Emerging EBPs and innovative practices are practices for which the research evidence base had not been finalized but appear very promising. Most SMHAs (30) were implementing or providing emerging EBPs or other innovative practices.

Emerging EBPs being implemented for children and adolescents included in-home intervention, matrix model for adolescents, risking connections, trauma-informed care, system of care models, motivational interviewing, child psychiatric rehabilitation, wraparound, family-based mental health services, and Aggression Replacement Therapy.

Emerging EBPs being implemented for adults included psychosocial rehabilitation, motivational interviewing, trauma-informed services, Dialectical Behavior Therapy, supported education, tobacco cessation treatment, crisis intervention training, recovery education, and wellness clinics.

Emerging EBPs being implemented for older adults included a collaborative model of mental healthcare, wraparound, and mental health-physical health integration.

3.20 Consumer-Operated Services

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

Forty SMHAs actively promoted consumer-operated services through a variety of methods, including endorsing their use in state plans, directly providing or funding training, providing incentives for providers to adopt their use, and funding aspects of training or service delivery. In 28 states, consumer-operated services were available in parts of the state, whereas in 11 states, they were available statewide. Additionally, 14 states planned to implement consumer-operated services either in parts of the state (6) or statewide (8).

SMHAs used a variety of funding sources for these services, including state general funds (23), Medicaid (8), the federal Community Mental Health Services Block Grant (19), local funds (6), and other funds (5).

3.21 Clinical Practice Guidelines

Clinical practice guidelines and treatment recommendations, based on research results regarding their efficacy, have been developed for particular treatments or medications. Most SMHAs (22) were engaged in education and/or dissemination activities related to clinical guidelines and treatment recommendations. Twenty-one SMHAs used clinical guidelines and treatment recommendations, 11 followed the American Psychiatric Association (APA), 6 followed the Texas Medication Algorithm Project (TMAP), and 4 used the Schizophrenia Patient Outcomes Research Team.

A number of the states used multiple clinical guidelines. Arizona required providers to be trained in the clinical guidelines posted on the SMHAs' Web site and included in documents incorporated by reference. In Massachusetts, state facilities were encouraged to use guidelines; however, they were not mandated for use. In New Jersey, the Division of Mental Health Services workgroup looked at the APA guidelines for the treatment of schizophrenia and TMAP. Some aspects of these two guidelines were incorporated into the division's guidelines. In Nebraska, clinical guidelines were used as references, but not required. They were reviewed in clinical meetings. Tennessee used clinical guidelines as part of Best Practice Guidelines that were made available to providers of behavioral health across the state. In Vermont, these guidelines were sent to the agencies and were used during site visits and utilization review procedures. Ohio used a combination of clinical guidelines for multiple medical and comorbid conditions. If cases had a problematic outcome, the CMHCs were requested to review the application of the guidelines to that situation as part of the review to ensure appropriate outcomes.

Clinical guidelines had been selected or adopted as official state policy in eight states (Arizona, Florida, Hawaii, Nevada, New York, Ohio, Texas, and Utah) for the treatment of persons with particular mental disorders. In Arizona, fidelity to the guidelines was monitored through regular evaluation. New York supported consultation with Office of Mental Health facilities to develop quality assurance indicators and certification requirements. Ohio used guidelines on borderline personality disorder, Integrated Dual Disorders Treatment; and mental illness and developmental disabilities. Texas used its Resiliency and Disease Management Guidelines that contain bundled service packages. Each package contains an array of services appropriate for the treatment of major depressive disorder, schizophrenia, or bipolar disorder.

3.22 Summary

Every SMHA had its own unique array of policies and initiatives, including determinations of eligibility for state-funded services; how the SMHA related to long-term care for consumers; how to enhance the development of individualized treatment plans and choice for consumers,

including the use of advanced directives; and the implementation and financing of evidenced-based mental health services. In 2010, SMHAs undertook major planning and policy initiatives in preparation for the implementation of healthcare reform (ACA) and the new federal parity statute. As part of these initiatives, SMHAs focused renewed attention on the health status of consumers to ensure that all of their health needs were addressed.

SMHAs worked with a variety of other state agencies, including Substance Abuse, Public Health, Medicaid, Health Insurance Commissioners, Corrections, Juvenile Justice, Housing, Welfare, Vocational Rehabilitation, Veterans, National Guard, and Native American tribal governments, to ensure that the health and behavioral health needs of mental health consumers were appropriately addressed. SMHAs increasingly conducted standardized health screens of consumers and worked with health providers to coordinate and integrate care. In addition, SMHAs promoted screening for histories of trauma and substance abuse problems among mental health consumers.

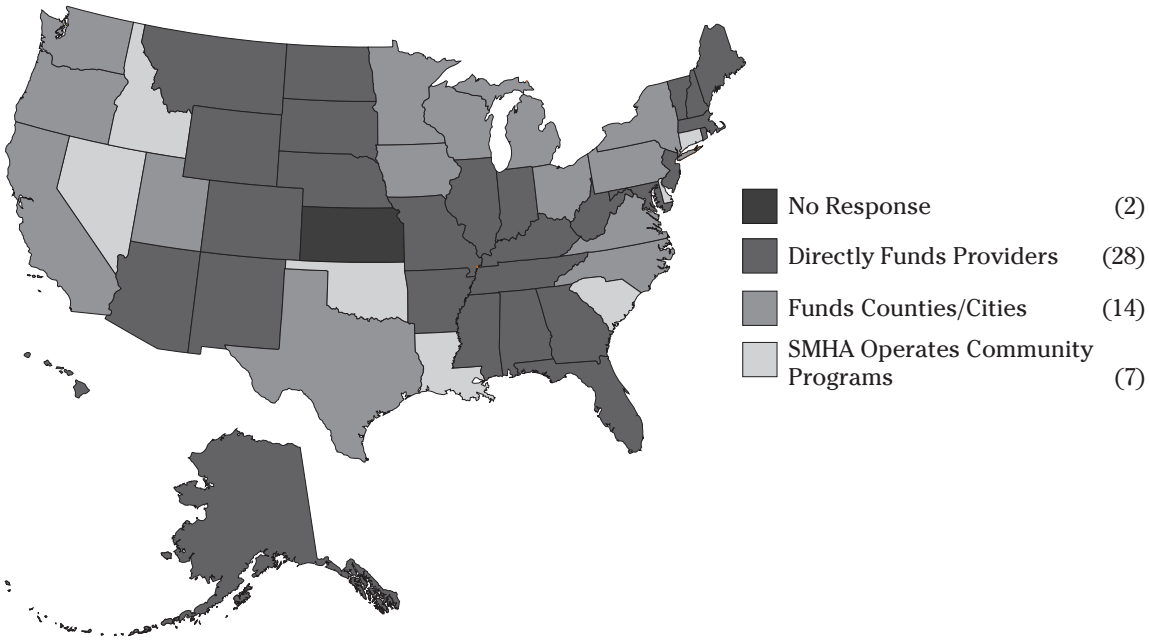
Many SMHAs had initiatives to improve the individualized treatment planning and service options available to consumers. SMHAs promoted policies to help consumers create psychiatric advanced directives and to empower consumers and families to have more choice in their services.

SMHAs also implemented and supported the implementation of an expanding array of EBPs. Support for EBPs included providing training for providers; using state general funds, MHBG funds, Medicaid, and other sources to reimburse for EBPs; and monitoring the fidelity of EBPs.

IV. Community Mental Health Services

Community mental health is driven by the goal of "better access to high-quality care for all Americans and allocation of more resources to community treatment" (Sharfstein, 2000, p. 616). In 2009, 95 percent (6.1 million) of the 6.4 million consumers served by the 58 state and territorial State Mental Health Agencies (SMHAs) received their services in the community. Expenditures for community services accounted for 70 percent ($25.6 billion) of the $36.7 billion spent by the SMHAs of the 50 states and the District of Columbia in FY 2008. SMHAs used a variety of methods to fund community services; figure 19 shows the primary methods SMHAs used to fund community mental health services. The SMHAs often used a combination of approaches to fund community mental health services. Most often, SMHAs directly funded, but did not operate, local community-based agencies (39 SMHAs). County/city governments were used to organize and provide mental health services by 24 SMHAs, and 14 SMHAs directly operated community programs. For example, Louisiana funded county or city mental health authorities in parts of the state and directly operated community programs.

Figure 19: Primary Methods SMHAs Used To Fund Community Mental Health Services



4.1 SMHA Relationships to Community Mental Health Providers

In 2010, 17,894* community mental health providers were funded and/or operated by 50 SMHAs. Of these, 17,712 providers were funded, but not operated, by the SMHA, and 182 additional community mental health programs were directly operated by the SMHAs. States varied from having as few as 8 community mental health providers in Montana, North Dakota, and Rhode Island to 8,938 providers in North Carolina.

4.1.1 Community Mental Health Controlling Entry to State Psychiatric Hospitals

Community mental health programs in 35 SMHAs performed a gatekeeping function over entry into state psychiatric hospitals. For voluntary clients, liaison activities were used by 36 SMHAs, preadmission screening (single portal of entry) was conducted by 34, and predischarge planning was conducted by 34 SMHAs. For involuntary clients, liaison activities were used by 38 SMHAs, preadmission screening (single portal of entry) was conducted by 36, and predischarge planning was conducted by 37 SMHAs.

4.2 Initiatives To Restructure Community-Based Mental Health Service Delivery

Twenty-seven SMHAs were restructuring their system of community-based mental health service delivery. Initiatives included restructuring administrative activities, refocusing on hospital diversion and recovery, increasing care coordination and wraparound services, improving continuity of care and crisis services, implementing deinstitutionalization, expanding EBPs, reforming payment structures, developing a comprehensive telehealth network, and increasing the role of consumers.

4.3 Community Mental Health Services Provided by SMHAs

SMHAs offered a variety of community mental health services, including extensive/intensive outpatient treatment (48); crisis services, including mobile crisis (48); outpatient testing and treatment (47); case management (46); Assertive Community Treatment (44); peer/consumer-operated services (44); residential support services (43); inpatient hospitalization (42); residential room and board (42); wraparound (42); supported employment (42); school-based services (38); in-home services (38); and collateral treatment (30).

4.4 Consumer-Operated Services

In its discussion about consumer-operated services, the Surgeon General's report on mental health stated, "Consumer staff are thought to gain meaningful work, to serve as role models for clients, and to enhance the sensitivity of the service system to the needs of people with mental disorders" (U.S. Department of Health and Human Services, 1999, p. 290). Following these recommendations, 34 SMHAs employed

*This number includes a duplicated count of children and adult providers in Georgia.

or required contracted service providers to employ self-identified consumers/survivors to provide peer services to other consumers/survivors in different settings. Of these, 76 percent specifically required the employment of consumers in community mental health programs. SMHAs supported consumer-operated services through direct funding (38), conference sponsorship (33), technical assistance (35), and office space (14). SMHAs spent over $33.2 million on more than 281 consumer-operated programs.

SMHAs also used peer specialists to provide services that were reimbursed by Medicaid. Peer specialists are consumers who have undergone a standardized training curriculum and have a certificate of successful completion of training. In 24 states, Medicaid reimbursed for adult peer specialists and for adolescent consumer peer specialists in 3 states. The SMHA was often involved in establishing peer specialist training programs. For example, in Indiana, a consumer completed a 5-day training and certification test through a process authorized by the SMHA that included ongoing education and recertification requirements.

4.4.1 Types of Consumer-Operated Services Funded by SMHAs

SMHAs funded a variety of consumer-operated services. The most commonly funded services were peer/mutual support, drop-in centers, advocacy, leadership skills training, and wellness/prevention services. See table 36 for information about the types of consumer-operated services funded by SMHAs.

Table 36: Types of Consumer-Operated Services Funded by SMHAs

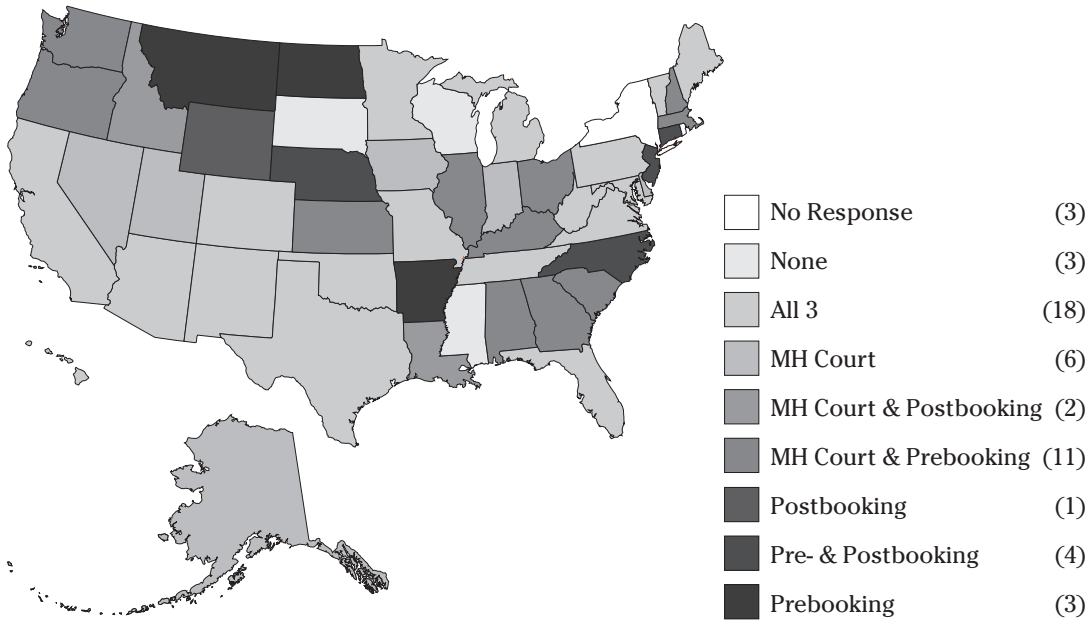
Services	Number of States
Peer/mutual support	41
Drop-in centers	34
Advocacy	33
Leadership skills training	32
Wellness/prevention services	26
Promotion of positive public attitudes	24
Technical assistance	20
Policy development	16
Social services	15
Vocational rehabilitation/employment	12
Transitional assistance	10
Client-staffed businesses	9
Nonresidential crisis intervention	8
Research activities	8
Case management	7
Residential crisis facility	5

4.5 SMHAs' Relationship to Criminal and Juvenile Justice

The GAINS Center, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), estimated approximately 800,000 persons with serious mental illness (SMI) were admitted annually to U.S. jails. According to the GAINS Center, "Over the past two decades, jail diversion programs have emerged as a viable and humane solution to the criminalization and inappropriate criminal detention of individuals with mental disorders. Diverting appropriate individuals from jail to community-based mental health treatment has been heralded for its potential benefits to the criminal justice system, the community and the diverted individual" (SAMHSA GAINS Center, n.d.).

Most SMHAs (43) had interventions to divert persons with mental illness from the criminal justice system into mental health treatment. The three major types of interventions used by SMHAs included mental health courts, prebooking diversion programs, and postbooking diversion programs (see figure 20).

Figure 20: Adult Criminal Justice Diversion Programs



Mental health courts were used in 37 states to help divert persons with mental illness from the criminal and juvenile justice systems. In 24 states, the mental health courts had access to dedicated or new resources to provide community-based treatments. In 33 states, there were 223 mental health courts, with an average of 6.8 mental health courts per state and a high of 41courts in California and a low of 1 court in 6 states (Kansas, Louisiana, Maine, Massachusetts, Vermont, and West Virginia). Mental health courts served 2,834 persons in 12 states, with an average of 236 persons served per state and a high of 500 persons in Maryland and Pennsylvania to a low of 34 persons in West Virginia. (The California SMHA could not provide an exact count of persons served by mental health courts but estimated that from 2,250 to 2,500 individuals were served.)

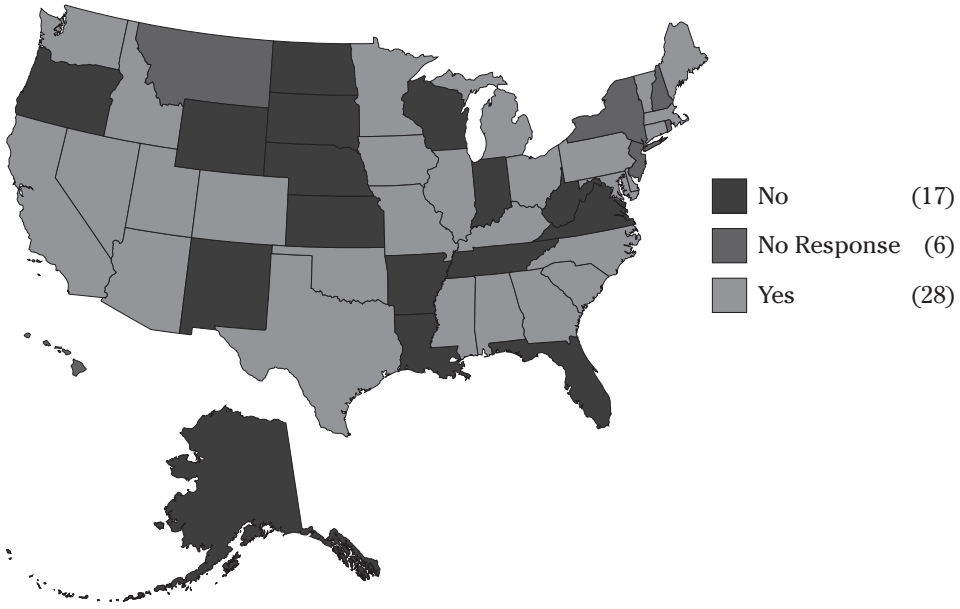
Prebooking diversion programs (designed to move clients into mental health services before they are "booked," or arrested) were adopted in 36 states. Since 2008, 26 SMHAs have had activities or funding to stimulate or support the prebooking diversion programs for adults. Twenty-five SMHAs had plans to stimulate or support prebooking programs for adults over the next fiscal year.

Postbooking, preadjudication diversion programs (designed to divert clients after their arrest) had been adopted in 25 states. Since 2008, 28 SMHAs have had activities or funding to stimulate or support the postbooking diversion programs for adults. Twenty-seven SMHAs had plans to stimulate or support postbooking programs for adults over the next fiscal year.

Thirty-five SMHAs adopted, funded, or operated programs designed to provide support for prisoners or jail detainees with mental illnesses and/or with co-occurring mental health and substance abuse disorders prior to their return to the community.

Twenty-eight SMHAs had programs to help divert youth with mental illnesses from the juvenile justice system into treatment (see figure 21). Youth diversion programs were most often at adjudication phase (22 SMHAs), followed by at intake (15), and at prearrest (13). In addition, Iowa and Oklahoma reported youths could be diverted at any point in the juvenile justice process; Idaho allowed diversion from detention centers; and in Missouri, youth diversion programs differed across the state's communities. Youth diversion programs were most often jointly administered by the SMHA and the juvenile justice agency (11 states), followed by being administered by the SMHA (6 states) or the juvenile justice agency (2 states).

Figure 21: SMHAs' Support Programs To Divert Youth With Mental Illnesses From Juvenile Justice Into Treatment



4.5.1 Provision of Mental Health Services to Persons in Prisons or Jails

SMHAs varied in their responsibility for the provision of mental health services to juveniles in the juvenile justice system and to inmates of local jails and detention centers. In most states (44), the state corrections agency was responsible for the provision of mental health services to adults in the corrections system (seven SMHAs were responsible for these services), whereas in 26 states, the state juvenile justice agency was responsible for providing mental health services to children in the juvenile justice system (15 SMHAs were responsible for these services). Only Maine, Missouri, and North Dakota were responsible for the provision of mental health services to adults, whereas Connecticut, Maine, Missouri, New Mexico, North Dakota, Oregon, and Utah were responsible for the provision of these services to juveniles with severe mental illness in local jails or detention centers. City and county mental health agencies were responsible for providing mental health services to adults in 21 states and juveniles in 20 states.

Most SMHAs funded, operated, or provided mental health services, which included probation, parole, alternatives to incarceration, juvenile probation/ suspension, etc., to adults (34) and juveniles (30) in the community correction population. Many SMHAs funded, operated, or provided mental health services to adults (28) and juveniles (21) in local jails or detention centers. A few SMHAs

provided mental health services for adults (seven) and juveniles (six) in local sheriffs' offices.

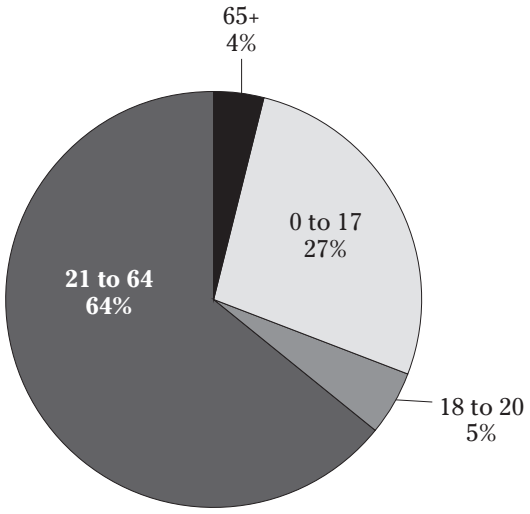
4.6 Characteristics of Persons Served in Community Settings

In 2009, 95 percent (6.1 million) of the 6.4 million consumers served by the 58 state and territorial SMHAs received their services in the community. Women represented 51.7 percent of the total number of consumers served in community settings and had a utilization rate of 20.2 per 1,000, whereas men represented 47.9 percent and had a utilization rate of 19.3 per 1,000 of the U.S. population.

4.6.1 Consumers Served, by Age

Consumers of all ages received services in community settings. Of the different age groups served, consumers ages 21 to 64 made up the majority (64 percent). See figure 22 for the percent distribution of consumers served in community mental health service settings, by age groups.

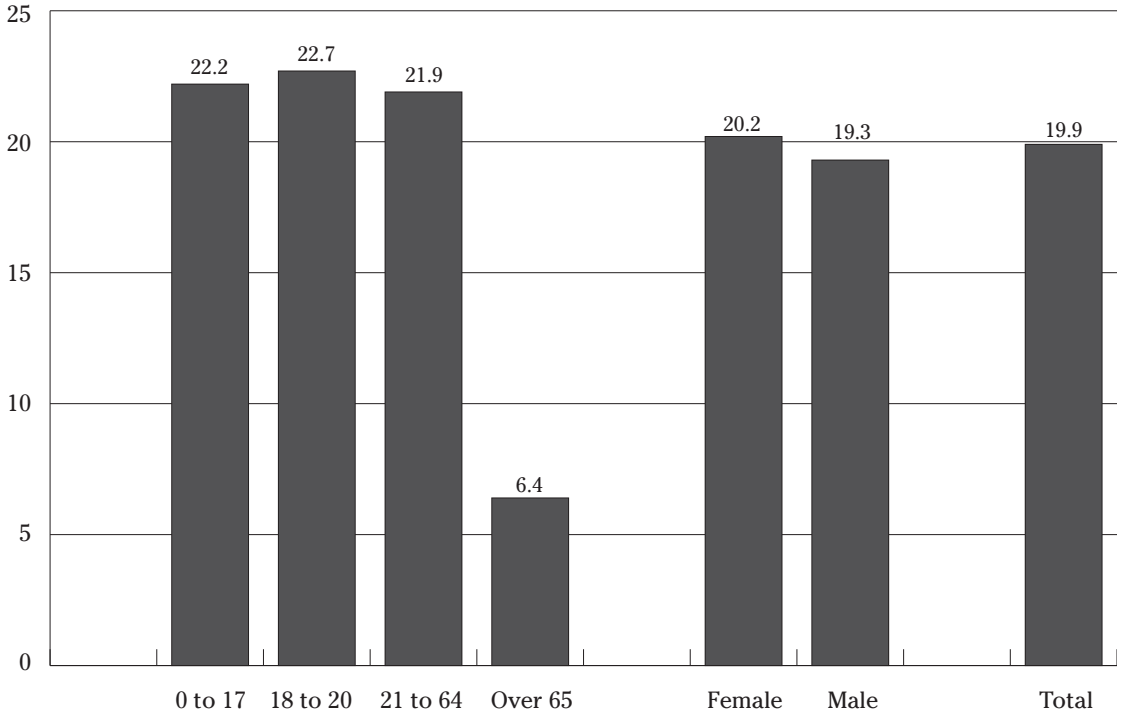
Figure 22: Percent Distribution of Consumers Served in Community Settings, by Age



4.6.2 Utilization Rates of Consumers Served in Community Settings, by Age

The total utilization rate (persons served per 1,000 state population) for community services was 19.9 in 2009 (see figure 23). Younger consumers had slightly higher average utilization rates than the overall population, with those aged 18 to 20 having the highest rate (22.7) and those aged 0 to 17 having the second highest (22.2). Those aged 21 to 64 had a utilization rate of 21.9, and those 65 and older had the lowest rate (6.4), perhaps because they were less likely to be served by SMHAs than by Medicare.

Figure 23: Utilization Rates (per 1,000 Population) of Persons Served in Community Settings, by Age and Gender



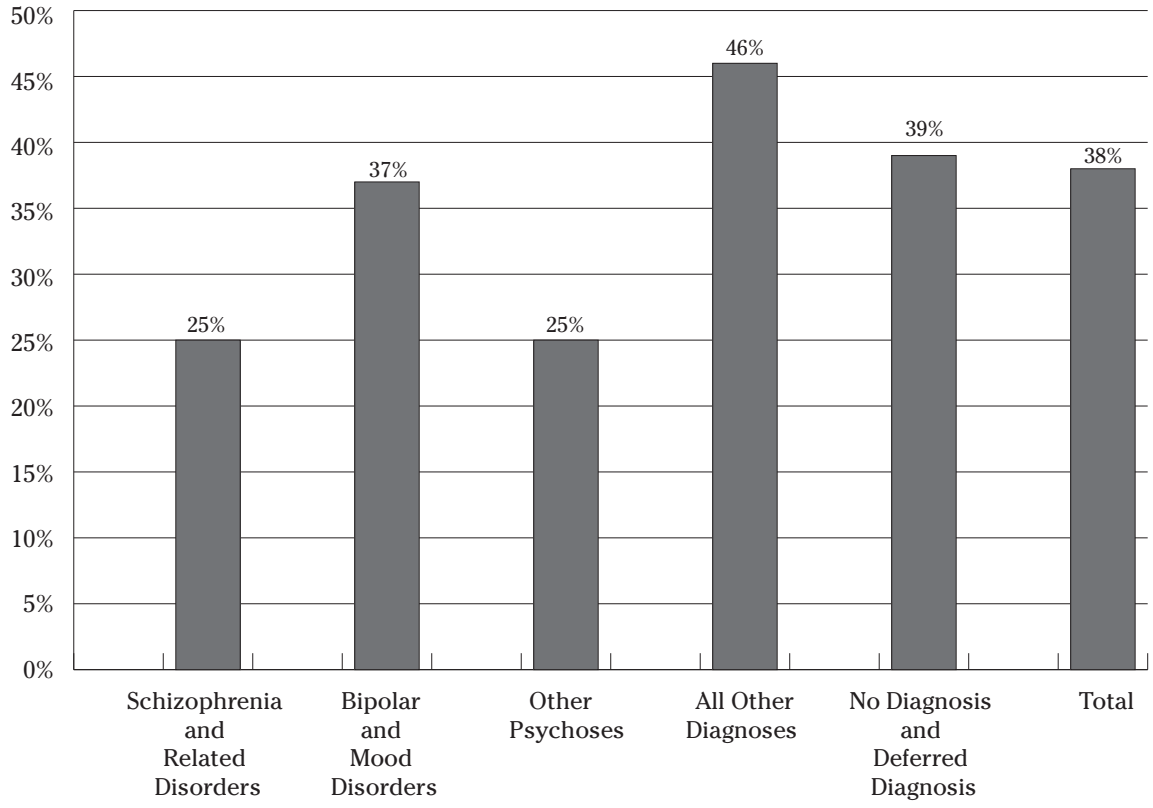
4.6.3 Employment Status of Consumers Served

Twenty-one percent of consumers served in community mental health settings were employed (56 SMHAs reporting). Almost half of adult consumers (46 percent) with known employment status were not in the labor force (i.e., not actively seeking employment), whereas 33 percent were unemployed. In 46 SMHAs, for consumers in the labor force, those with all other diagnoses had the highest employment rate (46 percent), whereas consumers diagnosed with schizophrenia and other psychoses had the lowest employment rate (25 percent). See figure 24 for employment status of adult consumers in the labor force, by diagnosis.

4.6.4 Living Situation of Mental Health Consumers Served

The majority (83 percent) of consumers served with a known living situation lived in private residences (56 SMHAs reporting), with the remainder living in a variety of settings, including foster homes, residential care facilities, institutional settings, and jails/correctional facilities. Three percent of consumers with a known living situation were reported as being homeless or living in shelters. See figure 25 for the percent of consumers served who were living in the different settings.

Figure 24: Employment Status of Adult Consumers, by Diagnosis

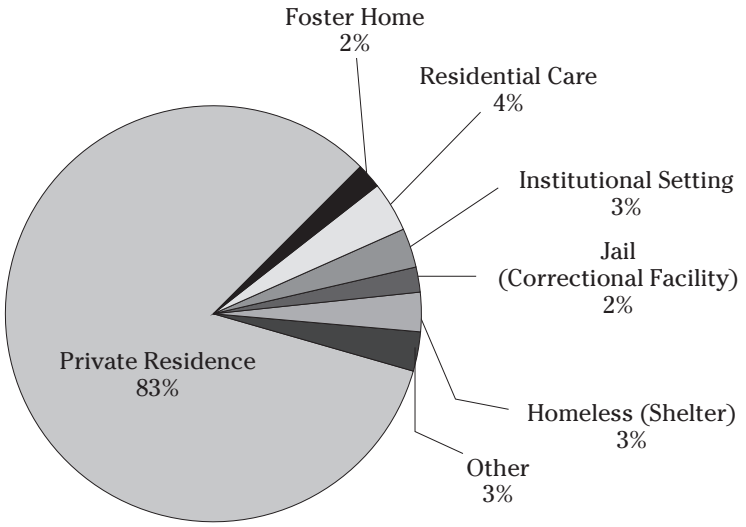


4.7 Financing of Community Mental Health Services

SMHAs used a mixture of state general and special funds, Medicaid, other federal funds, local government funds, and first- and third-party (insurance) funds to finance their community mental health systems. Although state general funds and Medicaid were the most commonly used funding sources, in six states (Alabama, California, Indiana, Maine, South Carolina, and Virginia), the SMHA received dedicated taxes for mental health. In 13 states, local counties/cities or other local taxing entities received dedicated taxes that paid for mental health services.

Table 37 shows the array of different funding sources used by SMHAs to finance community mental health services. Although all states used state general funds to finance some mental health services, state general funds were used most often for case management, crisis services, outpatient services, and supported employment. Medicaid was used most frequently for outpatient testing and treatment and extensive/intensive services as well as case management services. Peer/consumer-run services and inpatient hospital care, as well as residential board and care, were more often funded with state general funds than with Medicaid.

Figure 25: Living Situation of Consumers Served



The Mental Health Block Grant (MHBG) was used to fund a variety of services, with peer/consumer-run, outpatient, and case management being the most common.

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

Fourteen states were planning or implementing changes in how they financed the delivery of community mental health services. Most of the changes in financing were an expansion of the use of managed care or other modifications to control costs. For example, Florida was implementing a managed care entity initiative similar to a managed care or community-based care model. With managing entities, Florida will contract for a system of care, rather than contracting with individual service providers. Minnesota has a County-Health Care Organization collaborative model that will integrate behavioral health, physical health, and social services for adults with serious mental illnesses that are disabled and for children with serious emotional disturbances.

Table 37: Number of States Using Funding Sources for Community Mental Health Services, by Type of Service

Funding Sources	Inpatient Hospital Services	Residential: Room & Board	Residential: Support Services	Outpatient: Testing & Treatment	Extensive/Intensive Outpatient Services	Collateral Treatment	Case Management	Crisis Services	Assertive Community Treatment (ACT)	Supported Employment	School-Based Services	Wraparound Services	In-Home Services	Peer/Consumer-Run Services	Other
State General Fund	36	33	36	40	38	21	40	42	32	37	28	34	24	35	12
State Special Funds	5	5	5	8	6	4	7	7	4	4	4	4	3	3	2
State Medicaid Match	28	6	27	37	32	16	34	29	32	15	21	17	23	15	7
Medicaid (Federal)	20	10	28	41	42	22	39	35	32	19	31	24	29	17	9
Clinic Option	7	0	2	21	19	9	4	11	5	2	6	2	4	1	2
Rehabilitation Option	1	3	17	22	24	11	12	21	21	6	14	10	17	7	2
Targeted Case Management	1	0	3	2	3	3	24	2	5	1	3	3	2	1	1
1915(i) Option	0	0	2	1	2	1	2	1	0	1	0	0	0	1	0
1115 Waiver	5	1	3	5	5	1	7	4	5	3	5	3	5	3	1
1915(b) Waiver	8	3	6	8	8	5	7	7	6	5	8	5	7	5	1
1915(c) Waiver (HCBS)	1	2	8	7	4	5	5	4	1	4	2	8	9	1	2
EPSDT	4	2	5	11	10	3	6	5	0	0	7	2	4	1	2
Other Medicaid	5	0	2	1	2	0	2	1	0	0	1	1	1	1	0
Medicare	21	2	5	17	12	5	4	6	5	1	2	1	2	1	1
Veterans Affairs	6	3	5	8	5	3	6	3	3	3	1	1	2	0	0
SAMHSA MHBG	3	7	21	27	24	9	29	28	21	17	16	20	16	30	14

Table 37: Number of States Using Funding Sources for Community Mental Health Services, by Type of Service (Continued)

Funding Sources	Inpatient Hospital Services	Residential: Room & Board	Residential: Support Services	Outpatient: Testing & Treatment	Extensive/Intensive Outpatient Services	Collateral Treatment	Case Management	Crisis Services	Assertive Community Treatment (ACT)	Supported Employment	School-Based Services	Wraparound Services	In-Home Services	Peer/Consumer-Run Services	Other
Social Services Block Grant	0	1	4	8	7	5	6	4	2	2	2	2	4	2	2
Housing & Urban Development	0	13	5	1	1	1	3	0	1	1	1	1	1	0	0
Other Federal	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0
Local Government	9	10	10	13	12	9	14	14	13	12	11	9	11	9	3
First Party	14	13	11	17	17	9	15	14	11	8	8	8	8	6	1
Third Party	19	8	10	22	18	8	12	15	11	6	8	7	7	5	1
Charity	2	1	2	3	3	2	4	3	2	3	2	2	2	1	0
Other Funds	0	0	1	0	0	0	0	0	0	2	1	0	0	0	0

HCBS = Home and Community-Based Services.
ESPDT = Early and Periodic Screening, Diagnosis, and Treatment.

4.7.1 SMHA-Controlled Expenditures for Community Mental Health Programs, FY 2008

In FY 2008, SMHAs spent 70 percent ($25.6 billion) of their funds on community mental health programs, with California spending the highest amount ($4.3 billion) and South Dakota the lowest ($23.6 million). On a per capita basis, Maine expended the highest amount on community mental health programs ($288.66 for every resident in Maine), and Arkansas expended the lowest amount ($13.85). Of the $25.6 billion expended on community programs, 30 percent was spent for children under age 18, 54 percent was spent for adults over age 18, and 16 percent was unallocated by age (see table 38).

SMHAs expended the majority of their mental health program funds ($16.7 billion) on community-based ambulatory (less than 24-hour) services, accounting for 65 percent of community expenditures. In addition, SMHAs spent $3.6 billion (14 percent) on other 24-hour care (residential) services and $2.8 billion (11 percent) on inpatient and other community services (see table 39). Several states, such as Alaska (43 percent), Illinois (34 percent), Nebraska (26 percent), and Minnesota (25 percent), used their community mental health system to purchase much more psychiatric inpatient services than states do on average. States like Montana (44 percent), Massachusetts (43 percent), Kansas (40 percent), New Jersey (33 percent), Delaware (32 percent), and Maine (30 percent) purchased much higher than average levels of other 24-hour (residential) services through their community mental health system.

In addition to these services provided by community-based providers, state psychiatric hospitals in seven states provided over $373 million of less than 24-hour care, often through clinics staffed by a state hospital and located off its grounds.

4.7.2 Trends in Community Mental Health and State Hospital Ambulatory Expenditures

From FY 1981 to FY 2008, SMHA-controlled expenditures for community mental health and state hospital ambulatory programs increased from $2 billion to $26.3 billion. When constant inflation-adjusted dollars were looked at, expenditures increased from $2 billion in 1981 to $6 billion in 2008, an increase of 200 percent over the 27 years (see figure 26).

From FY 2001 to FY 2008, community mental health and state hospital ambulatory expenditures increased by 8.2 percent per year. However, when adjusted for inflation and population growth, expenditures increased by only 2.9 percent per year. During this period, 49 SMHAs increased their community mental health and state hospital ambulatory expenditures, whereas 2 SMHAs expended less in 2008 than in 2001. As shown in figure 27, over the 27-year period from FY 1981 to FY 2008, SMHA-controlled community and state hospital ambulatory expenditures increased 10 percent per year. When adjusted for inflation and population growth, expenditures increased by only 3.1 percent over this period. During this decade (the 2000s), SMHA-controlled community and state hospital ambulatory expenditures have had slower growth rates than during the 1990s.

Table 38: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Age, FY 2008

State	Children/Adolescents			Adults/Elderly (18 & over)			Unallocated by Age			Total Community Expenditures (in millions)	Per Capita
	Total (in millions)	Per Capita	%	Total (in millions)	Per Capita	%	Total (in millions)	Per Capita	%		
Alabama	$24.70	$22.02	13%	$127.00	$36.00	66%	$39.50	$8.50	21%	$191.20	$41.12
Alaska	$59.83	$332.62	39%	$93.76	$193.45	61%	$0.00	$0.00	0%	$153.59	$231.12
Arizona	$377.20	$220.95	37%	$646.80	$135.50	63%	$0.00	$0.00	0%	$1,024.00	$158.01
Arkansas (a)	$4.87	$6.93	12%	$3.70	$1.72	9%	$30.89	$10.85	78%	$39.46	$13.85
California (b)	$1,526.26	$162.99	36%	$2,740.74	$100.60	64%	$0.21	$0.01	0%	$4,267.21	$116.56
Colorado	$106.18	$87.96	37%	$182.29	$49.19	63%	$0.00	$0.00	0%	$288.46	$58.71
Connecticut (ac)	$0.00	$0.00	0%	$395.90	$147.64	100%	$0.00	$0.00	0%	$395.90	$113.32
Delaware (ac)	NA	NA	NA	$48.20	$72.70	100%	$0.00	$0.00	0%	$48.20	$55.45
District of Columbia	$31.51	$281.28	30%	$73.78	$154.70	70%	$0.00	$0.00	0%	$105.29	$178.78
Florida	$83.31	$20.81	21%	$305.16	$21.41	79%	$0.00	$0.00	0%	$388.47	$21.28
Georgia (a)	$74.66	$29.29	29%	$182.96	$25.86	71%	NA	NA	NA	$257.62	$26.77
Hawaii (c)	$64.94	$227.69	35%	$123.10	$127.51	65%	$0.00	$0.00	0%	$188.04	$150.35
Idaho	$11.13	$26.97	31%	$24.30	$21.96	69%	$0.00	$0.00	0%	$35.42	$23.32
Illinois	$244.10	$76.78	32%	$520.70	$53.75	68%	$0.00	$0.00	0%	$764.80	$59.44
Indiana	$112.25	$70.84	30%	$259.52	$54.20	70%	NA	NA	NA	$371.77	$58.33
Iowa	$0.00	$0.00	0%	$3.70	$1.62	1%	$318.64	$106.20	99%	$322.34	$107.43
Kansas	$107.30	$153.18	49%	$72.30	$34.73	33%	$40.20	$14.45	18%	$219.80	$79.00
Kentucky	$43.60	$43.25	43%	$56.20	$17.31	56%	$0.80	$0.19	1%	$100.60	$23.64
Louisiana	$16.85	$15.20	14%	$107.42	$32.67	86%	$0.00	$0.00	0%	$124.27	$28.27
Maine (b)	$187.08	$680.61	49%	$190.24	$183.26	50%	$1.68	$1.28	0%	$379.00	$288.66

Table 38: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Age, FY 2008 (Continued)

State	Children/Adolescents			Adults/Elderly (18 & over)			Unallocated by Age			Total Community Expenditures (in millions)	Per Capita
	Total (in millions)	Per Capita	%	Total (in millions)	Per Capita	%	Total (in millions)	Per Capita	%		
Maryland	$224.19	$167.23	38%	$291.86	$68.45	50%	$70.96	$12.66	12%	$587.01	$104.74
Massachusetts (a)	$91.10	$63.84	14%	$537.90	$106.20	86%	$0.00	$0.00	0%	$629.00	$96.89
Michigan (b)	$167.80	$70.20	15%	$957.50	$125.84	85%	$0.00	$0.00	0%	$1,125.30	$112.54
Minnesota	$175.08	$139.55	28%	$447.51	$112.97	72%	$0.00	$0.00	0%	$622.60	$119.37
Mississippi	$64.50	$84.12	41%	$92.50	$42.91	59%	$0.00	$0.00	0%	$157.00	$53.72
Missouri	$40.96	$28.82	20%	$168.78	$37.75	80%	$0.00	$0.00	0%	$209.74	$35.60
Montana	$58.54	$265.64	51%	$55.75	$74.99	49%	$0.00	$0.00	0%	$114.28	$118.58
Nebraska (b)	$6.88	$15.39	10%	$64.06	$48.18	90%	$0.00	$0.00	0%	$70.94	$39.93
Nevada	$22.54	$33.75	17%	$106.66	$55.49	83%	$0.00	$0.00	0%	$129.19	$49.88
New Hampshire	$21.75	$74.14	22%	$14.47	$14.17	15%	$62.83	$47.80	63%	$99.05	$75.35
New Jersey (b)	$373.75	$182.54	32%	$801.13	$120.97	68%	$7.29	$0.84	1%	$1,182.18	$136.35
New Mexico (ac)	$94.86	$188.80	66%	$49.72	$33.77	34%	$0.00	$0.00	0%	$144.59	$73.21
New York (b)	$0.00	$0.00	0%	$0.00	$0.00	0%	$2,629.80	$135.10	100%	$2,629.80	$135.10
North Carolina	$950.57	$423.67	66%	$490.46	$71.31	34%	$5.29	$0.58	0%	$1,446.32	$158.56
North Dakota	$3.94	$27.55	13%	$26.16	$53.26	87%	$0.00	$0.00	0%	$30.10	$47.46
Ohio	$199.71	$73.14	34%	$396.43	$45.33	66%	NA	NA	NA	$596.14	$51.94
Oklahoma (b)	$12.30	$13.58	9%	$118.80	$43.76	91%	$0.00	$0.00	0%	$131.10	$36.21
Oregon	$97.71	$112.63	29%	$237.97	$81.52	71%	$0.00	$0.00	0%	$335.69	$88.65
Pennsylvania (ac)	$1,458.54	$528.07	51%	$1,174.84	$121.39	41%	$240.00	$19.29	8%	$2,873.38	$230.98
Rhode Island (c)	NA	NA	NA	$82.13	$100.40	100%	NA	NA	NA	$82.13	$78.48

Table 38: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Age, FY 2008 (Continued)

State	Children/Adolescents			Adults/Elderly (18 & over)			Unallocated by Age			Total Community Expenditures (in millions)	Per Capita
	Total (in millions)	Per Capita	%	Total (in millions)	Per Capita	%	Total (in millions)	Per Capita	%		
South Carolina	$49.70	$46.63	29%	$118.50	$35.13	70%	$1.70	$0.38	1%	$169.90	$38.28
South Dakota	$7.83	$39.50	33%	$14.50	$24.05	61%	$1.29	$1.61	5%	$23.62	$29.49
Tennessee	$156.90	$106.12	38%	$257.00	$54.40	62%	$0.00	$0.00	0%	$413.90	$66.73
Texas (b)	$87.10	$12.95	17%	$411.40	$23.52	83%	$0.00	$0.00	0%	$498.50	$20.59
Utah (b)	$41.29	$48.60	34%	$81.24	$43.18	66%	NA	NA	NA	$122.54	$44.87
Vermont	$62.80	$487.09	56%	$49.50	$100.68	44%	$0.00	$0.00	0%	$112.30	$180.95
Virginia	$92.30	$50.63	26%	$265.10	$45.50	74%	$0.00	$0.00	0%	$357.40	$46.73
Washington	$107.00	$69.43	21%	$257.20	$51.85	52%	$134.40	$20.67	27%	$498.60	$76.68
West Virginia (b)	$5.20	$13.47	5%	$22.90	$16.05	24%	$68.20	$37.62	71%	$96.30	$53.12
Wisconsin	NA	NA	NA	NA	NA	NA	$391.77	$69.65	100%	$391.77	$69.65
Wyoming (b)	$13.80	$107.44	31%	$30.33	$75.63	69%	$0.00	$0.00	0%	$44.13	$83.35
Total	$7,764.41	$105.01	30%	$13,780.07	$65.75	54%	$4,045.46	$30.82	16%	$25,589.94	$84.49
Average (Mean)	$152.24			$270.20			$79.32			$501.76	
Median	$74.66	$73.14		$123.10	$53.26		$39.85	$11.75		$219.80	$69

Note: In some states (Connecticut, Delaware, and Rhode Island), a separate state agency was responsible for providing mental health services to children.
a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
b = SMHA-controlled expenditures include funds for mental health services in jails or prison.
c = Children's mental health expenditures are not included in SMHA-controlled expenditures.
NA = Services are provided, but exact expenditures are unallocatable.

Table 39: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Service Type, FY 2008 (in millions)

State	Inpatient		Other 24-Hour Care		Less Than 24-Hour Care		Other/Not Available		Community Expenditures
	$	%	$	%	$	%	$	%	$
Alabama	$2.40	1%	$45.50	24%	$115.60	61%	$27.70	15%	$191.20
Alaska (a)	$66.40	43%	$18.50	12%	$68.70	45%	$0.00	0%	$153.60
Arizona	$135.20	13%	$84.40	8%	$804.40	79%	$0.00	0%	$1,024.00
Arkansas (a)	NA	0%	NA	NA	$39.50	100%	NA	NA	$39.50
California	$322.30	8%	$387.40	9%	$3,093.60	73%	$463.90	11%	$4,267.20
Colorado	$0.00	0%	$0.70	0%	$2.80	1%	$285.00	99%	$288.50
Connecticut (ac)	$44.40	11%	$79.30	20%	$272.20	69%	$0.00	0%	$395.90
Delaware (ac)	$4.00	8%	$15.20	32%	$24.10	50%	$4.90	10%	$48.20
District of Columbia	$0.00	0%	$6.50	6%	$98.80	94%	$0.00	0%	$105.30
Florida	$0.00	0%	$93.10	24%	$295.30	76%	$0.00	0%	$388.50
Georgia	NA	0%	$27.50	11%	$230.10	89%	NA	NA	$257.60
Hawaii	$14.20	8%	$47.30	25%	$111.90	60%	$14.70	8%	$188.00
Idaho	$0.00	0%	$1.60	5%	$33.80	95%	$0.00	0%	$35.40
Illinois	$262.80	34%	$127.50	17%	$374.50	49%	$0.00	0%	$764.80
Indiana	NA	0%	NA	NA	NA	NA	$371.80	100%	$371.80
Iowa	$5.10	2%	$33.30	10%	$64.20	20%	$219.80	68%	$322.30
Kansas	NA	0%	$86.90	40%	$132.90	61%	NA	NA	$219.80
Kentucky	$0.00	0%	$23.70	24%	$76.90	76%	$0.00	0%	$100.60
Louisiana	$8.00	7%	$1.80	2%	$114.40	92%	$0.00	0%	$124.30

Table 39: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Service Type, FY 2008 (in millions) (Continued)

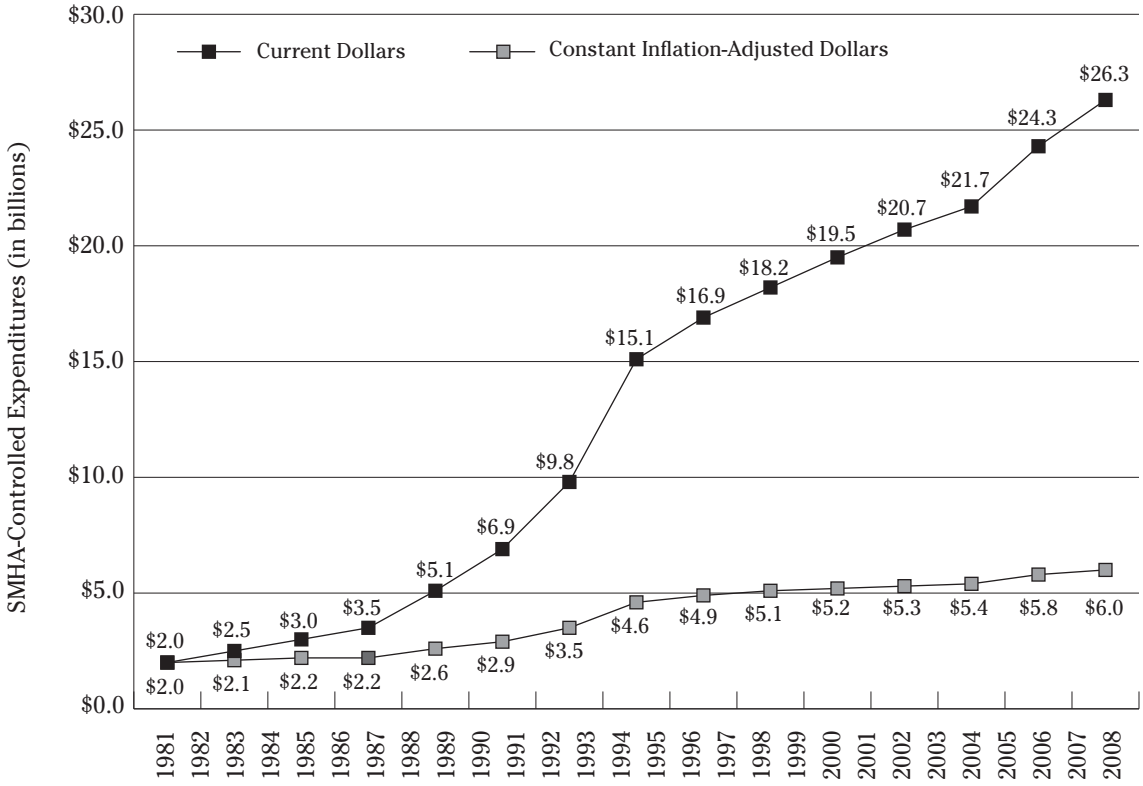
State	Inpatient		Other 24-Hour Care		Less Than 24-Hour Care		Other/Not Available		Community Expenditures
	$	%	$	%	$	%	$	%	$
Maine (b)	$62.20	16%	$115.40	30%	$200.00	53%	$1.40	0%	$379.00
Maryland (b)	$100.50	17%	$86.90	15%	$399.60	68%	$0.00	0%	$587.00
Massachusetts (c)	$94.20	15%	$271.90	43%	$262.90	42%	$0.00	0%	$629.00
Michigan (b)	$132.40	12%	$202.20	18%	$570.70	51%	$220.00	20%	$1,125.30
Minnesota	$152.60	25%	$67.30	11%	$402.70	65%	$0.00	0%	$622.60
Mississippi (b)	$0.00	0%	$0.00	0%	$157.00	100%	$0.00	0%	$157.00
Missouri	$3.40	2%	$25.30	12%	$181.00	86%	$0.00	0%	$209.70
Montana	$4.70	4%	$50.60	44%	$59.00	52%	$0.00	0%	$114.30
Nebraska (b)	$18.20	26%	$10.80	15%	$41.90	59%	$0.00	0%	$70.90
Nevada	$0.00	0%	$25.40	20%	$103.80	80%	$0.00	0%	$129.20
New Hampshire	$1.70	2%	$14.20	14%	$70.90	72%	$12.30	12%	$99.10
New Jersey	$200.10	17%	$384.60	33%	$545.30	46%	$52.20	4%	$1,182.20
New Mexico	$18.90	13%	$43.20	30%	$82.40	57%	$0.00	0%	$144.60
New York (b)	$595.80	23%	$521.30	20%	$1,512.70	58%	$0.00	0%	$2,629.80
North Carolina	$61.00	4%	$213.80	15%	$1,141.50	79%	$30.00	2%	$1,446.30
North Dakota	$0.20	1%	$5.50	18%	$24.30	81%	$0.00	0%	$30.10
Ohio	$6.80	1%	$51.00	9%	$538.40	90%	NA	NA	$596.10
Oklahoma	$15.30	12%	$5.80	4%	$110.00	84%	$0.00	0%	$131.10
Oregon	$18.50	6%	$70.60	21%	$82.40	25%	$164.30	49%	$335.70

Table 39: SMHA-Controlled Mental Health Expenditures for Community-Based Programs, by Service Type, FY 2008 (in millions) (Continued)

State	Inpatient		Other 24-Hour Care		Less Than 24-Hour Care		Other/Not Available		Community Expenditures
	$	%	$	%	$	%	$	%	$
Pennsylvania (b)	$198.40	7%	$40.80	1%	$2,394.20	83%	$240.00	8%	$2,873.40
Rhode Island (c)	$2.10	3%	$16.80	20%	$63.30	77%	NA	NA	$82.10
South Carolina	$1.70	1%	$31.70	19%	$134.80	79%	$1.70	1%	$169.90
South Dakota	$0.00	0%	$0.00	0%	$23.60	100%	$0.00	0%	$23.60
Tennessee	$86.60	21%	$0.00	0%	$327.30	79%	$0.00	0%	$413.90
Texas (b)	$23.60	5%	$18.50	4%	$0.00	0%	$456.40	92%	$498.50
Utah (b)	$14.20	12%	$17.70	14%	$90.70	74%	NA	NA	$122.50
Vermont	$3.10	3%	$22.50	20%	$86.70	77%	$0.00	0%	$112.30
Virginia (b)	$13.60	4%	$82.40	23%	$261.40	73%	$0.00	0%	$357.40
Washington	$62.20	13%	$14.90	3%	$419.40	84%	$2.10	0%	$498.60
West Virginia (b)	$6.80	7%	NA	NA	$89.50	93%	$0.00	0%	$96.30
Wisconsin	$43.50	11%	$59.60	15%	$288.70	74%	NA	NA	$391.80
Wyoming (a)	$0.00	0%	$0.00	0%	$44.10	100%	$0.00	0%	$44.10
Total	$2,807.20	11%	$3,550.90	14%	$16,663.70	65%	$2,568.10	10%	$25,589.90
Average (Mean)	$55.00		$69.60		$326.70		$50.40		$501.80
Median	$18.70		$42.00		$115.60		$52.20		$219.80

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

Figure 26: Trends in SMHA-Controlled Spending for Community and State Hospital Ambulatory Mental Health Services, FY 1981 to FY 2008



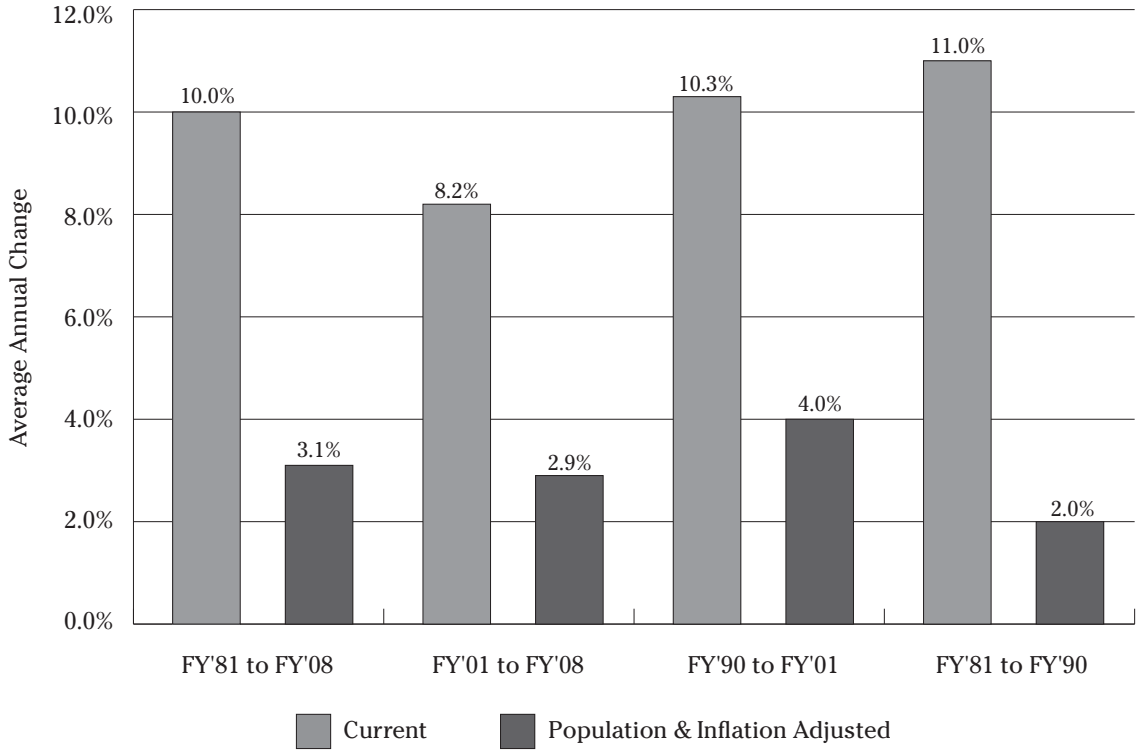
4.7.3 SMHA-Controlled Revenues for Community Mental Health Programs, FY 2008

SMHAs controlled $26.1 billion in revenues (70 percent of total SMHA-controlled revenues) dedicated to community mental health programs in FY 2008. SMHAs received funding from a variety of sources, including state general funds, Medicaid, Medicare, local government, MHBG, and other state and federal sources.

In FY 2008, 54.7 percent of SMHA-controlled funds came from state government sources. The largest share of state funds came from state general and other funds (31.2 percent) and the state Medicaid match (23.6 percent).

The federal government was the second largest funding source (37.3 percent) of the SMHAs' community mental health revenues. Federal Medicaid was the single largest source of revenues, accounting for 32.8 percent, whereas the MHBG (1.5 percent), Medicare (1.2 percent), Social Services Block Grant (0.3 percent), and other SAMHSA (0.4 percent) and other federal funds (1.1 percent) together accounted for 4.5 percent of the SMHA-controlled revenues. Overall, Medicaid (combined state match and federal share) was the largest single funding source of SMHA-controlled community programs at 56.4 percent.

Figure 27: Average Annual Change in SMHA-Controlled Community and State Hospital Ambulatory Mental Health Services Expenditures, by Decade, FY 1981 to FY 2008

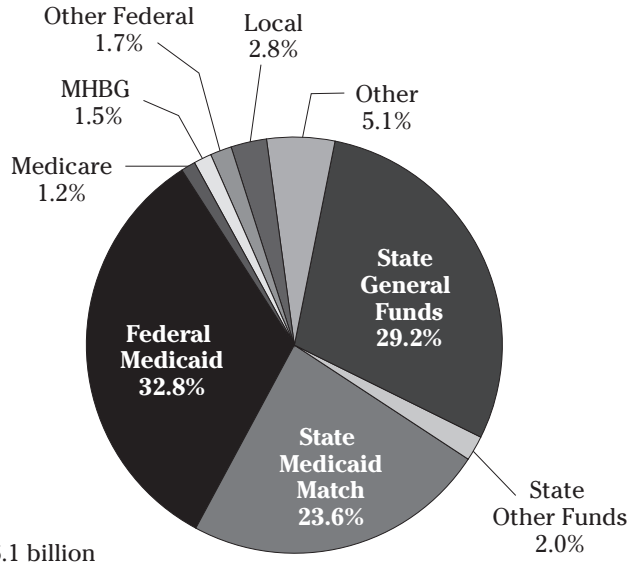


In addition, other SMHA-controlled revenues for community mental health programs included 2.8 percent from local city and county governments and an additional 5.1 percent from other sources. Such sources included private health insurance reimbursement and consumer copays, as well as donations and all other funding sources (see figure 28 for a breakdown of total revenues, by funding source, and table 40).

4.7.4 Trends in SMHA-Controlled Expenditures and Revenues for Community Mental Health Services

The sources of revenue SMHAs relied on to provide community mental health services have shifted over time. Traditionally, state government tax dollars appropriated to the SMHA as general or special funds were the largest source of revenue for SMHAs. In FY 1981, state general funds represented 80 percent of the SMHAs' community mental health revenues, whereas Medicaid (state and federal) accounted for only 2 percent. Since 1981, state general funds declined while Medicaid funds increased, and in FY 2002, Medicaid became the largest single source of revenue, representing 44 percent of community mental health revenues (see figure 29). In FY 2008, Medicaid contributed 56 percent of all revenues for community mental health services.

Figure 28: Percentage of SMHA-Controlled Revenues for Community Mental Health Programs, by Funding Sources, FY 2008



Total SMHA Revenues = $26.1 billion

Note: Numbers are rounded.

4.7.5 Initiatives To Transform Financing of Mental Health Services

Thirty-two SMHAs planned or implemented changes in how the delivery of mental health services was financed. In Arizona, state general funds for non-Title IX individuals were limited to crisis services, supported housing, and medications. Colorado developed a unit costing and relative value unit system. For the Children's Division, Connecticut planned to use more blended funding approaches. Florida implemented a managing entity initiative in which the department contracts for a system of care, rather than contract with individual service providers. In Georgia, there were ongoing conversations with child-serving agencies (the SMHA, Juvenile Justice, Child Welfare, and Education) regarding opportunities for blending/braiding funding streams. The SMHA in Kentucky explored the potential use of a 1915 waiver under the new Health Care Reform Act. Maine planned to begin a three-phase, 3-year managed care initiative for all Medicaid services in 2012. Minnesota reported plans to implement a county-Health Care Operations collaborative model to integrate behavioral health, physical health, and social services. North Carolina planned to expand its current waiver from one to two local management entities. New Hampshire planned to apply for a 1915(b) waiver and to switch from its current fee-for-service system to a per member per month capitation model. Vermont's Medicaid waiver allowed it to fund different financing models. West Virginia's Medicaid office planned to move all Temporary Assistance for Needy Families and Supplemental Security Income recipients into a managed care program.

Table 40: SMHA-Controlled Community Mental Health Revenues, by Funding Source and State, FY 2008 (in millions)

State	State General and Other Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd-Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Alabama	$71.90	37%	$109.60	56%	$0.00	0%	$6.70	3%	$1.30	1%	$0.00	0%	$0.00	0%	$7.00	4%	$196.50
Alaska	$29.00	19%	$123.60	80%	$0.00	0%	$0.60	0%	$0.30	0%	$0.00	0%	$0.00	0%	$0.00	0%	$153.60
Arizona	$116.00	11%	$858.70	84%	$0.00	0%	$8.10	1%	$2.10	0%	$0.00	0%	$40.50	4%	$0.00	0%	$1,025.40
Arkansas (a)	$33.10	84%	$0.00	0%	$0.00	0%	$3.70	9%	$2.60	7%	$0.00	0%	$0.00	0%	$0.00	0%	$39.50
California (b)	$1,247.70	29%	$2,108.00	49%	$34.70	1%	$56.60	1%	$7.20	0%	$0.00	0%	$23.79	1%	$789.27	18%	$4,267.20
Colorado	$43.10	15%	$236.60	82%	$0.00	0%	$5.20	2%	$3.50	1%	$0.00	0%	$0.00	0%	$0.00	0%	$288.50
Connecticut (ac)	$375.60	93%	$10.20	3%	$1.90	0%	$5.00	1%	$9.80	2%	$0.00	0%	$0.20	0%	$2.30	1%	$405.00
Delaware (ac)	$31.00	64%	$14.90	31%	$0.10	0%	$0.30	1%	$1.90	4%	$0.00	0%	$0.00	0%	$0.00	0%	$48.20
District of Columbia	$84.30	91%	$5.70	6%	$0.00	0%	$0.80	1%	$1.60	2%	$0.00	0%	$0.00	0%	$0.00	0%	$92.30
Florida	$324.10	83%	$19.40	5%	$0.00	0%	$25.10	6%	$19.90	5%	$0.00	0%	$0.00	0%	$0.00	0%	$388.50
Georgia (a)	$224.00	87%	NA	NA	NA	NA	$15.00	6%	$5.80	2%	NA	NA	NA	NA	$12.86	5%	$257.60
Hawaii (c)	$156.70	87%	$19.90	11%	$0.20	0%	$1.90	1%	$1.40	1%	$0.00	0%	$0.30	0%	$0.00	0%	$180.40
Idaho	$26.10	74%	$3.10	9%	$0.00	0%	$1.70	5%	$4.10	11%	$0.00	0%	$0.39	1%	$0.00	0%	$35.40
Illinois	$315.30	41%	$427.60	56%	$0.00	0%	$15.30	2%	$6.60	1%	$0.00	0%	$0.00	0%	$0.00	0%	$764.80
Indiana	$45.10	12%	$312.50	84%	$0.00	0%	$7.40	2%	$6.70	2%	$0.00	0%	$0.00	0%	$0.00	0%	$371.80
Iowa	$58.20	19%	$205.10	66%	$0.00	0%	$3.30	1%	$13.90	4%	$31.00	10%	$0.00	0%	$0.00	0%	$311.50
Kansas	$54.60	25%	$162.40	74%	NA	NA	$2.50	1%	$0.30	0%	NA	NA	NA	NA	NA	NA	$219.80
Kentucky	$55.80	55%	$33.30	33%	$0.90	1%	$5.40	5%	$3.40	3%	$0.00	0%	$1.80	2%	$0.00	0%	$100.60
Louisiana	$60.70	49%	$8.30	7%	$0.00	0%	$3.00	2%	$41.00	33%	$0.00	0%	$0.00	0%	$11.30	9%	$124.30
Maine (b)	$38.30	10%	$337.60	89%	$0.00	0%	$1.70	0%	$1.40	0%	$0.00	0%	$0.00	0%	$0.00	0%	$379.00

Table 40: SMHA-Controlled Community Mental Health Revenues, by Funding Source and State, FY 2008 (in millions) (Continued)

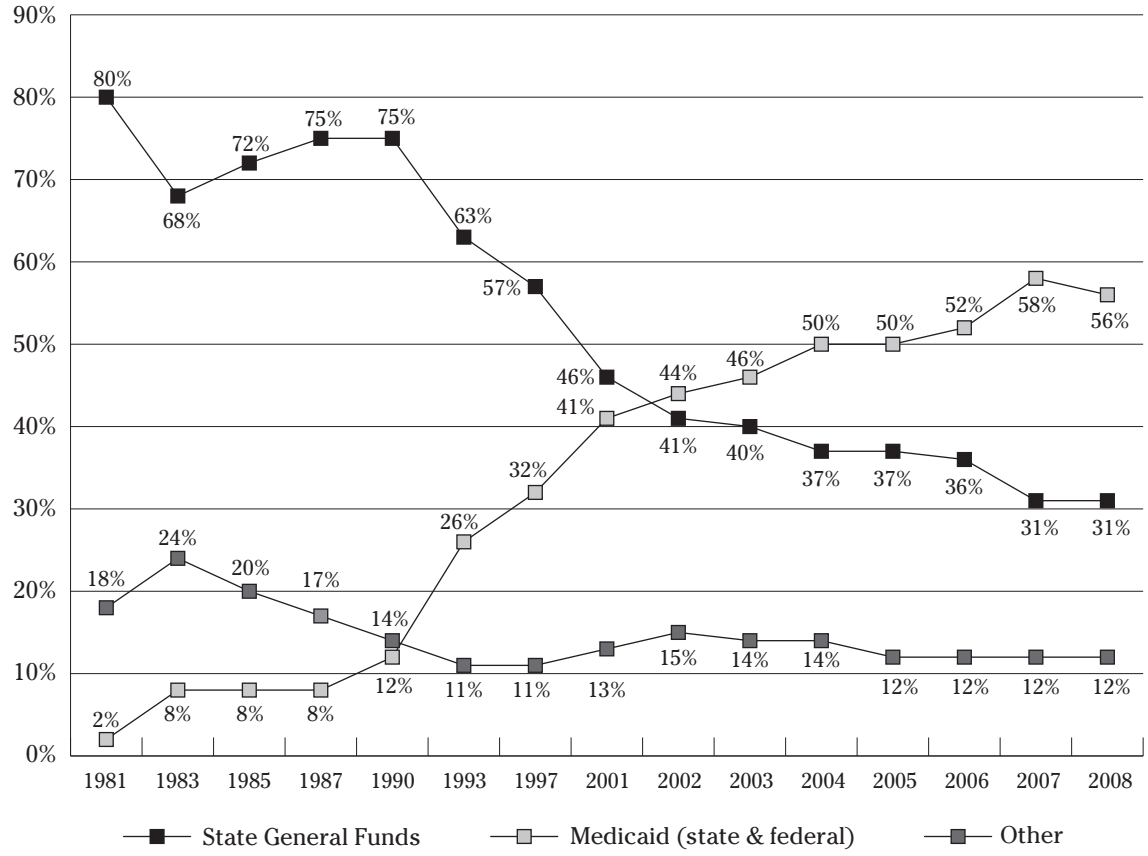
State	State General and Other Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd-Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Maryland	$337.00	57%	$231.70	39%	$0.00	0%	$10.50	2%	$7.80	1%	$0.00	0%	$0.00	0%	$0.00	0%	$587.00
Massachusetts (a)	$615.80	79%	$139.20	18%	$4.30	1%	$7.70	1%	$5.50	1%	$0.00	0%	$0.40	0%	$5.10	1%	$778.00
Michigan (b)	$189.00	17%	$847.30	75%	NA	NA	$14.70	1%	$31.70	3%	$15.90	1%	NA	NA	$26.70	2%	$1,125.30
Minnesota	$217.00	35%	$357.60	57%	$0.00	0%	$5.80	1%	$13.00	2%	$12.60	2%	$6.24	1%	$10.43	2%	$622.60
Mississippi	$17.40	11%	$131.40	84%	$0.00	0%	$3.90	2%	$4.30	3%	$0.00	0%	$0.00	0%	$0.00	0%	$157.00
Missouri	$75.00	34%	$122.20	56%	$9.60	4%	$6.50	3%	$5.90	3%	$0.00	0%	$0.00	0%	$0.46	0%	$219.60
Montana	$19.50	17%	$91.40	80%	$0.00	0%	$1.20	1%	$2.20	2%	$0.00	0%	$0.00	0%	$0.00	0%	$114.30
Nebraska (b)	$40.70	57%	$16.10	23%	$0.00	0%	$2.60	4%	$0.30	0%	$0.00	0%	$7.10	10%	$4.13	6%	$70.90
Nevada	$87.90	68%	$19.40	15%	$5.10	4%	$1.60	1%	$8.30	6%	$0.00	0%	$1.01	1%	$5.82	5%	$129.20
New Hampshire	$3.90	4%	$86.30	87%	$2.50	2%	$1.40	1%	$4.90	5%	$0.00	0%	$0.00	0%	$0.00	0%	$99.00
New Jersey (b)	$595.80	50%	$423.10	36%	$30.90	3%	$11.80	1%	$6.20	1%	$43.00	4%	$37.15	3%	$34.30	3%	$1,182.20
New Mexico (ac)	$29.60	20%	$113.00	78%	$0.00	0%	$1.90	1%	$0.10	0%	$0.00	0%	$0.00	0%	$0.00	0%	$144.60
New York (b)	$461.00	18%	$1,409.60	56%	$223.90	9%	$26.50	1%	$84.40	3%	$54.40	2%	$166.40	7%	$111.00	4%	$2,537.20
North Carolina	$90.20	6%	$1,287.30	89%	NA	NA	$9.80	1%	$1.80	0%	$57.10	4%	NA	NA	NA	NA	$1,446.30
North Dakota	$13.90	46%	$7.20	24%	$0.00	0%	$0.80	3%	$5.50	18%	$0.00	0%	$0.00	0%	$2.73	9%	$30.10
Ohio	$267.00	26%	$354.40	35%	NA	NA	$13.30	1%	$13.30	1%	$362.10	36%	NA	NA	NA	NA	$1,010.10
Oklahoma (b)	$103.60	79%	$17.10	13%	$1.90	1%	$4.10	3%	$1.90	1%	$0.00	0%	$0.70	1%	$1.80	1%	$131.10
Oregon	$64.40	19%	$266.10	79%	$0.00	0%	$3.70	1%	$0.50	0%	$0.00	0%	$0.00	0%	$0.93	0%	$335.70
Pennsylvania (ac)	$552.50	19%	$2,216.00	77%	$0.00	0%	$14.40	1%	$71.70	2%	$18.80	1%	$0.00	0%	$0.00	0%	$2,873.40
Rhode Island (c)	$13.10	16%	$67.60	82%	NA	NA	$1.10	1%	$0.30	0%	$0.00	0%	NA	NA	NA	NA	$82.10
South Carolina	$67.40	38%	$80.20	46%	$0.00	0%	$5.60	3%	$8.50	5%	$3.10	2%	$10.90	6%	$0.50	0%	$176.20
South Dakota	$8.90	39%	$11.80	51%	$0.00	0%	$0.90	4%	$1.40	6%	$0.00	0%	$0.20	1%	$0.00	0%	$23.20
Tennessee	$28.20	7%	$374.60	91%	$0.00	0%	$7.60	2%	$3.50	1%	$0.00	0%	$0.00	0%	$0.00	0%	$413.90

Table 40: SMHA-Controlled Community Mental Health Revenues, by Funding Source and State, FY 2008 (in millions) (Continued)

State	State General and Other Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd-Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Texas (b)	$292.70	59%	$125.20	25%	$0.00	0%	$30.80	6%	$25.40	5%	$19.70	4%	$4.70	1%	$0.00	0%	$498.50
Utah (b)	$6.00	5%	$112.10	91%	NA	NA	$2.70	2%	$1.70	1%	NA	NA	NA	NA	NA	NA	$122.50
Vermont	$1.00	1%	$108.70	97%	$0.00	0%	$0.80	1%	$1.80	2%	$0.00	0%	$0.00	0%	$0.00	0%	$112.30
Virginia	$171.70	48%	$175.20	49%	$0.00	0%	$9.90	3%	$0.60	0%	$0.00	0%	$0.00	0%	$0.00	0%	$357.40
Washington	$171.20	34%	$311.70	63%	$0.00	0%	$8.30	2%	$1.00	0%	$0.00	0%	$0.00	0%	$6.40	1%	$498.60
West Virginia (b)	$43.60	45%	$50.40	52%	$0.00	0%	$2.00	2%	$0.30	0%	$0.00	0%	$0.00	0%	$0.00	0%	$96.30
Wisconsin	$110.90	28%	$144.60	37%	NA	NA	$7.40	2%	$4.50	1%	$124.50	32%	NA	NA	NA	NA	$391.80
Wyoming (b)	$31.80	72%	$9.50	22%	$0.00	0%	$0.50	1%	$2.40	5%	$0.00	0%	$0.00	0%	$0.00	0%	$44.10
Total	$8,118.10	31%	$14,704.60	56%	$315.90	1%	$389.30	1%	$455.40	2%	$742.10	3%	$301.78	1%	$1,033.03	5%	$26,060.30
Average (Mean)	$159.20		$288.30		$6.20		$7.60		$8.90		$14.60		$7.02		$22.96		$511.00
Median	$67.40		$123.60		$2.50		$5.00		$3.50		$31.00		$0.00		$0.00		$219.80

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

Figure 29: Percentage of SMHA-Controlled Revenues for Community Mental Health Services From Major Funding Sources, FY 1981 to FY 2008



4.8 Summary

In 2009, 95 percent of consumers served by the SMHAs received community-based services. SMHAs provide a wide variety of services in community settings. Extensive/intensive outpatient treatment (48), crisis services including mobile crisis (48), outpatient testing and treatment (47), and case management (46) were the most frequently offered services. SMHAs devoted a significant portion of their SMHA-controlled revenues on community mental health services. In FY 2008, SMHAs spent $25.6 billion, or 70 percent of their funds, on community mental health programs. The majority (65 percent) of these funds were spent on community-based ambulatory services (less than 24-hour care). Funding for these community-based services came from a variety of sources, with Medicaid (56.4 percent) and state general revenues, along with other state funds (31.2 percent), provided most of the funding.

SMHAs organized and funded their community mental health services using several different organizational approaches. Most commonly (39 states), the SMHA directly funded, but did not operate, local community-based agencies. In 19 states, the SMHA funded county or city mental health authorities either statewide (16) or in parts of the state (3). In 14 states, the SMHAs directly operated community programs.

V. Psychiatric Hospitalization and Forensic Services

In 2009, psychiatric hospitals and wards operated by State Mental Health Agencies (SMHAs) served 2.6 percent of all mental health consumers who received services provided by the SMHA, or 167,002 individuals. These hospitals had expenditures of $10.3 billion, or 28 percent of all SMHA-controlled expenditures. In 2010, 49 SMHAs operated and staffed, or funded, 216 state psychiatric hospitals that provided specialized inpatient psychiatric care. Rhode Island was the only state that did not have a stand-alone state-operated psychiatric hospital; however, Rhode Island's SMHA operated psychiatric beds within the state's general hospital.

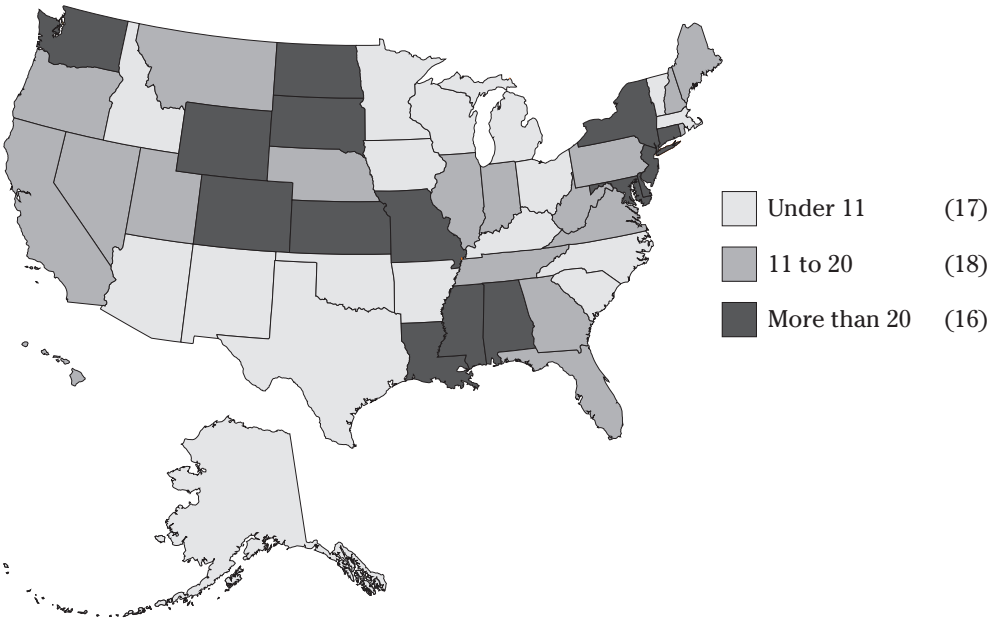
Forty-four SMHAs were responsible for the operation of state psychiatric hospitals, whereas in six states, another agency was tasked with this responsibility, most commonly the Department of Health and Human Services. In North Carolina, the state psychiatric hospitals were operated by the Division of State Operated Healthcare Facilities. States varied widely in the rate of hospitalization per 1,000 state population, ranging from a low of 0.1 in Arizona and Michigan to 2.7 in South Dakota, whereas the U.S. rate was 0.5. The rate of hospital residents per 100,000 state population, measured at the start of the year, was 15 for the United States and ranged from 3.9 in Arizona to 68.8 in the District of Columbia (see figure 30 and table 41).

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

5.1 Characteristics of Persons Served in State Hospitals

In 2009, 167,002 consumers were served in state psychiatric hospitals (2.6 percent of the total population receiving services from SMHAs). Most consumers (82 percent) served in psychiatric hospitals ages 21 to 64 (see figure 31 for a complete breakdown, by age and gender). Sixteen states did not provide services to children in state psychiatric hospitals. Of the 35 states that provided services to adults and children, children made up 5 percent of consumers served at the beginning of 2009. Males represented 64 percent of patients in state psychiatric hospitals.

Figure 30: State Psychiatric Hospital Residents per 100,000 Population



The average length of stay (LOS) for discharged consumers was 196 days. The median LOS in state psychiatric hospitals for children (ages 0 to 17) was 78, ranging from a minimum of 2 days in Wisconsin (18 states reported 0 days) to a maximum of 354 days in Nebraska. The median LOS for adults (ages 18 and older) was 155 days, ranging from a minimum of 1 day in the District of Columbia (two states reported 0 days) to a maximum of 173 days in Florida (see table 41).

5.2 Role of State Psychiatric Hospitals

Every state government operated psychiatric inpatient beds that provided services to consumers with high levels of need, including those who were a threat to themselves and/or others. State psychiatric hospitals provided acute care services, long-term treatment, and often, forensic services to mental health consumers. Most states used their state psychiatric hospitals to serve adults, elderly consumers, and forensic patients. Thirty-five SMHAs used psychiatric hospital beds to treat children and adolescents. Thirteen SMHAs used their state psychiatric hospitals to provide acute, intermediate, and long-term inpatient care to all population groups (children, adolescents, adults, elderly, and forensic). See table 42 for the number of SMHAs that provided psychiatric inpatient care to particular populations.

Table 41: Number of State-Operated Psychiatric Hospitals, Residents, and Length of Stay

State	Number of State Hospitals (state operated & funded, 2010)	Number of Residents (start of year)[1]	Number of Children (0–17, start of year)[1]	Number of Adults (18+, start of year)[1]	Residents per 100,000 Population[2]	State Hospital Admissions (2009)[1]	Median LOS (days)—Children 0–17 (discharged clients)[1]	Median LOS (days)—Adults 18+ (discharged clients)[1]
Alabama	6	1,130	6	1,124	24.2	2,628	135	54
Alaska	1	72	5	67	10.5	1,173	24	9
Arizona	1	252	6	246	3.9	161	155	146
Arkansas	1	203	31	172	7.1	962	265	35
California	5	5,144	0	5,144	14.0	3,098	0	150
Colorado	2	1,314	64	1,250	26.6	2,344	10	19
Connecticut	3	711	61	650	20.3	1,392	85	62
Delaware	1	273	0	273	31.3	449	0	17
District of Columbia	1	407	0	407	68.8	260	0	1
Florida	7	3,242	0	3,242	17.7	2,654	0	173
Georgia	7	1,133	88	1,045	11.7	11,137	7	8
Hawaii	1	179	0	179	13.9	193	0	114
Idaho	2	161	11	150	10.6	712	38	54
Illinois	9	1,444	8	1,436	11.2	10,299	19	10
Indiana	6	962	74	888	15.1	649	311	157
Iowa	4	163	33	130	5.4	1,091	14	19
Kansas	3	711	6	705	25.4	4,318	0	0
Kentucky	4	440	0	440	10.3	8,359	0	8
Louisiana	4	952	52	900	21.6	4,094	72	11
Maine	2	146	0	146	11.1	523	0	50

Table 41: Number of State-Operated Psychiatric Hospitals, Residents, and Length of Stay (Continued)

State	Number of State Hospitals (state operated & funded, 2010)	Number of Residents (start of year)[1]	Number of Children (0–17, start of year)[1]	Number of Adults (18+, start of year)[1]	Residents per 100,000 Population[2]	State Hospital Admissions (2009)[1]	Median LOS (days)—Children 0–17 (discharged clients)[1]	Median LOS (days)—Adults 18+ (discharged clients)[1]
Maryland	7	1,146	15	1,131	20.3	1,527	26	82
Massachusetts	4	698	12	686	10.7	952	120	84
Michigan	5	545	58	487	5.4	1,349	0	0
Minnesota	10	327	29	298	6.3	2,463	21	16
Mississippi	5	1,137	79	1,058	38.7	4,340	80	29
Missouri	9	1,340	49	1,291	22.7	5,998	11	7
Montana	1	189	0	189	19.5	738	0	40
Nebraska	2	304	10	294	17.0	307	354	104
Nevada	3	310	45	265	11.9	4,031	23	15
New Hampshire	1	187	16	171	14.2	2,278	8	7
New Jersey	5	2,060	0	2,060	23.7	2,629	0	77
New Mexico	1	159	0	159	8.0	1,103	0	22
New York	25	5,234	465	4,769	26.9	7,815	38	81
North Carolina	4	690	51	639	7.5	7,249	12	10
North Dakota	1	179	5	174	27.9	480	21	21
Ohio	6	1,048	0	1,048	9.1	5,724	0	16
Oklahoma	3	334	30	304	9.2	3,349	31	55
Oregon	2	732	0	732	19.3	934	0	90
Pennsylvania	7	1,760	0	1,760	14.1	1,265	0	148
Rhode Island*	0	132	0	132	12.6	791	0	7

Table 41: Number of State-Operated Psychiatric Hospitals, Residents, and Length of Stay (Continued)

State	Number of State Hospitals (state operated & funded, 2010)	Number of Residents (start of year)[1]	Number of Children (0–17, start of year)[1]	Number of Adults (18+, start of year)[1]	Residents per 100,000 Population[2]	State Hospital Admissions (2009)[1]	Median LOS (days)—Children 0–17 (discharged clients)[1]	Median LOS (days)—Adults 18+ (discharged clients)[1]
South Carolina	4	485	19	466	10.8	2,717	14	15
South Dakota	1	234	50	184	29.1	1,969	89	12
Tennessee	5	813	30	783	13.1	10,994	7	5
Texas	12	2,154	107	2,047	8.9	14,694	20	15
Utah	1	320	41	279	11.7	397	281	127
Vermont	1	50	0	50	8.0	267	12	19
Virginia	11	1,476	25	1,451	19.0	4,884	11	23
Washington	3	1,356	46	1,310	20.7	2,512	270	70
West Virginia	2	289	0	289	15.9	1,208	0	19
Wisconsin	2	614	109	505	10.9	6,548	2	6
Wyoming	1	118	0	118	22.2	427	0	46
Total	214	44,459	1,736	43,723	15.0	158,435	78	155
Median	3	545	12	487	14.0	1,969		
Maximum	25	5,234	465	5,144	68.8	14,694	354	173
Minimum	0	50	0	50	3.9	161.0	0	0

[1]2009 Uniform Reporting System Tables.
[2]U.S. Census 2009 Resident Population (http://www.census.gov/popest/datasets.html).
LOS = length of stay.
*Rhode Island has state-operated psychiatric inpatient beds that are part of a general hospital.

Figure 31: Consumers Served in All State Psychiatric Hospitals, by Age and Gender

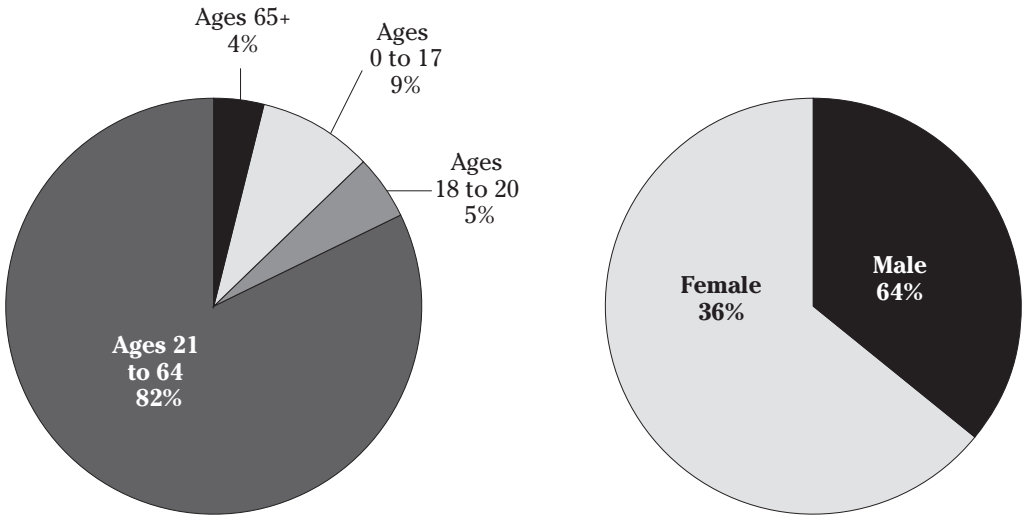


Table 42: Number of SMHAs Using State Psychiatric Hospitals, by Age and Service, 2009 (48 SMHAs reporting)

Population	Acute Inpatient (less than 30 days)		Intermediate Inpatient (30–90 days)		Long-Term Inpatient (more than 90 days)	
	Number of SMHAs	SMHAs (percent)	Number of SMHAs	SMHAs (percent)	Number of SMHAs	SMHAs (percent)
Children (0–12)	20	44%	21	45%	17	35%
Adolescents (13–17)	27	60%	29	62%	23	48%
Adults (18–64)	44	98%	46	98%	46	96%
Elderly (65+)	40	89%	44	94%	45	94%
Forensic	44	98%	45	94%	48	94%

5.3 The Closing and Reorganization of State Psychiatric Hospitals

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

Seventeen SMHAs planned to downsize and/or close approximately 43 state hospitals. Alabama, Connecticut, Georgia, Louisiana, Michigan, Missouri, New Jersey, North Carolina, and Pennsylvania have collectively closed 11 hospitals between 2009 and 2010. In addition, Georgia, North Carolina, and Vermont planned to close state psychiatric hospitals. Rather than eliminate state-operated inpatient psychiatric services altogether, many states opted to reorganize their state psychiatric hospital systems. Thirteen SMHAs were closing hospital wards, 10 were downsizing one or more hospitals, 5 were reducing the size of wards, 5 were replacing an old hospital with a new one, 3 were consolidating 2 or more hospitals into 1 facility, 3 were transferring hospital patients to community inpatient facilities, 3 were increasing the size of 1 or more hospitals, and 1 (North Carolina) was planning to open a new hospital within the next 2 years. Kansas was transferring children from the state hospital to a state-funded private community setting. Maryland planned to purchase beds in the private sector for uninsured diversion to community services. Nevada was planning to reduce hospital staff. New York was converting inpatient wards to outpatient residential programs (transitional placement programs).

Of the five states that privatized at least a portion of operations within state hospitals (Alabama, Delaware, Georgia, Kansas, and Missouri), one (Georgia) privatized an entire hospital, and four states privatized portions of the hospitals. Alabama privatized an adolescent unit. Delaware privatized a nursing home level of care unit and a detoxification unit. Kansas privatized adult acute care in two hospitals and children's services in one. Missouri privatized an acute care and emergency department in two hospitals.

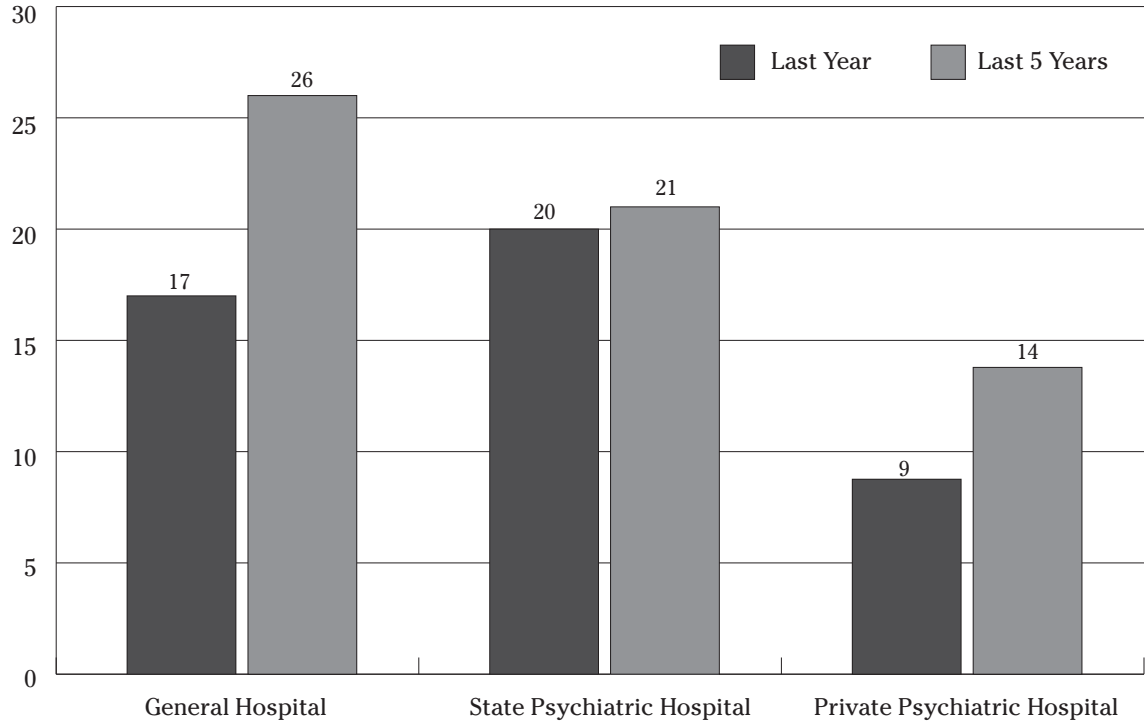
5.4 Inpatient Psychiatric Bed Shortages

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

Thirty-one SMHAs have experienced a decline in psychiatric inpatient bed capacity over the past 5 years (see figure 32). Of these, 26 have collectively experienced a decline of 1,195 general hospital specialty unit psychiatric beds; 21 have collectively experienced a decline of 2,373 state psychiatric hospital beds; and 14 have collectively experienced a decline of 119 private psychiatric hospital beds since 2005.

The elimination of these beds led to 31 states facing a shortage of any psychiatric inpatient beds, 22 states experiencing a shortage of acute beds, 14 states experiencing a shortage of long-term beds, and 17 experiencing a shortage of forensic beds. The impact of these shortages was felt in various ways, including increased waiting lists for

Figure 32: Number of States Experiencing a Decline of Psychiatric Beds Over the Past 1 and 5 Years



state hospital beds in 22 states, increased waiting lists for other psychiatric beds in 12 states, increased resistance to closing additional state hospital beds in 13 states, and overcrowding in state hospitals in 9 states. In Louisiana, the waiting list for entry into forensic beds increased because of transfers from local prisons and jails. In New Hampshire, the shortage of psychiatric beds was especially difficult for the state's very rural areas. Ohio was concerned that former patients were being shifted into nursing homes. South Carolina experienced difficulty in accepting transfers in a timely fashion under its Interstate Compact Agreement. South Dakota could not admit voluntary patients most of the time. Virginia's state hospitals could no longer admit patients to acute beds in a timely manner. In Washington, patients were boarding in community acute care hospitals. In West Virginia, shortages led to increased payments to private hospitals.

Despite the widespread shortages of hospital beds, only 16 states had a model of how many psychiatric inpatient beds were needed. Georgia, Maryland, North Carolina, and Oregon used their utilization trends over time. Missouri's model was based on a literature search and benchmarking against other states. Mississippi projected its need for psychiatric beds based on a ratio of 0.21 bed per 1,000 of the population aged 18

and above for adults and a ratio of 0.55 bed per 1,000 of the population for youth. Vermont developed a Vermont-specific actuarial model.

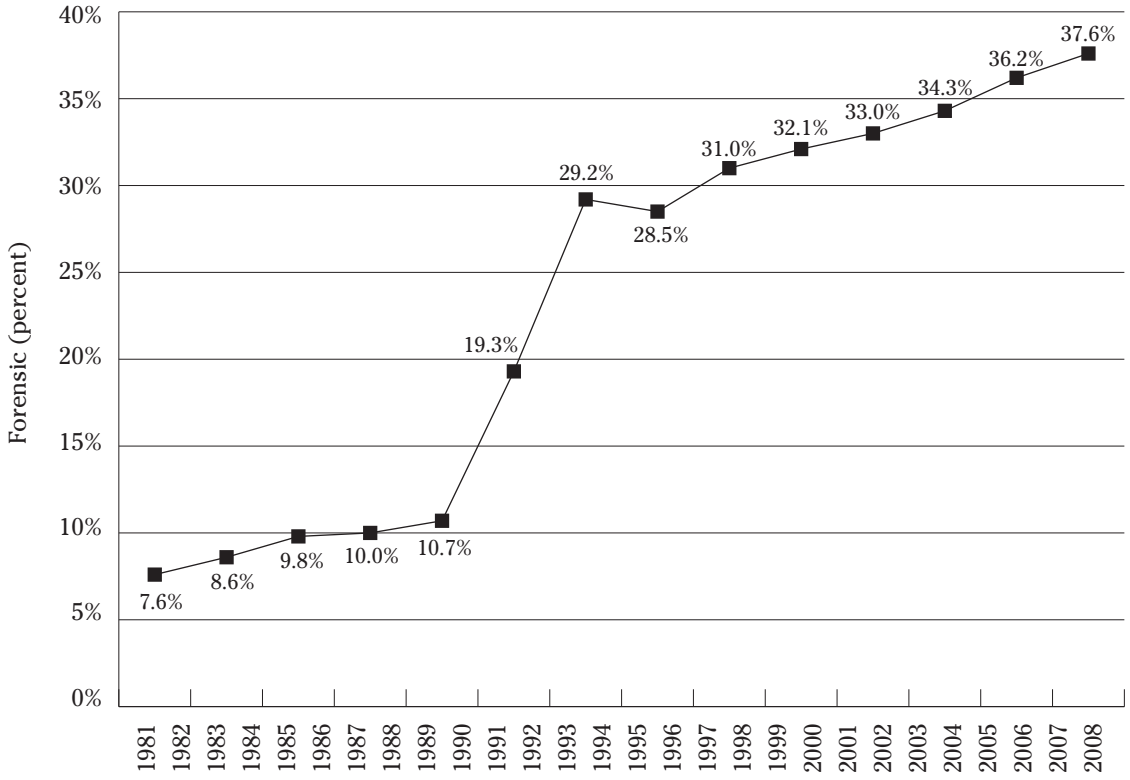
SMHAs addressed their bed shortages in a variety of ways. Colorado, Hawaii, Louisiana, Maryland, Minnesota, Montana, North Carolina, South Carolina, South Dakota, Texas, Virginia, and West Virginia increased the capacity of community programs to serve clients who formerly would have been hospitalized. Alaska, Georgia, Kansas, and South Carolina added capacity outside the state hospitals. Florida converted forensic step-down beds to civil beds and improved collaboration to discharge individuals who were ready to return to the community. Iowa sought funding from the legislature to maintain current psychiatric bed capacity and worked to prevent hospitalizations and increase community capacity. Idaho explored alternatives to forensic bed capacity. Missouri worked with community general hospitals to provide acute care services, attempting to develop non-Institution for Mental Disease (IMD) alternatives such as 16 beds or fewer facilities, Missouri also closed state-operated acute care units and psychiatric emergency rooms. Nevada, North Dakota, and Oregon added psychiatric hospital capacity. New Hampshire had an unfunded 10-year plan to address the shortages. Ohio looked to implement nursing home placements. South Carolina increased its use of telepsychiatry to determine whether inpatient or alternative services were appropriate for clients. Texas had an overcapacity plan that diverted patients from full hospitals to those with capacity. Virginia had utilization management committees that managed admissions to and discharges from state hospitals or purchased local psychiatric beds. Wisconsin worked to decrease hospitalizations by funding regional crisis programs. West Virginia contracted with private providers for more civil commitment beds. West Virginia also added forensic beds to both state facilities and 20 civil commitment beds at 1 facility; developed community group homes, housing units, and day supports; and increased crisis care coordination services and built up community and peer supports.

5.5 Forensic Mental Health Services

Forensic services provide evaluation and treatment to persons who have a mental illness and come into contact with the criminal justice system. SMHAs varied widely in their responsibilities for providing mental health services to forensic clients. One-third of all consumers in state hospitals were involuntarily criminally committed. Since 1993, state psychiatric hospital expenditures have increasingly been applied to forensic services, tripling from 10.7 percent of total state psychiatric hospital expenditures in 1993 to 37.6 percent in 2008 (see figure 33).

In FY 2008, SMHAs spent $3.1 billion of funds allocated to state psychiatric hospitals on forensic services and an additional $442 million on sex offender services. The amount of funds individual SMHAs spent on each classification

Figure 33: SMHA-Controlled Forensic and Sex Offender Mental Health Expenditures as a Percentage of State Psychiatric Hospital Expenditures, FY 1983 to FY 2008



varied widely state to state. California spent the most ($908.3 million), whereas North Dakota and South Dakota spent $0 on forensic services. Expenditures for sex offenders also varied greatly, with Minnesota (35 percent of all state hospital expenditures) and Nebraska (34 percent) spending the highest portion of their state hospital budget on sex offender services. However, California ($151.6 million) and New York ($28.7 million) expended the most on sex offender services in state hospitals (see table 43).

5.5.1 State Psychiatric Hospital Expenditures per Patient Day, by Legal Status

Expenditures in state psychiatric hospitals are often compared on the basis of the average cost of providing care per patient day (how many total days patients were in the hospital divided by total hospital expenditures). In FY 2008, state psychiatric hospitals provided 17.6 million patient days of care (50 states reporting). In these states, the average expenditures per patient day were $547, and the median expenditures were $548 per patient day. States ranged from a high of $1,327 per patient day in Vermont to a low of $250 per patient day in South Dakota.

Table 43: SMHA-Controlled Mental Health Expenditures for Forensic and Sex Offender Services in State Psychiatric Hospitals, FY 2008 (in millions)

State	Forensic (in millions)	Per Capita	% of Total	Rank	Sex Offenders (in millions)	Per Capita	% of Total	Rank	Total State Psychiatric Hospital-Inpatient
Alabama	$14.6	$3.14	9%	41	$0.0				$167.0
Alaska	$3.2	$4.85	12%	39	$0.0				$27.0
Arizona	$30.0	$4.63	39%	14	$10.9	$1.68	14%	5	$77.9
Arkansas (a)	$6.8	$2.40	17%	33	$0.0				$39.7
California (b)	$908.3	$24.81	77%	1	$151.6	$4.14	13%	6	$1,172.7
Colorado	$48.7	$9.92	45%	7	NA				$107.2
Connecticut (ac)	$96.1	$27.51	45%	8	$0.0				$211.7
Delaware (ac)	$7.7	$8.90	17%	34	N/A				$46.0
District of Columbia	$45.2	$76.77	45%	9	$1.0	$1.71	1%	15	$100.5
Florida	$154.0	$8.43	42%	10	$24.4	$1.34	7%	11	$366.6
Georgia (a)	$69.4	$7.21	34%	18	NA				$205.1
Hawaii (c)	NA		NA		NA				$58.3
Idaho	$0.0	$0.03	0%	46	$0.0				$29.9
Illinois	$132.2	$10.27	41%	11	$25.7	$2.00	8%	8	$325.1
Indiana	$45.4	$7.12	24%	26	$0.0				$188.4
Iowa	$0.5	$0.16	1%	45	$6.3	$2.11	10%	7	$63.0
Kansas	$26.2	$9.42	30%	24	$18.0	$6.47	20%	4	$88.6
Kentucky	$12.3	$2.89	11%	40	NA				$116.6
Louisiana	$62.9	$14.31	34%	17	NA				$182.5
Maine (b)	$16.8	$12.76	30%	23	NA				$55.8
Maryland	$131.7	$23.49	54%	4	$0.0				$244.3

Table 43: SMHA-Controlled Mental Health Expenditures for Forensic and Sex Offender Services in State Psychiatric Hospitals, FY 2008 (in millions) (Continued)

State	Forensic (in millions)	Per Capita	% of Total	Rank	Sex Offenders (in millions)	Per Capita	% of Total	Rank	Total State Psychiatric Hospital-Inpatient
Massachusetts (a)	$60.0	$9.24	26%	25	$0.0				$227.7
Michigan (b)	$52.0	$5.20	23%	27	N/A				$226.5
Minnesota	$78.4	$15.04	39%	13	$71.4	$13.69	35%	1	$202.1
Mississippi	$4.1	$1.40	3%	44	$0.0				$151.5
Missouri	$93.4	$15.85	39%	12	$16.4	$2.79	7%	10	$236.9
Montana	$5.4	$5.65	20%	30	$0.0				$27.1
Nebraska (b)	$7.8	$4.39	17%	35	$15.8	$8.88	34%	2	$46.6
Nevada	$8.5	$3.28	12%	38	$0.0				$68.7
New Hampshire	$0.0		0%		$0.0				$53.2
New Jersey (b)	$91.4	$10.54	18%	32	$9.9	$1.14	2%	14	$502.5
New Mexico (ac)	$8.3	$4.20	38%	15	NA				$21.8
New York (b)	$157.6	$8.10	13%	36	$28.7	$1.47	2%	13	$1,207.3
North Carolina	$11.4	$1.25	4%	43	NA				$324.4
North Dakota	$0.0		0%		$0.0				$10.8
Ohio	$150.8	$13.14	66%	2	$0.0				$228.7
Oklahoma (b)	$20.1	$5.55	36%	16	$0.0				$55.7
Oregon	$72.3	$19.10	57%	3	NA				$127.7
Pennsylvania (ac)	$65.7	$5.28	13%	37	$0.0				$511.2
Rhode Island (c)	NA		NA		NA				$32.9
South Carolina	$18.7	$4.21	21%	28	$6.2	$1.40	7%	9	$89.0
South Dakota	$0.0		0%		$0.0				$21.8

Table 43: SMHA-Controlled Mental Health Expenditures for Forensic and Sex Offender Services in State Psychiatric Hospitals, FY 2008 (in millions) (Continued)

State	Forensic (in millions)	Per Capita	% of Total	Rank	Sex Offenders (in millions)	Per Capita	% of Total	Rank	Total State Psychiatric Hospital-Inpatient
Tennessee	$36.9	$5.95	21%	29	$0.0				$176.6
Texas (b)	$116.8	$4.82	33%	19	$0.0				$349.9
Utah (b)	$16.6	$6.08	31%	22	NA				$54.2
Vermont	$9.9	$15.99	46%	6	NA				$21.5
Virginia	$23.4	$3.06	7%	42	$10.1	$1.32	3%	12	$332.1
Washington	$44.3	$6.81	18%	31	$0.0				$241.4
West Virginia (b)	$15.5	$8.55	33%	20	$0.0				$47.0
Wisconsin	$99.9	$17.76	51%	5	$45.6	$8.11	23%	3	$196.2
Wyoming (b)	$6.9	$12.99	31%	21	$0.0				$22.1
Total	$3,088.2		32.5%		$442.1		4.6%		$9,512.1
Average (Mean)	$63.0				$11.9				$190.0
Median	$26.2		26.4%		$0.0		7.9%		$116.6
States Reporting	46				15				51

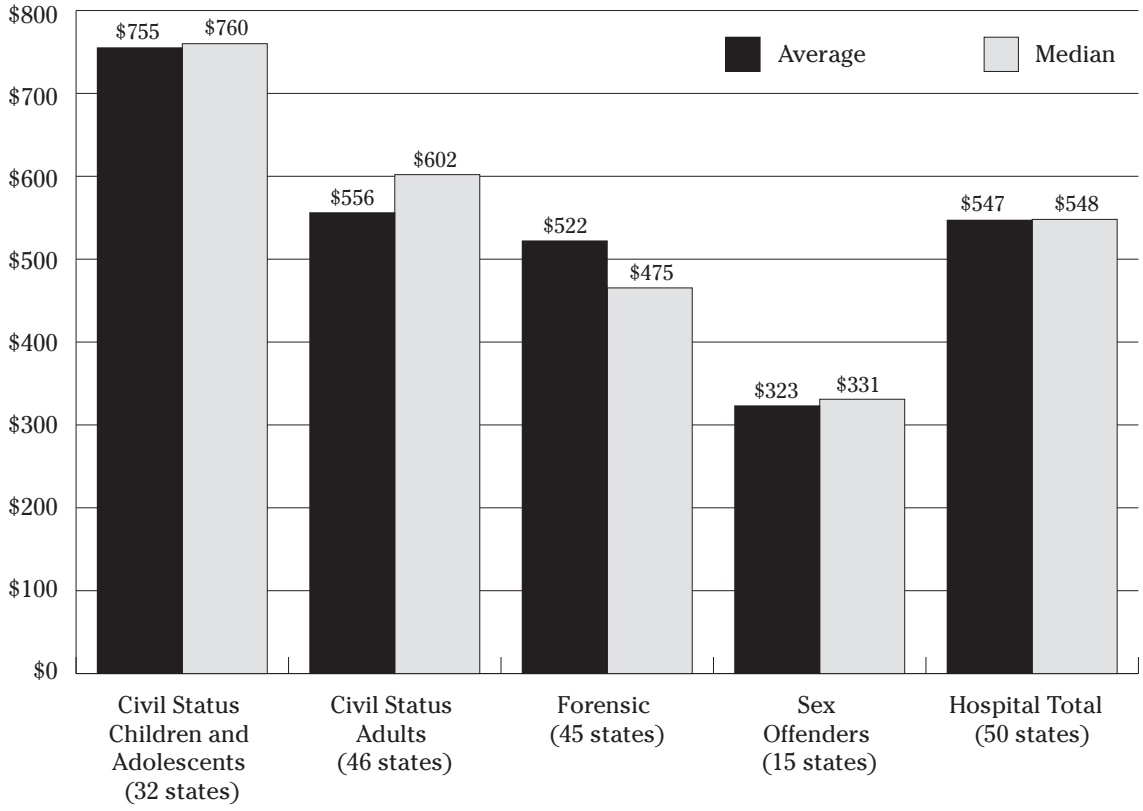
a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures.
b = SMHA-controlled expenditures include funds for mental health services in jails or prisons.
c = Children's mental health expenditures are not included in SMHA-controlled expenditures.
NA = Services were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

Civil status (both voluntary and involuntary) clients had higher costs per patient day than forensic status clients (see figure 34). Civil status children had the highest average expenditures per patient day at $755, followed by civil status adults at $556. Forensic status patients ($522) and persons in state psychiatric hospitals under sexual offender commitment statuses ($323) had the lowest average costs per patient day.

5.5.2 Organization of State Forensic Mental Health Services

In 30 states, forensic mental health services were the direct responsibility of the SMHA. In 13 states, the SMHA and the Department of Corrections shared the responsibility of forensic mental health services. In Alaska, the Departments of Mental Health and Corrections each had separate responsibilities for forensic mental health services. In New Mexico, it was the responsibility of the Behavioral Health Services Division of the Human Services Department. In Oregon, it was the responsibility of Addictions and

Figure 34: Average and Median State Psychiatric Hospital Expenditures per Patient Day, by Patient Legal Status, FY 2008



Mental Health, Oregon State Hospital, the Psychiatric Security Review Board, and the Department of Corrections.

Only seven SMHAs (California, Maine, Maryland, Missouri, New York, South Dakota, and Wisconsin) were responsible for providing direct services to consumers within the adult prison system, and 15 provided direct services within the juvenile justice system. The state's corrections agency was most often responsible for administering services and perimeter security for these consumers.

Twenty-seven SMHAs had a central administrative management unit responsible for planning, administering, and/or monitoring forensic services. Twenty-five SMHAs had a mental health forensic director, and 19 SMHAs had another staff person who had responsibility for forensic mental health services. The Forensic Director most often reported directly to the SMHA Commissioner (10), the Division Director (9), or the Deputy Assistant Director of Mental Health (4). Six SMHAs (Alaska, Iowa, South Dakota, Vermont, Washington, and Wyoming) had no person or group within the SMHA designated responsible for overseeing forensic services.

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

Forty-five states had a not guilty by reason of insanity (NGRI) statute. In these states, persons charged with a crime could be found not guilty or not criminally responsible because of their mental illness. Persons ruled NGRI are often sent to state psychiatric hospitals for treatment until they are found to be well and safe enough to be discharged into the community. Twenty-seven out of the 45 states with an NGRI statute reported 1,160 individuals were found NGRI in 2009, ranging from no individuals found NGRI in Alaska, Delaware, Mississippi, New Mexico, Nevada, Pennsylvania, Utah, and Vermont to 144 individuals in Ohio.

Fourteen states had a guilty but mentally ill (GBMI) statute. In these states, criminal defendants can be found guilty of a crime even though they have been diagnosed with a mental illness. (The GBMI statute means that in addition to punishment for the crime, the defendant is in need of mental health treatment.) Seven out of the 14 states with a GBMI statute reported 157 individuals were found GBMI in 2009, ranging from 0 persons in Pennsylvania to 82 in Oregon. Only 12 states had both NGRI and GBMI statutes.

5.5.4 Sex Offenders

Twenty-seven states were required by state law to provide specifically for the hospitalization or commitment of sex offenders (those classified as sexually violent predators, sexually dangerous persons, and others). The use of such laws had increased since the 1997 U.S. Supreme Court decision in *Kansas v. Hendricks*, which affirmed state laws that allow persons completing prison sentences to be committed to psychiatric institutions for treatment if they are found to be dangerous by the courts (*Kansas v. Hendricks*, 1997). These laws sometimes required agencies such as the SMHA, the Department of Corrections, or another state agency to provide services to sex offenders; however, the responsibility of these services was often divided among several agencies. Table 44 displays the type of services and the agencies that were responsible for the provision of these services for sex offenders.

Table 44: Responsibilities for Sex Offender Services

Services	Responsible Agency				
	SMHA	Department of Corrections	SMHA With Corrections or Another Agency	Other	Total
Screening corrections inmates to identify candidates for commitment proceedings	3	10	3	5	21
Evaluating individuals whose commitment someone else has petitioned	11	1	0	6	18
Providing the facility in which the committed individual is served	15	3	2	1	21
Providing for administration of the commitment facility	15	3	1	1	20
Providing or paying for clinical services	15	2	1	0	18
Providing or paying for security services	14	3	1	2	20

SMHAs spent $442.1 million to provide sex offender services in state psychiatric hospitals in 2008 (22 states did not report specific services for sex offenders). On average, SMHAs spent $11.9 million to provide these services. California spent the most ($151.6 million), and the District of Columbia spent the least ($1 million). On a per capita basis, Minnesota expended the most ($13.69 per state resident), and New Jersey expended the least ($1.14 per state resident).

5.6 Financing of SMHA Operated and Funded Psychiatric Hospitals

The most common funding source for state psychiatric hospitals was state general funds, followed by Medicare, Medicaid, and third-party (insurance) payments. As table 45 shows, state psychiatric hospital inpatient services for adults (ages 21 to 64) were most often funded by state general funds, followed by third-party (insurance) or first-party funds and then Medicare.

Table 45: Financing Sources Used To Fund Mental Health Services in State Psychiatric Hospitals, by Hospital Patient Population

State	Children (under age 21)	Adults (ages 21–64)	Older Adults (ages 65+)	Forensic	Sex Offender	Other 24-Hour Care (residential)	State Hospital Ambulatory	Other State Hospital
State General Fund	27	44	40	41	22	15	13	3
State Special Funds	6	8	8	7	3	2	2	1
State Medicaid Match	27	16	31	11	4	8	9	2
Medicaid (Federal)	19	11	25	6	1	10	5	0
Medicare	5	26	35	13	4	4	4	1
Veterans Affairs	0	6	6	1	0	0	1	1
Other Federal	4	3	2	2	0	2	2	1
Local Government	5	6	5	4	1	3	3	0
First Party	22	32	29	14	7	8	7	1
Third Party	26	34	32	11	6	8	9	2
Charity	4	7	6	3	1	2	2	2
Other Funds	1	1	1	1	0	0	0	1

For children (under age 21), state general funds, Medicaid, and third-party payers were the most common funding sources for state psychiatric hospital inpatient services. Inpatient services for forensic patients and sex offenders were paid for mostly by state general funds, with few states billing insurance, Medicaid, or Medicare for these services.

Table 46 shows the various funding sources states used to pay for any state psychiatric hospital services. This table shows that although most states used a combination of state general funds, Medicaid, and first- and third-party payments, 10 states (California, Colorado, Iowa, Michigan, Minnesota, Mississippi, New York, North Carolina, Tennessee, and Wisconsin) also received local government payments for services at state psychiatric hospitals. Additionally, seven states (Kentucky, Mississippi, New Hampshire, North Carolina, Ohio, South Carolina, and Wisconsin) received reimbursements from the Department of Veterans Affairs.

Table 46: Sources Used To Fund State Psychiatric Hospitals

State	State General Funds	State Special Funds	State Medicaid Match	Medicaid (federal)	Medicare	Veterans Affairs	Other Federal	Local Government	1st Party	3rd Party	Charity	Other
Alabama	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Alaska	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Arizona	Yes	No	No	No	Yes	No	No	No	No	No	No	No
Arkansas	Yes	No	No	Yes	Yes	No	No	No	Yes	Yes	No	No
California	Yes	No	No	No	Yes	No	No	Yes	No	Yes	No	No
Colorado	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	Yes
Connecticut (Adults)	Yes	No	Yes	No	No	No	No	No	No	No	No	No
Connecticut (Children)	Yes	No	No	No	No	No	No	No	No	Yes	No	No
Delaware	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
District of Columbia	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
Florida	Yes	No	No	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes
Georgia	Yes	No	No	Yes	Yes	No	No	No	Yes	Yes	Yes	No
Hawaii	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No
Idaho	Yes	Yes	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	No
Illinois	Yes	No	Yes	No	Yes	No	No	No	No	No	No	No
Indiana	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Iowa	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	No
Kansas	Yes	No	Yes	Yes	No	No	No	No	Yes	Yes	No	No
Kentucky	Yes	No	No	Yes	Yes	Yes	No	No	Yes	Yes	No	No
Louisiana	Yes	No	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Maine	Yes	No	Yes	Yes	No	No	No	No	No	Yes	No	No
Maryland	Yes	No	No	No	No	No	No	No	No	No	No	No
Massachusetts	No	No	No	No	No	No	No	No	No	No	No	No
Michigan	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	No
Minnesota	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No
Mississippi	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Missouri	Yes	No	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Montana	No	No	No	No	No	No	No	No	No	No	No	No

Table 46: Sources Used To Fund State Psychiatric Hospitals (Continued)

State	State General Funds	State Special Funds	State Medicaid Match	Medicaid (federal)	Medicare	Veterans Affairs	Other Federal	Local Government	1st Party	3rd Party	Charity	Other
Nebraska	Yes	No	No	Yes	No	No	No	No	No	No	No	No
Nevada	Yes	No	Yes	No	Yes	No	No	No	Yes	Yes	No	No
New Hampshire	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No
New Jersey	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	No
New Mexico	Yes	No	Yes	No	No	No	No	No	Yes	Yes	No	No
New York	Yes	No	Yes	No	Yes	No	No	Yes	Yes	Yes	No	No
North Carolina	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
North Dakota	Yes	No	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Ohio	Yes	No	No	No	Yes	Yes	No	No	Yes	Yes	No	No
Oklahoma	Yes	No	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Oregon	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No	No
Pennsylvania	Yes	No	Yes	Yes	Yes	No	No	No	No	No	No	No
Rhode Island	No	No	No	No	No	No	No	No	No	No	No	No
South Carolina	Yes	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No	No
South Dakota	No	No	No	No	No	No	No	No	No	No	No	No
Tennessee	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes	No	No
Texas	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	No
Utah	Yes	No	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Vermont	Yes	No	Yes	Yes	No	No	No	No	No	No	No	No
Virginia	Yes	No	Yes	Yes	No	No	Yes	No	Yes	Yes	Yes	No
Washington	Yes	No	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
West Virginia	Yes	No	Yes	Yes	Yes	No	No	No	Yes	Yes	No	No
Wisconsin	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes	Yes	No	No
Wyoming	Yes	No	Yes	Yes	No	No	No	No	No	No	No	No
Yes	46	9	36	32	35	7	7	10	33	36	7	2
No	4	41	14	18	15	43	43	40	17	14	43	48
NR (not reported)	2	2	2	2	2	2	2	2	2	2	2	2

5.6.1 Overall Expenditures for State Psychiatric Hospitals, FY 2008

In FY 2008, SMHAs expended $10.3 billion, or 28 percent of all SMHA-controlled expenditures, on state psychiatric hospitals. New York spent the highest amount ($1.7 billion, or 37 percent of total SMHA-controlled expenditures), and North Dakota spent the least ($17.7 million, or 37 percent of total SMHA-controlled expenditures). South Dakota spent the highest percentage of SMHA-controlled expenditures on state psychiatric hospitals (63 percent), whereas Arizona spent the lowest (7 percent). Of the $10.3 billion state psychiatric hospital expenditures, 92 percent were spent providing services to the elderly and adults over the age of 18, 6 percent for children under age 18, and 2 percent were unallocated by age (see table 47).

The majority (93.2 percent) of expenditures for state psychiatric hospitals were dedicated to inpatient psychiatric services (see table 48). The remainder of funds was applied to less than 24-hour services (3.6 percent) and other 24-hour services—a variety of services along a continuum of living arrangements ranging from basic room and board with minimal supervision through 24-hour medical, nursing, and/or intensive therapeutic programs—(3.1 percent). Seven states used state psychiatric hospitals to provide less than 24-hour services (Louisiana, Mississippi, Missouri, Nevada, New York, South Carolina, and Wyoming), and these states ranged from a high of $341.8 million (New York) to a low of $400,000 (Wyoming).

5.6.2 Trends in State Psychiatric Hospital-Inpatient Services Expenditures

As SMHAs continued to reduce the size and presence of state psychiatric hospitals and more frequently treated consumers in community-based treatment settings, funding for inpatient care in psychiatric hospitals continued to decline. From FY 1981 to FY 2008, SMHA-controlled expenditures for state psychiatric hospital-inpatient services increased from $3.8 billion to $9.5 billion. However, when adjusted for inflation, expenditures actually decreased from $3.8 billion in FY 1981 to $2.2 billion in FY 2008, a decline of 43 percent (see figure 35).

From FY 2001 to FY 2008, state psychiatric hospital-inpatient services expenditures increased by 4 percent per year. During the same period, 43 SMHAs increased their state psychiatric hospital-inpatient services expenditures, whereas 8 expended less in 2008 than in 2001. However, when adjusted for inflation and population growth, expenditures decreased by 7.6 percent (an annualized decrease of 1.1 percent per year) this decade. As a result of inflation and population growth, only 21 SMHAs increased state psychiatric hospital-inpatient expenditures this decade, whereas 29 SMHAs decreased their hospital-inpatient services expenditures.

Table 47: SMHA-Controlled Mental Health Expenditures for State Psychiatric Hospitals, by Age, FY 2008 (in millions)

State	Children/Adolescents			Adults (over age 18)			Unallocated, by Age			Total State Hospital Expenditures	
	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita
Alabama	NA	NA	NA	NA	NA	NA	$167.00	$35.92	100%	$167.00	$35.92
Alaska	$3.91	$21.76	14%	$23.08	$47.63	86%	$0.00	$0.00	0%	$27.00	$40.63
Arizona	$4.60	$2.69	6%	$73.30	$15.36	94%	$0.00	$0.00	0%	$77.90	$12.02
Arkansas (a)	$3.28	$4.66	5%	$68.64	$31.98	95%	$0.00	$0.00	0%	$71.91	$25.25
California (b)	$1.19	$0.13	0%	$1,171.47	$43.00	100%	$0.00	$0.00	0%	$1,172.66	$32.03
Colorado	$15.27	$12.65	14%	$95.38	$25.74	86%	$0.00	$0.00	0%	$110.65	$22.52
Connecticut (ac)	$0.00	$0.00	0%	$211.70	$78.95	100%	$0.00	$0.00	0%	$211.70	$60.59
Delaware (ac)	NA	NA	NA	$45.99	$69.37	100%	$0.00	$0.00	0%	$45.99	$52.91
District of Columbia	$0.00	$0.00	0%	$99.57	$208.79	100%	$0.00	$0.00	0%	$99.57	$169.08
Florida	$0.00	$0.00	0%	$366.64	$25.72	100%	$0.00	$0.00	0%	$366.64	$20.08
Georgia (a)	$13.63	$5.35	7%	$191.47	$27.07	93%	NA	NA	NA	$205.10	$21.31
Hawaii (c)	NA	NA	NA	$58.27	$60.36	100%	$0.00	$0.00	0%	$58.27	$46.59
Idaho	$2.20	$5.33	7%	$27.70	$25.04	93%	$0.00	$0.00	0%	$29.90	$19.69
Illinois	$2.40	$0.75	1%	$322.70	$33.31	99%	$0.00	$0.00	0%	$325.10	$25.27
Indiana	$11.97	$7.55	6%	$176.47	$36.85	94%	$0.00	$0.00	0%	$188.44	$29.57
Iowa	$11.10	$15.58	24%	$35.95	$15.71	76%	$0.00	$0.00	0%	$47.05	$15.68
Kansas	$2.00	$2.86	2%	$86.60	$41.60	98%	NA	NA	NA	$88.60	$31.84
Kentucky	$0.00	$0.00	0%	$116.60	$35.91	100%	$0.00	$0.00	0%	$116.60	$27.40
Louisiana	$19.70	$17.78	10%	$167.98	$51.09	90%	$0.00	$0.00	0%	$187.68	$42.70
Maine (b)	$0.00	$0.00	0%	$55.84	$53.79	100%	$0.00	$0.00	0%	$55.84	$42.53

Table 47: SMHA-Controlled Mental Health Expenditures for State Psychiatric Hospitals, by Age, FY 2008 (in millions) (Continued)

State	Children/Adolescents			Adults (over age 18)			Unallocated, by Age			Total State Hospital Expenditures	
	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita
Maryland	$34.68	$25.87	12%	$244.68	$57.39	88%	$0.00	$0.00	0%	$279.35	$49.85
Massachusetts (a)	$14.60	$10.23	10%	$126.00	$24.88	90%	$0.00	$0.00	0%	$140.60	$21.66
Michigan (b)	$19.80	$8.28	9%	$206.70	$27.17	91%	$0.00	$0.00	0%	$226.50	$22.65
Minnesota	$11.63	$9.27	6%	$193.39	$48.82	94%	$0.00	$0.00	0%	$205.02	$39.31
Mississippi	$21.40	$27.91	13%	$138.00	$64.02	87%	$0.00	$0.00	0%	$159.40	$54.55
Missouri	$22.55	$15.87	9%	$237.29	$53.08	91%	$0.00	$0.00	0%	$259.84	$44.10
Montana	NA	NA	NA	$29.35	$39.47	100%	NA	NA	NA	$29.35	$30.45
Nebraska (b)	$2.67	$5.97	6%	$43.89	$33.00	94%	$0.00	$0.00	0%	$46.56	$26.20
Nevada	$10.00	$14.97	13%	$66.79	$34.75	87%	$0.00	$0.00	0%	$76.79	$29.65
New Hampshire	$4.96	$16.91	7%	$69.72	$68.27	93%	$0.00	$0.00	0%	$74.68	$56.81
New Jersey (b)	$0.00	$0.00	0%	$502.50	$75.88	100%	$0.00	$0.00	0%	$502.50	$57.96
New Mexico (ac)	$0.00	$0.00	0%	$44.58	$30.27	100%	$0.00	$0.00	0%	$44.58	$22.57
New York (b)	$221.50	$50.25	13%	$1,435.20	$95.32	87%	$0.00	$0.00	0%	$1,656.70	$85.11
North Carolina	$33.94	$15.13	10%	$317.04	$46.09	90%	NA	NA	NA	$350.98	$38.48
North Dakota	$1.20	$8.36	7%	$16.49	$33.56	93%	$0.00	$0.00	0%	$17.68	$27.88
Ohio	NA	NA	NA	$228.69	$26.15	100%	NA	NA	NA	$228.69	$19.93
Oklahoma (b)	$8.50	$9.38	15%	$47.20	$17.39	85%	$0.00	$0.00	0%	$55.70	$15.38
Oregon	$0.00	$0.00	0%	$127.74	$43.76	100%	$0.00	$0.00	0%	$127.74	$33.73
Pennsylvania (ac)	$0.00	$0.00	0%	$511.19	$52.82	100%	$0.00	$0.00	0%	$511.19	$41.09
Rhode Island (c)	NA	NA	NA	$32.91	$40.24	100%	NA	NA	NA	$32.91	$31.45

Table 47: SMHA-Controlled Mental Health Expenditures for State Psychiatric Hospitals, by Age, FY 2008 (in millions) (Continued)

State	Children/Adolescents			Adults (over age 18)			Unallocated, by Age			Total State Hospital Expenditures	
	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita	%	Total	Per Capita
South Carolina	$9.50	$8.91	9%	$90.60	$26.86	91%	$0.00	$0.00	0%	$100.10	$22.55
South Dakota	$5.08	$25.61	12%	$16.77	$27.83	39%	$21.28	$26.56	49%	$43.13	$53.84
Tennessee	$10.40	$7.03	6%	$166.20	$35.18	94%	$0.00	$0.00	0%	$176.60	$28.47
Texas (b)	$38.50	$5.72	11%	$322.10	$18.42	89%	$0.00	$0.00	0%	$360.60	$14.89
Utah (b)	$12.47	$14.68	23%	$41.76	$22.20	77%	NA	NA	NA	$54.24	$19.86
Vermont	$0.00	$0.00	0%	$21.50	$43.73	100%	$0.00	$0.00	0%	$21.50	$34.64
Virginia	$11.30	$6.20	3%	$320.80	$55.07	97%	$0.00	$0.00	0%	$332.10	$43.42
Washington	$11.00	$7.14	5%	$230.40	$46.44	95%	$0.00	$0.00	0%	$241.40	$37.13
West Virginia (b)	$0.00	$0.00	0%	$47.00	$32.94	100%	$0.00	$0.00	0%	$47.00	$25.93
Wisconsin	$18.50	$14.07	9%	$177.70	$41.22	91%	NA	NA	NA	$196.20	$34.88
Wyoming (b)	$0.50	$3.91	2%	$29.54	$73.67	98%	$0.00	$0.00	0%	$30.05	$56.75
Total	$615.93	$8.33	6%	$9,479.07	$42.05	92%	$188.28	$34.54	2%	$10,283.28	$33.95
Average (Mean)	$12.08			$185.86			$3.69			$201.63	
Median	$11.05	$9.09		$108.09	$39.85		$94.14	$31.24		$116.60	$31.84

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

Table 48: SMHA-Controlled State Psychiatric Hospital Expenditures, by Service Type, FY 2008 (in millions)

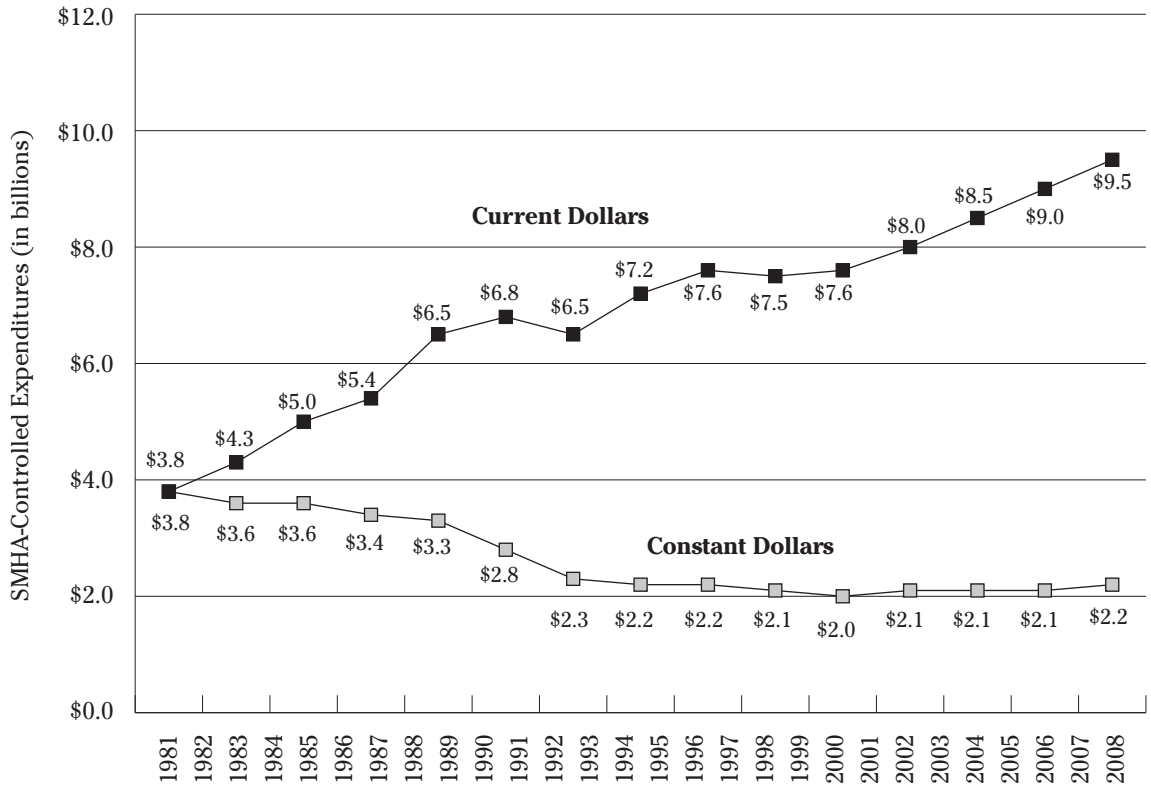
State	Inpatient Services		Other 24-Hour Services		Less Than 24-Hour Services		Total State Hospital Expenditures	Rank
	$	%	$	%	$	%	$	
Alabama	$167.00	100.00%	NA	NA	NA	NA	$167.00	22
Alaska	$27.00	100.00%	$0.00	0.00%	$0.00	0.00%	$27.00	49
Arizona	$77.90	100.00%	$0.00	0.00%	$0.00	0.00%	$77.90	31
Arkansas (a)	$39.74	55.30%	$32.17	44.70%	$0.00	0.00%	$71.91	34
California (b)	$1,172.66	100.00%	$0.00	0.00%	$0.00	0.00%	$1,172.66	2
Colorado	$107.15	96.80%	$3.50	3.20%	$0.00	0.00%	$110.65	27
Connecticut (ac)	$211.70	100.00%	$0.00	0.00%	$0.00	0.00%	$211.70	15
Delaware (ac)	$45.99	100.00%	NA	NA	NA	NA	$45.99	42
District of Columbia	$99.57	100.00%	$0.00	0.00%	$0.00	0.00%	$99.57	29
Florida	$366.64	100.00%	$0.00	0.00%	$0.00	0.00%	$366.64	5
Georgia (a)	$205.10	100.00%	NA	NA	NA	NA	$205.10	16
Hawaii (c)	$58.27	100.00%	NA	NA	NA	NA	$58.27	35
Idaho	$29.90	100.00%	$0.00	0.00%	$0.00	0.00%	$29.90	47
Illinois	$325.10	100.00%	$0.00	0.00%	$0.00	0.00%	$325.10	9
Indiana	$188.44	100.00%	$0.00	0.00%	$0.00	0.00%	$188.44	19
Iowa	$35.63	75.70%	$11.42	24.30%	$0.00	0.00%	$47.05	39
Kansas	$88.60	100.00%	NA	NA	NA	NA	$88.60	30
Kentucky	$116.60	100.00%	$0.00	0.00%	$0.00	0.00%	$116.60	26
Louisiana	$182.50	97.20%	$3.12	1.70%	$2.05	1.10%	$187.68	20
Maine (b)	$55.84	100.00%	$0.00	0.00%	$0.00	0.00%	$55.84	36
Maryland	$244.29	87.40%	$35.06	12.60%	$0.00	0.00%	$279.35	10
Massachusetts (a)	$133.40	94.90%	$7.20	5.10%	$0.00	0.00%	$140.60	24
Michigan (b)	$226.50	100.00%	$0.00	0.00%	$0.00	0.00%	$226.50	14
Minnesota	$202.08	98.60%	$2.94	1.40%	$0.00	0.00%	$205.02	17
Mississippi	$151.50	95.00%	$0.80	0.50%	$7.10	4.50%	$159.40	23
Missouri	$236.89	91.20%	$16.77	6.50%	$6.18	2.40%	$259.84	11
Montana	$27.08	92.30%	$2.26	7.70%	NA	NA	$29.35	48
Nebraska (b)	$46.56	100.00%	$0.00	0.00%	$0.00	0.00%	$46.56	41
Nevada	$68.67	89.40%	$0.00	0.00%	$8.12	10.60%	$76.79	32
New Hampshire	$53.21	71.20%	$21.47	28.80%	$0.00	0.00%	$74.68	33
New Jersey (b)	$502.50	100.00%	$0.00	0.00%	$0.00	0.00%	$502.50	4

Table 48: SMHA-Controlled State Psychiatric Hospital Expenditures, by Service Type, FY 2008 (in millions) (Continued)

State	Inpatient Services		Other 24-Hour Services		Less Than 24-Hour Services		Total State Hospital Expenditures	Rank
	$	%	$	%	$	%	$	
New Mexico (ac)	$21.83	49.00%	$22.74	51.00%	$0.00	0.00%	$44.58	43
New York (b)	$1,207.30	72.90%	$107.60	6.50%	$341.80	20.60%	$1,656.70	1
North Carolina	$324.41	92.40%	$26.57	7.60%	NA	NA	$350.98	7
North Dakota	$10.84	61.30%	$6.84	38.70%	$0.00	0.00%	$17.68	51
Ohio	$228.69	100.00%	NA	NA	NA	NA	$228.69	13
Oklahoma (b)	$55.70	100.00%	$0.00	0.00%	$0.00	0.00%	$55.70	37
Oregon	$127.74	100.00%	$0.00	0.00%	$0.00	0.00%	$127.74	25
Pennsylvania (ac)	$511.19	100.00%	$0.00	0.00%	$0.00	0.00%	$511.19	3
Rhode Island (c)	$32.91	100.00%	NA	NA	NA	NA	$32.91	45
South Carolina	$88.90	88.80%	$3.60	3.60%	$7.60	7.60%	$100.10	28
South Dakota	$43.13	100.00%	$0.00	0.00%	$0.00	0.00%	$43.13	44
Tennessee	$176.60	100.00%	$0.00	0.00%	$0.00	0.00%	$176.60	21
Texas (b)	$349.90	97.00%	$10.70	3.00%	$0.00	0.00%	$360.60	6
Utah (b)	$54.24	100.00%	NA	NA	NA	NA	$54.24	38
Vermont	$21.50	100.00%	$0.00	0.00%	$0.00	0.00%	$21.50	50
Virginia	$332.10	100.00%	$0.00	0.00%	$0.00	0.00%	$332.10	8
Washington	$241.40	100.00%	$0.00	0.00%	$0.00	0.00%	$241.40	12
West Virginia (b)	$47.00	100.00%	$0.00	0.00%	$0.00	0.00%	$47.00	40
Wisconsin	$196.20	100.00%	NA	NA	NA	NA	$196.20	18
Wyoming (b)	$22.14	73.70%	$7.50	25.00%	$0.40	1.30%	$30.05	46
Total	$9,587.73	93.20%	$322.29	3.10%	$373.26	3.60%	$10,283.28	51
Average (Mean)	$187.99		$6.32		$7.32		$201.63	
Median	$116.60		$9.10		$7.10		$116.60	

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

Figure 35: Trends in SMHA-Controlled Spending for State Psychiatric Hospital-Inpatient Services, FY 1981 to FY 2008

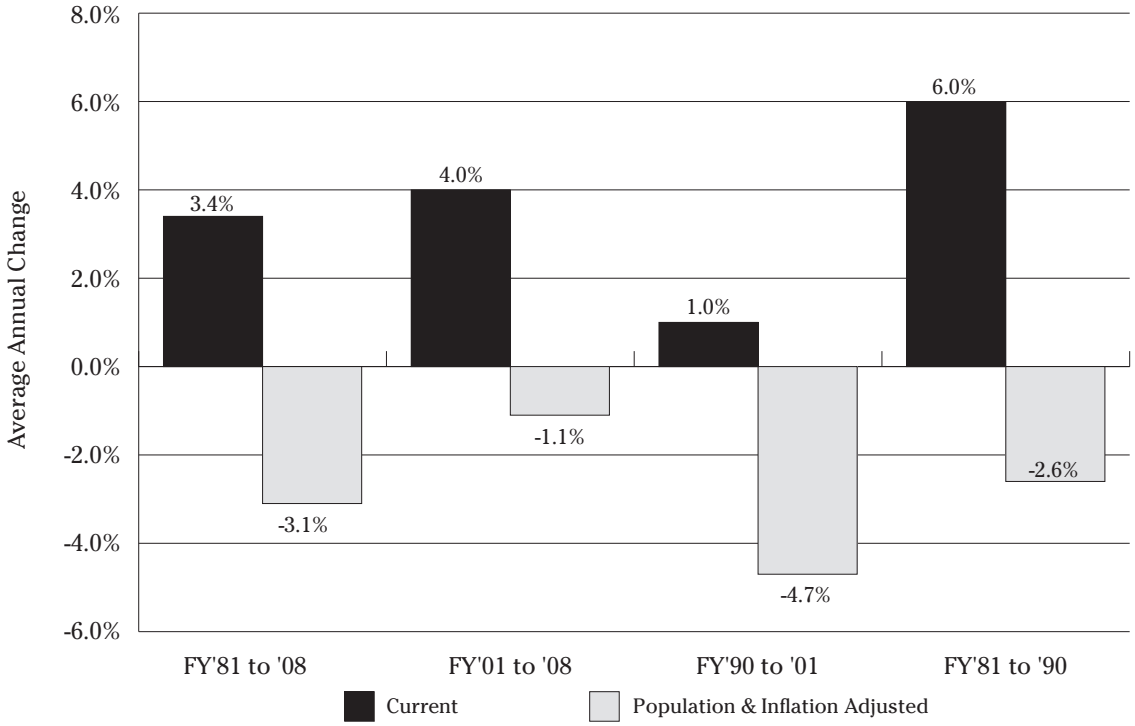


As shown in figure 36, over the 27-year period from FY 1981 to FY 2008, SMHA-controlled state psychiatric hospital inpatient expenditures increased by 3.4 percent per year. When adjusted for inflation and population growth, expenditures actually decreased by 3.1 percent per year over this time period. In inflation- and population-adjusted dollars, state psychiatric hospitals experienced a slower loss of expenditures during this decade than during the two prior decades.

5.6.3 Overall Revenues of State Psychiatric Hospitals, FY 2008

SMHAs controlled $10.46 billion in revenues (28 percent of total SMHA-controlled revenues) dedicated to state psychiatric hospitals in FY 2008. SMHAs received funding from a variety of sources, including state general funds, Medicaid, Medicare, other federal sources, local government, and first- and third-party payments (insurance).

Figure 36: Average Annual Change in SMHA-Controlled State Psychiatric Hospital Expenditures, by Decade, FY 1981 to FY 2008

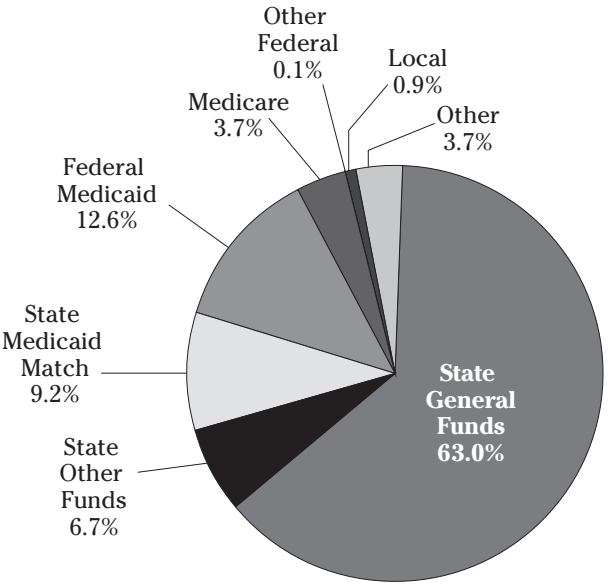


In FY 2008, 78.9 percent of SMHA-controlled funds for state psychiatric hospital services came from state government sources. The largest share of state funds came from state general funds (63 percent) and the state Medicaid match (9.2 percent).

Funding from the federal government accounted for 16.4 percent of the total SMHA-controlled state psychiatric hospital revenues. The federal Medicaid share was the single largest source of federal revenues, accounting for 12.6 percent of state psychiatric hospital revenues. Total Medicaid (state and federal shares combined) represented 21.8 percent of state psychiatric hospital revenues. Medicaid's IMD rules restricted payments for inpatient treatment in psychiatric hospitals to children (under age 21) and older adults (over age 65). Services to adult patients ages 21 to 64 in psychiatric hospitals (IMDs) were not eligible for Medicaid reimbursement.

State psychiatric hospitals received over $392 million in Medicare payments (3.7 percent of revenues) in FY 2008. Medicare payments at state psychiatric hospitals ranged from a high of 17 percent of hospital funding in North Dakota to eight states that reported no Medicare payments at their state psychiatric hospitals (California, Florida, Hawaii, Maine, Maryland, Montana, Oregon, and Wyoming).

Figure 37: SMHA-Controlled Revenues for State Psychiatric Hospitals, by Funding Sources, FY 2008



Total State Hospital Revenues = $10.5 billion

In addition, SMHAs received 1 percent of their revenues from local city and county governments and 3.7 percent from other sources, which included private health insurance reimbursements and consumer copays, as well as donations and all other funding sources. See figure 37, above, for a breakdown of total revenues, by funding sources.

Table 49 shows that SMHAs varied in their funding sources. Hawaii, Montana, and Wyoming relied entirely on state general and other revenue funds, but Iowa, Maine, and Rhode Island did not use any state general funds for state psychiatric hospitals. Medicaid was the largest funding source of state psychiatric hospitals in Maine and Rhode Island (100 percent in each state) and was responsible for 71 percent of funding of the state psychiatric hospital in New Hampshire.

5.6.4 Trends in Financing of State Psychiatric Hospitals

Since FY 1981, state general funds have been the largest source of state psychiatric hospital revenues. Although state general funds continued to be the largest source of funding for state psychiatric hospitals, during the 1990s, Medicaid funding increased while state general funds decreased. However, during the current decade, this trend reversed as SMHAs increasingly used state general funds to pay for state psychiatric hospitals. In FY 1981, state general funds represented 71 percent of the SMHAs' state psychiatric hospitals revenues, whereas Medicaid (state and federal) accounted for 19 percent. In FY 2008, the mix of funding sources was very similar to 27 years earlier, with state general funds representing 70 percent, whereas Medicaid increased slightly to 22 percent (see figure 38).

Table 49: SMHA-Controlled State Psychiatric Hospital Revenues, by Funding Sources and State, FY 2008 (in millions)

State	State General and Other Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd-Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Alabama	$120.2	71%	$21.1	12%	$17.2	10%	$0	0%	$0.1	0%	$0.0	0%	$0.0	0%	$10.9	6%	$169.5
Alaska	$7.4	27%	$15.0	56%	$2.7	10%	$0	0%	$0.5	2%	$0.0	0%	$1.4	5%	$0.0	5%	$27.0
Arizona	$70.0	91%	$0.0	0%	$0.5	1%	$0	0%	$4.1	5%	$0.0	0%	$2.2	3%	$0.0	3%	$76.8
Arkansas (a)	$33.1	46%	$31.1	43%	$3.4	5%	$0	0%	$0.0	0%	$0.0	0%	$3.9	5%	$0.4	6%	$71.9
California (b)	$1,077.4	92%	$7.3	1%	$0.0	0%	$0	0%	$0.0	0%	$0.0	0%	$9.8	1%	$78.1	7%	$1,172.7
Colorado	$89.7	81%	$9.0	8%	$7.5	7%	$0	0%	$0.4	0%	$1.1	1%	$3.0	3%	$0.0	3%	$110.7
Connecticut (ac)	$210.0	94%	$4.2	2%	$5.6	3%	$0	0%	$0.1	0%	$0.0	0%	$2.2	1%	$1.2	2%	$223.3
Delaware (ac)	$43.8	92%	$1.2	2%	$0.6	1%	$0	0%	$1.0	2%	$0.0	0%	$1.2	2%	$0.0	2%	$47.8
District of Columbia	$95.4	96%	$0.4	0%	$3.7	4%	$0	0%	$0.2	0%	$0.0	0%	$0.0	0%	$0.0	0%	$99.6
Florida	$262.8	72%	$103.8	28%	$0.0	0%	$0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$366.6
Georgia (a)	$161.3	79%	NA	NA	$11.6	6%	NA	NA	$0.0	0%	NA	NA	$0.9	0%	$31.3	16%	$205.1
Hawaii (c)	$48.9	100%	$0.0	0%	$0.0	0%	$0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$48.9
Idaho	$22.9	77%	$4.8	16%	$1.4	5%	$0	0%	$0.0	0%	$0.0	0%	$0.6	2%	$0.1	3%	$29.9
Illinois	$304.8	94%	$8.2	3%	$10.0	3%	$0	0%	$0.0	0%	$0.0	0%	$1.9	1%	$0.2	1%	$325.1
Indiana	$135.0	72%	$46.5	25%	$5.6	3%	$0	0%	$0.0	0%	$0.0	0%	$0.8	0%	$0.4	1%	$188.4
Iowa	$0.0	0%	$1.8	3%	$3.2	5%	$0	0%	$0.0	0%	$6.7	10%	$1.2	2%	$55.9	83%	$68.8
Kansas	$62.2	70%	$26.4	30%	NA	NA	NA	NA	$0.0	0%	NA	NA	$0.0	0%	NA	NA	$88.6
Kentucky	$67.8	58%	$35.3	30%	$11.0	9%	$0	0%	$0.0	0%	$0.0	0%	$2.5	2%	$0.0	2%	$116.6
Louisiana	$80.2	43%	$92.7	49%	$0.7	0%	$0.4	0%	$1.2	1%	$0.0	0%	$0.0	0%	$12.5	7%	$187.7

Table 49: SMHA-Controlled State Psychiatric Hospital Revenues, by Funding Sources and State, FY 2008 (in millions) (Continued)

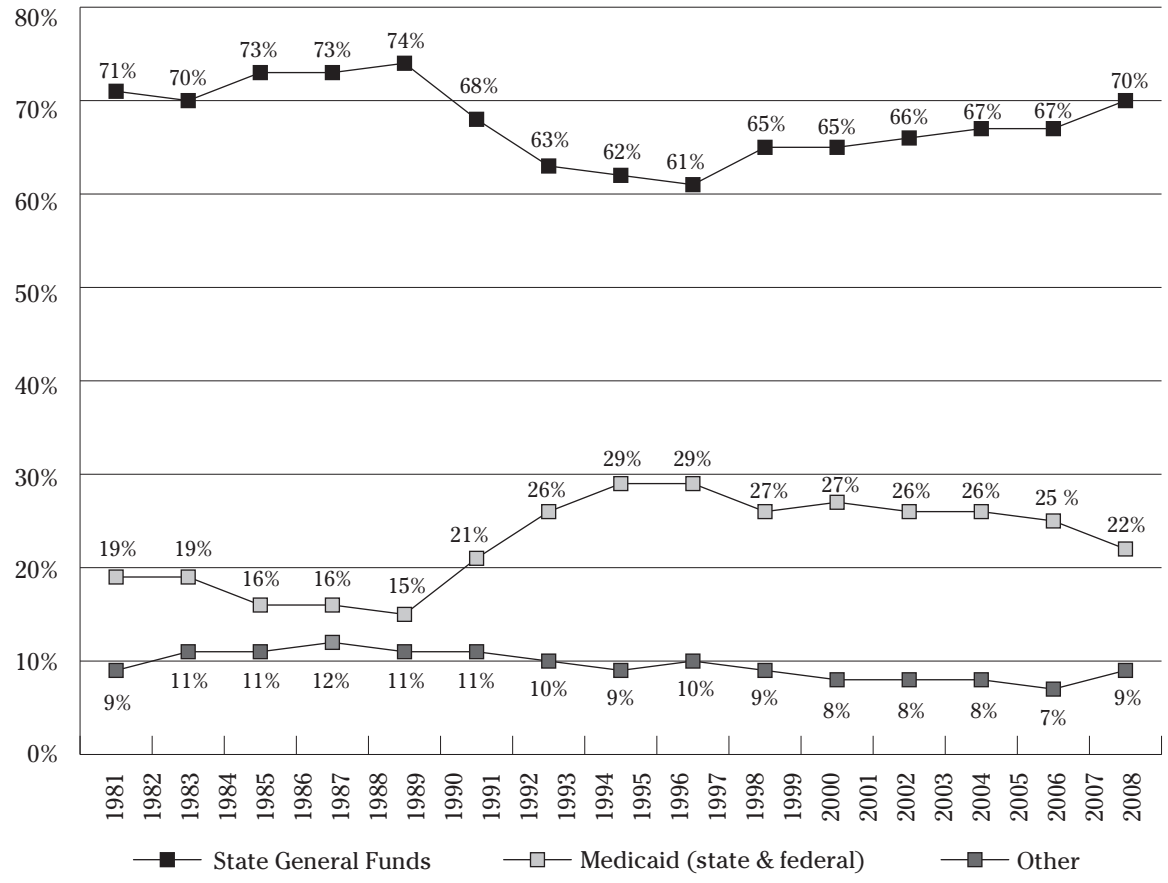
State	State General and Other Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd-Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Maine (b)	$0.0	0%	$55.8	100%	$0.0	0%	$0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$55.8
Maryland	$255.5	91%	$23.7	8%	$0.0	0%	$0	0%	$0.2	0%	$0.0	0%	$0.0	0%	$0.0	0%	$279.4
Massachusetts (a)	$140.6	92%	$6.8	4%	$4.4	3%	$0	0%	$0.0	0%	$0.0	0%	$0.6	0%	$1.0	1%	$153.4
Michigan (b)	$186.5	82%	$22.7	10%	$0.8	0%	$0	0%	$0.1	0%	$14.6	6%	$1.8	1%	NA	1%	$226.5
Minnesota	$154.8	76%	$13.2	6%	$5.4	3%	$0	0%	$0.0	0%	$22.6	11%	$9.0	4%	$0.0	4%	$205.0
Mississippi	$131.7	83%	$6.4	4%	$8.4	5%	$0	0%	$0.0	0%	$0.0	0%	$0.8	1%	$12.1	8%	$159.4
Missouri	$252.0	62%	$145.6	36%	$5.0	1%	$0	0%	$1.0	0%	$0.0	0%	$3.2	1%	$0.0	1%	$406.8
Montana	$29.3	100%	$0.0	0%	$0.0	0%	$0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$29.3
Nebraska (b)	$43.7	94%	$0.8	2%	$0.5	1%	$0	0%	$1.5	3%	$0.0	0%	$0.0	0%	$0.0	0%	$46.6
Nevada	$62.3	81%	$9.7	13%	$4.3	6%	$0	0%	$0.1	0%	$0.0	0%	$0.0	0%	$0.4	1%	$76.8
New Hampshire	$7.2	10%	$53.3	71%	$8.4	11%	$0	0%	$0.2	0%	$0.0	0%	$0.0	0%	$5.5	7%	$74.7
New Jersey (b)	$415.2	83%	$33.0	7%	$21.5	4%	$0	0%	$0.0	0%	$27.9	6%	$5.0	1%	$0.0	1%	$502.5
New Mexico (ac)	$37.6	84%	$4.8	11%	$0.3	1%	$0	0%	$0.0	0%	$0.0	0%	$0.1	0%	$1.8	4%	$44.6
New York (b)	$573.3	35%	$963.6	58%	$78.7	5%	$0	0%	$0.0	0%	$22.2	1%	$18.8	1%	$0.0	1%	$1,656.6
North Carolina	$269.1	77%	$30.7	9%	$26.9	8%	NA	NA	$0.1	0%	$1.6	0%	$8.8	3%	$13.8	6%	$351.0
North Dakota	$8.0	45%	$2.5	14%	$3.0	17%	$0	0%	$0.0	0%	$0.0	0%	$1.4	8%	$2.9	24%	$17.7
Ohio	$199.8	90%	$0.4	0%	$20.1	9%	NA	NA	$0.0	0%	$0.0	0%	$1.6	1%	NA	1%	$222.0
Oklahoma (b)	$45.1	81%	$6.3	11%	$3.0	5%	$0	0%	$0.0	0%	$0.0	0%	$0.6	1%	$0.7	2%	$55.7
Oregon	$94.9	74%	$26.1	20%	$0.0	0%	$0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$6.7	5%	$127.7

Table 49: SMHA-Controlled State Psychiatric Hospital Revenues, by Funding Sources and State, FY 2008 (in millions) (Continued)

State	State General and Other Funds		Total Medicaid		Medicare		CMHS MHBG		Other Federal		Local Government		1st/3rd-Party Payments		Other Revenues		Total SMHA Revenues
	$	%	$	%	$	%	$	%	$	%	$	%	$	%	$	%	
Pennsylvania (ac)	$401.1	78%	$66.0	13%	$32.8	6%	$0	0%	$0.0	0%	$0.0	0%	$11.3	2%	$0.0	2%	$511.2
Rhode Island (c)	$0.0	0%	$32.9	100%	NA	NA	$0	0%	$0.0	0%	$0.0	0%	$0.0	0%	NA	NA	$32.9
South Carolina	$68.7	66%	$30.8	30%	$0.8	1%	$0	0%	$0.0	0%	$0.0	0%	$1.9	2%	$1.3	3%	$103.5
South Dakota	$27.4	66%	$10.4	25%	$2.9	7%	$0	0%	$0.1	0%	$0.0	0%	$0.0	0%	$0.5	1%	$41.3
Tennessee	$122.5	69%	$46.2	26%	$6.3	4%	$0	0%	$0.0	0%	$0.0	0%	$1.2	1%	$0.4	1%	$176.6
Texas (b)	$300.3	83%	$25.4	7%	$22.8	6%	$0	0%	$0.6	0%	$0.0	0%	$11.5	3%	$0.0	3%	$360.6
Utah (b)	$33.7	62%	$17.1	31%	$1.6	3%	$0	0%	$0.1	0%	NA	NA	$0.0	0%	$1.8	3%	$54.2
Vermont	$21.2	99%	$0.0	0%	$0.1	0%	$0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.2	1%	$21.5
Virginia	$233.9	72%	$56.2	17%	$18.1	6%	$0	0%	$0.0	0%	$0.0	0%	$5.6	2%	$9.5	5%	$323.3
Washington	$60.4	25%	$148.8	62%	$21.0	9%	$0	0%	$0.0	0%	$0.0	0%	$11.2	5%	$0.0	5%	$241.4
West Virginia (b)	$22.9	49%	$18.3	39%	$3.5	7%	$0	0%	$0.0	0%	$0.0	0%	$2.1	4%	$0.2	5%	$47.0
Wisconsin	$164.7	84%	$13.6	7%	$6.5	3%	NA	NA	$0.0	0%	NA	NA	$11.4	6%	NA	6%	$196.2
Wyoming (b)	$30.0	100%	$0.1	0%	$0.0	0%	$0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$0.0	0%	$30.1
Total	$7,286.5	70%	$2,280.1	22%	$391.6	4%	$0.4	0%	$11.5	0%	$96.7	1%	$139.4	1%	$250.0	2%	$10,456.2
Average (Mean)	$142.9		$44.7		$7.7		$0.0		$0.2		$1.9		$2.7		$5.4		$205.0
Median	$92.3		$19.7		$5.0		$0.4		$0.1		$14.6		$1.2		$0.2		$116.6

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

Figure 38: Percentage of SMHA-Controlled State Psychiatric Hospital Mental Health Revenues, by Major Sources, FY 1981 to FY 2008



5.7 Summary

Every state government operated psychiatric inpatient beds that provided intensive services to consumers with high levels of need, including those who were a threat to themselves or others. In 2009, 2.6 percent of SMHA consumers were served in state psychiatric hospitals. Eighty-two percent of the consumers served in these hospitals were aged 21 to 64.

Psychiatric hospitals often provided forensic services to mental health consumers. Forensic services provided evaluation and treatment to persons with mental illness referred to the SMHA after contact with the criminal justice system. Males represented 64 percent of patients in state psychiatric hospitals. One-third of all consumers in state hospitals were involuntarily criminally committed.

In FY 2008, SMHAs spent $10.3 billion, or 28 percent of all SMHA-controlled expenditures, on state psychiatric hospitals. The majority of expenditures for state psychiatric hospitals were dedicated to inpatient services (93 percent), with the rest spent on less than 24-hour services (3.6 percent) and other 24-hour services (3.1 percent). SMHAs expended $3.1 billion on forensic services and an additional $442 million on sex offender services.

VI. Workforce

State initiatives to retain and boost the supply of the public health workforce serving the mental health system continued despite the many challenges experienced as a result of the economic slowdown. This section reviews the State Mental Health Agencies' (SMHAs') most recent workforce status in reported full-time equivalents (FTEs) at the state psychiatric hospitals, staffing shortages experienced at the state psychiatric hospitals and community-based programs, and the expanded role of licensed professionals. The discussion is followed by an analysis of the SMHAs' strategies and initiatives to retain, recruit, train, and improve the quality of their workforce. Other workforce-related topics, such as the organization's cultural competency initiatives, staff cross-training, and the use of technology in delivering mental health services in the rural/frontier areas, are also presented.

6.1 Recent Status of Mental Health Workforce

6.1.1 Number of FTEs in State Psychiatric Hospitals

For a typical workweek, 118,572.5 FTEs staffed the state psychiatric hospitals in 45 SMHAs. Sixty-nine percent of the FTE workforce provided direct patient care (including clinical, treatment, and rehabilitation-related work), and the other 31 percent provided indirect patient care (including administrative and support for direct patient care).

Vermont reported the lowest total number of FTEs (Vermont had 1 state hospital with 50 residents at the start of 2009), whereas New York reported the highest number of FTEs (New York had 26 state hospitals with 5,236 residents at the start of 2009). The median number of FTEs reported for direct patient care was 1,088 and 447 for indirect patient care, as shown in table 50.

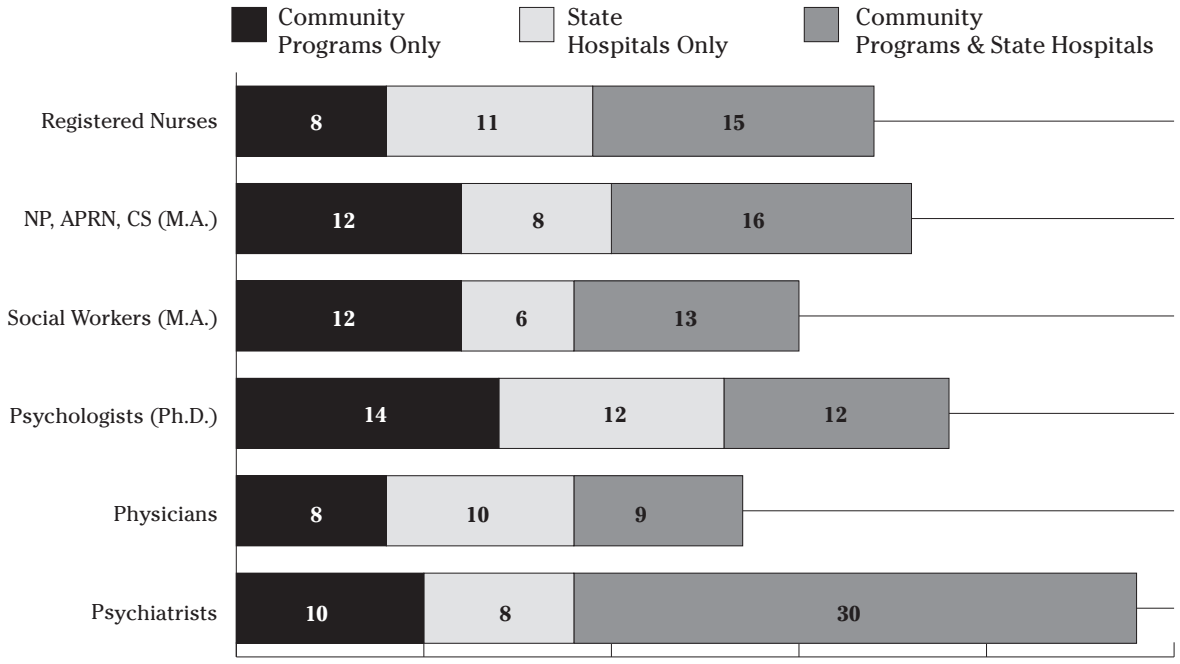
Table 50: 2009 Staffing Patterns at State Psychiatric Hospitals (45 states reporting)

Staff	Number of FTEs		
	Minimum	Maximum	Median
Direct Patient Care	170.2	10,027.8	1,088.0
Indirect Patient Care	22.0	5,139.6	447.0
Total Staff	202.6	15,167.4	1,643.0

6.1.2 Staffing Shortages

All 49 reporting SMHAs experienced shortages of mental health staff. Psychiatrists were the professional discipline in which the shortage (48 SMHAs) was most acute, followed by Ph.D.-level psychologists (38 SMHAs). SMHAs also identified shortages for social workers, nurse practitioners (NPs), advanced practice registered nurses (APRNs), and clinical specialists (CSs) in community-based programs, whereas shortages for registered nurses and other physicians were experienced in state psychiatric hospitals. Figure 39 shows the distribution of the number of SMHAs, by type of profession and treatment location where workforce shortages were experienced.

Figure 39: Number of SMHAs Reporting Shortages in Professional Classification, by Treatment Location

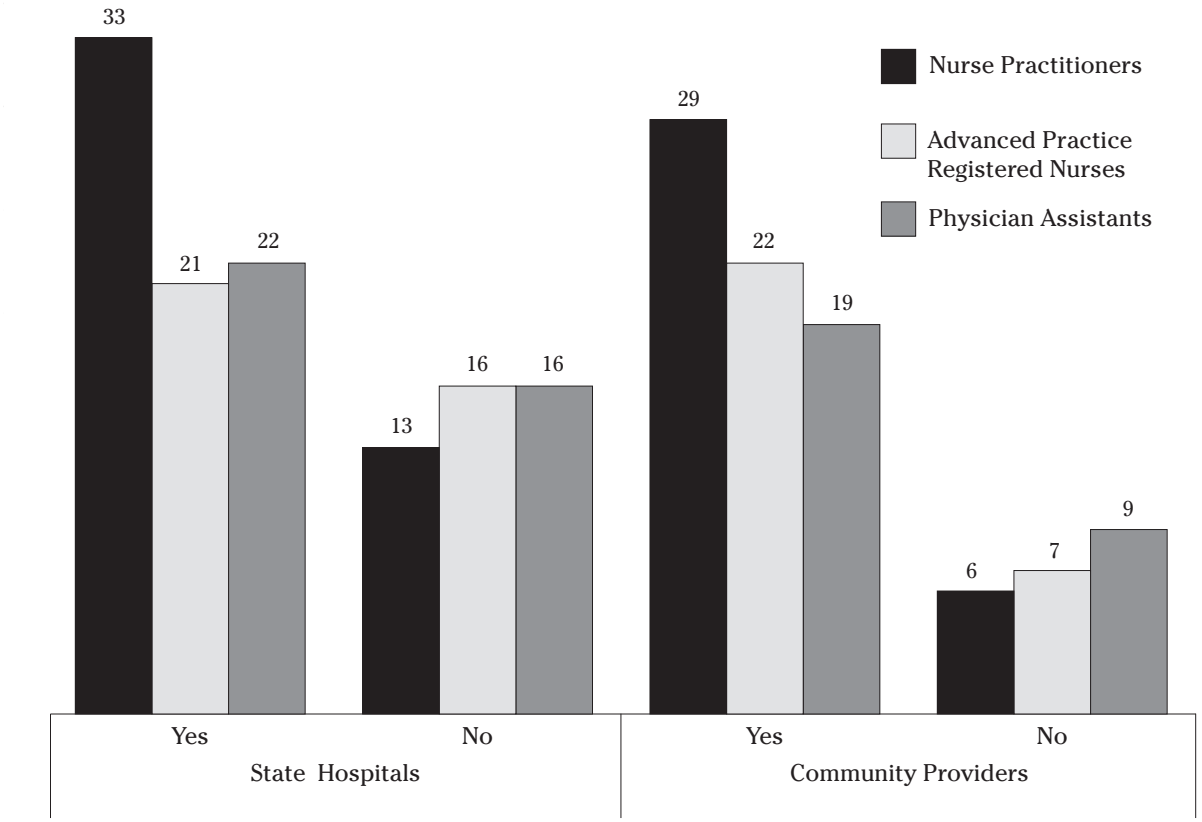


In addition to the mental health disciplines cited in figure 39, SMHAs cited other professions in which they experienced shortages. These disciplines included pharmacists and pharmacy staff, occupational therapists, physical therapists, dietitians, substance abuse counselors, healthcare technicians, psychiatric technicians, dentists/hygienists, licensed vocational nurses, and licensed practical nurses.

6.2 Expanded Role of Other Licensed Professionals

One of the methods that SMHAs used to mitigate existing shortages in professional workforce, particularly for psychiatrists, was the extension of prescription privileges to other licensed healthcare professionals. It is important to note that not all states allowed delegation of this medical responsibility. Figure 40, below, shows the distribution in the number of SMHAs with prescription privileges extended to NP, APRN, and physician assistants working at the state psychiatric hospitals or at community-based programs. In addition, dentists, psychologists, and clinical pharmacy practitioners were also cited as having prescribing privileges in some states.

Figure 40: Number of SMHAs Reporting Prescribing Privileges of Other Licensed Professionals



Licensed professionals other than physicians were also utilized for other clinical tasks, such as medication monitoring, history and physicals, client assessments, and treatment planning. Table 51 shows the number of SMHAs reporting use of these professionals, by clinical task.

Table 51: Clinical Responsibilities of Other Licensed Professionals

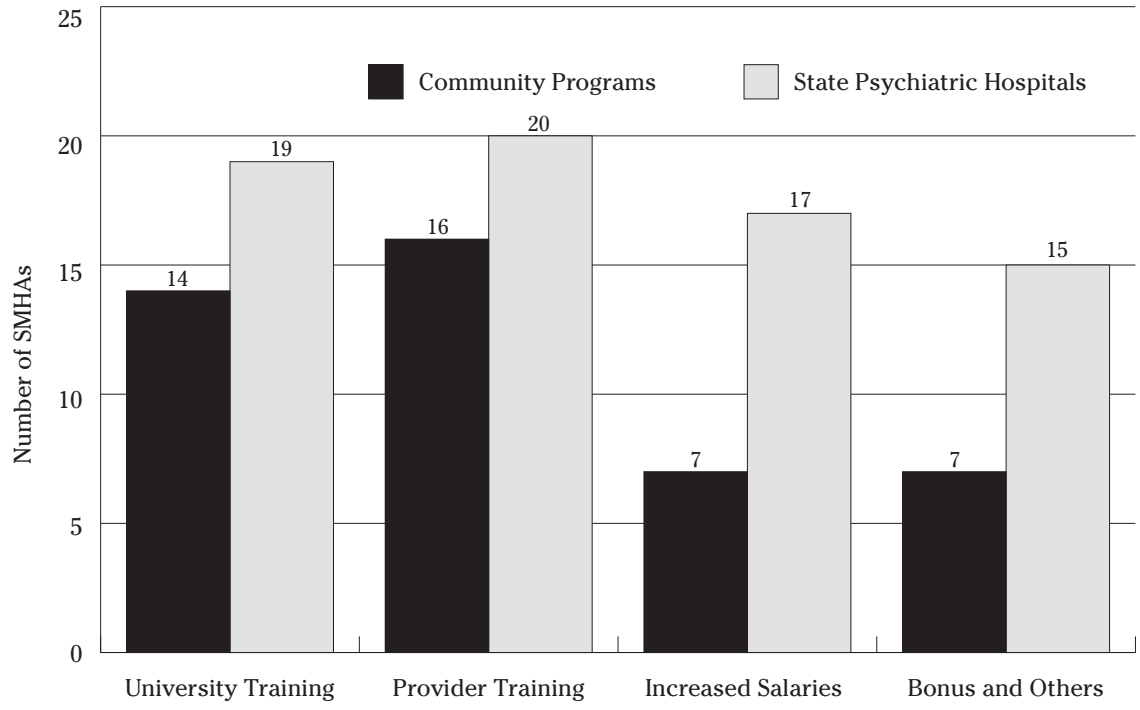
Responsibility	Nurse Practitioners	Advanced Practice Registered Nurses	Physician Assistants
Medication monitoring	39	30	31
History and physicals	41	28	28
Other*	6	6	6

*This clinical responsibility includes assessment, treatment planning, group therapy, and health maintenance.

6.3 Workforce Strategies and Initiatives

SMHAs took steps to retain existing personnel and/or to address shortages in the workforce. Thirty SMHAs had special initiatives to help address the staffing shortages. Figure 41 shows the number of states that used different types of initiatives to address shortages for state psychiatric hospitals and community mental health providers. At community-based programs, 16 SMHAs provided staff training, and 14 SMHAs provided university-based training. For state psychiatric hospitals, SMHAs provided staff training (20 SMHAs) and university-based training (19 SMHAs), which were the most common approaches used.

Figure 41: State Initiatives To Address Workforce Shortages



6.3.1 Additional Recruitment and Retention Initiatives

In addition to the recruitment initiatives discussed above, SMHAs used job fairs; open houses; internships; loan forgiveness or repayments; stipends; tuition reimbursements; sponsorship of continuing medical education credits for professional staff; better salaries (made periodic adjustments, adopted differential pay, and increased hiring rates); targeted/concentrated recruitment of needed professionals; statewide, nationwide, and international recruitment; sabbatical leave programs; career pathways; educational grants; employment orientations to students; and conversion of psychiatrist positions to psychiatric APRN.

To increase the professional workforce supply, some states partnered with universities/schools through various ways, such as funding postdoctoral programs (Colorado), funding faculty positions (Missouri), operating specialized residency programs for rural frontiers (New Mexico), sponsoring residency programs (Oklahoma), sponsoring fellowship programs (Pennsylvania), and partnering with a school district to recruit high school graduates for a career track as a registered nurse (Texas). See table 52 for the number of SMHAs that had relationships with specific university departments and professional schools.

SMHAs also had relationships with schools of pharmacy; schools for physician assistants; community college systems; technical schools; and schools for occupational therapy, physical therapy, music therapy, and recreation therapy.

Table 52: Number of SMHAs Having Relationships With University Departments and Professional Schools

	Number of SMHAs	SMHAs (percent)
Social Work	46	92%
Psychology	42	89%
Psychiatry	42	88%
Nursing	39	83%

The existing relationships included development of a mental health concentration for a degree program; curriculum and training development, facilitation, and use of the university as a training site; and internships, externships, practicums, clinical rotations, residencies, and clinical faculties.

6.3.2 Workforce Quality Improvement

Thirty-four SMHAs maintained a management system that was used to track and manage staff training. Forty-four SMHAs reported special initiatives to improve the quality of their mental health workforce. For example, in California, the Mental Health Services Act included a workforce education and training (WET) component with both local and state activities. The revenue collected

for this component was divided between statewide programs, and dollars were given to the counties to administer their own local WET programs. This revenue amounted to roughly $450 million for statewide programs and another $450 million distributed at the local level. All of the programs developed with this funding were designed to improve the quality of the mental health workforce. Regional partnerships were initiated at the state level. These were designed to allow counties to address mutual needs on a regional level. Each of the five regional partnerships, throughout the state, identified its own priorities to respond to the needs of its particular counties. Examples of projects that the regional partnerships have funded or contributed funding to include a weekend Master of Social Work (M.S.W.) program, a distance learning M.S.W. program, a nurse practitioner program, a high school academy, and training provided to current staff on various topics. A statewide technical assistance center, Working Well Together, was developed to assist counties in successfully recruiting, hiring, and maintaining consumers as public mental health workers. In addition to the statewide efforts, the 58 counties across the state were in various stages of developing and implementing their own WET efforts.

SMHAs used e-learning technology to improve the training of the workforce while limiting travel. E-learning approaches used by SMHAs included online training (46 SMHAs), video conferencing (42 SMHAs), and DVD training (37 SMHAs). Some of the online trainings were in the form of discussion boards, online posting boards, Webinars, and Webcasts. The South Carolina Education Television and conference calls were also used for training in South Carolina.

6.4 Addressing Disparities: Cultural Competency, Cross-Training, and Rural Frontier

The workforce shortages became more pronounced when SMHAs dealt with health disparities. SMHAs used a variety of constructs to measure disparity within its served population. Some SMHAs used demographic characteristics such as age and gender, whereas others identified special populations.

6.4.1 Identifying Disparities in Mental Health Services

Age, gender, race/ethnicity, and other cultural groups and attributes were used by SMHAs to identify disparities. Initiatives that identified disparities, by age, were implemented in 20 SMHAs; by race/ethnicity in 22 SMHAs; by gender in 19 SMHAs; and by other cultural attributes or groups in 17 SMHAs.

Some states focused on certain groups to determine existing disparities in mental healthcare. These groups included the tribal youth in state custody; older adults with co-occurring substance abuse disorders; early childhood (0 to 5); adults 60 years and older; ethnic minorities; other underserved groups, such as gays, lesbians, bisexuals, transgender, deaf/hard of hearing, Appalachians, etc.; and the transition-age group (young adults).

6.4.2 Cultural Competency

Twenty-four SMHAs had a Cultural Competency Plan. Of these, 17 SMHAs included measurable objectives. Some examples of measurable objectives included level of targeted population outreach, rate of consumer satisfaction, access, outcomes, and participation rates of minority groups in major decisionmaking bodies.

Twenty-five SMHAs addressed the topic of linguistic competence in various aspects: Seventeen SMHAs assisted providers or other organizations in educational material translations, 14 SMHAs made provider and service directories available in other languages, 15 SMHAs assisted in obtaining training materials for clinical staff in the use of interpreters, 12 SMHAs reported monitoring staff language skills, and 14 SMHAs set standards for mental health interpreters.

State plans also addressed several levels of cultural competency, including staff level, agency policies, and services. Some of the initiatives in the state plans involved evaluation of staff competency and development of staff cultural competency training; customization of treatment guidelines appropriate to Native Americans; reflection of cultural sensitivity and appreciation of diversity in agency mission, vision, value statements, contracts, rules, etc.; and integration of cultural competency in the system of care, in the organization's strategic plan, and in the agency's workforce initiatives.

6.4.3 Cross-Training of Workforce

Although 36 SMHAs provided cross-training of staff for dual diagnosis (mental health and substance abuse), only 12 SMHAs had special initiatives to cross-train staff for medical comorbidity. SMHAs' initiatives on dual diagnosis were largely focused on increasing staff capacity through training, technical assistance, workshops, conferences, and workgroups. Some of the focus areas included clinical supervision, certification of behavioral health counselors, use of assessment tools for co-occurring disorders, treatment of addiction, implementation of capability training for co-occurring disorders, privacy issues, laws on client confidentiality, and staff competency standards.

Health initiatives to address medical comorbidity included training on the medical aspects of co-occurring disorders, physical healthcare, sponsoring of health conferences, and the conduct of health screening during clinical assessment.

SMHAs utilized mental health consumers and family members as trainers for mental health staff. Five SMHAs included mental health consumers as trainers, whereas 27 SMHAs used both consumers and family members as trainers.

6.4.4 Rural Frontier

Thirty-seven SMHAs carried out initiatives to improve access to mental health services in the rural and geographically remote areas. Seventeen SMHAs recruited and trained mental health professionals specifically for these service areas.

Forty-three states promoted the use of telemedicine as a means of delivering mental health services. In order to promote its use successfully, 25 SMHAs reimbursed mental health providers for the service, whereas 32 SMHAs had this telemedicine service as a Medicaid-reimbursable expense. Seven SMHAs revised their licensure or scope-of-practice restrictions to promote the use of telemedicine.

The use of telemedicine was promoted through several SMHA initiatives, such as the inclusion of telemedicine in strategic plans; making telemedicine a reimbursable service under Medicaid or state funding; providing educational and technical consultation to providers in its use and purchase; and partnering with local hospitals, correctional facilities, and outpatient facilities for equipment installation.

SMHA initiatives for improving the rural/frontier mental health system were largely based on the use of such advanced technology as telemedicine, telepsychiatry, telehealth, video conferencing, and teleconferencing. Other initiatives that SMHAs used were adopting a comprehensive project to increase the Medicaid billing rates in rural areas, integrating traditional healing practices under Medicaid-reimbursable expense, colocating mental health services with primary care, implementing pilot programs in rural areas, and increasing provider network and/or professional staff.

6.5 Summary

All SMHAs reported experiencing shortages of their mental health workforce. Psychiatrists and Ph.D.-level psychologists were the professional disciplines most frequently identified as shortage areas. SMHAs had a number of initiatives to retain existing personnel and to support training and education to increase the size of their workforce. Many SMHAs had established relationships with universities and colleges within their state to increase the mental health workforce prepared to work in SMHA systems. SMHAs most often reported having relationships with Schools of Social Work, Psychiatry, Psychology, and Nursing. Most SMHAs used technology such as online trainings, video conferencing, and DVD training to improve the quality of their mental health workforce. Most SMHAs cross-trained mental health staff to address dual diagnoses of mental health and substance abuse. Some SMHAs were also cross-training staff to address physical health needs of mental health consumers.

To address shortages of psychiatrists, many states extended prescribing privileges to other licensed health professionals, such as nurse practitioners, advanced practice nurses, physician assistants, and other licensed professionals. These other licensed professionals were also being used for

other clinical tasks, such as monitoring medications, conducting physicals and histories, performing client assessments, and conducting treatment planning.

The cultural competence of the mental health workforce was a concern being addressed by SMHAs. Almost half the states had a cultural competence plan, and SMHAs conducted evaluations of staff cultural competence, including consumer linguistic and other cultural competencies, provided training, and developed customized treatment guidelines.

Most SMHAs had initiatives to improve access to mental health services in rural and geographically remote areas. Some SMHAs had recruitment and training initiatives to increase their rural mental health workforce. Telemedicine was used by 43 SMHAs to deliver mental health services, and 25 SMHAs reimbursed for telemedicine services.

VII. Management Information Systems and Research Functions

All State Mental Health Agencies (SMHAs) measured the quality, outcomes, and effectiveness of their services through the collection and reporting of information about the mental health services they funded and operated. The location of Management Information Systems (MIS) and how these systems were organized varied widely among states. In most states, MIS functions were located within the SMHA, but in some states, these MIS functions were consolidated into an office in an umbrella state agency outside of the SMHA.

7.1 Organization of MIS Functions

SMHA MIS responsibilities fell to a variety of agencies. It was the responsibility of 33 SMHAs to generate and analyze data and performance reports. Fourteen SMHAs shared the responsibility for these functions with another state agency. In three states, these responsibilities were located outside of the SMHA. As table 53 shows, many information management functions were located outside of the SMHA or shared with another agency (usually located in the SMHA's umbrella organization). These other agencies may have had requirements that limited the flexibility and autonomy of the SMHAs in changing their information system requirements and outcome reports.

Thirty-three SMHAs were part of an umbrella agency that ran computer hardware for the SMHA, and 34 SMHAs were part of an umbrella agency that controlled hardware acquisition decisions for the SMHA.

Table 53: Organizational Locations of Information Management Functions

Functions	Within the SMHA	Shared Between the SMHA and Another Agency	Outside the SMHA (in a separate agency)
Generating data and performance reports	33	14	3
Data management (e.g., updating and quality control)	23	17	10
Management and operation of computers	13	20	16
Data warehouses that link SMHA data with other state agency data	14	11	18

As states increasingly colocated the responsibility for managing substance abuse and mental health services, states also combined their information management functions. In 29 states, the information management functions for mental health and substance abuse services were combined. In 10 states, the information management functions for three major disabilities (mental health, substance abuse, and intellectual disabilities) were combined.

7.1.1 Additional Information Management Responsibilities of SMHAs

SMHAs varied regarding their responsibility for maintaining the SMHA's computer network, maintenance, help desk, and other information management functions. Most SMHAs had responsibility for the maintenance of the computer network and telecommunications located either within an independent state information technology (IT) agency or within an umbrella state agency, instead of within the SMHA (see table 54). SMHAs were most often responsible for developing applications, providing computer training, and performing help desk functions.

Table 54: SMHA Responsibilities for Managing IT

IT Function	Managed In-House (within SMHA)	Contracted to Vendor	Managed by an Umbrella State Agency	Provided by an Independent State IT Agency	Managed by Other
Computer Network	17	2	17	20	7
Telecommunications	11	3	15	23	7
Applications Development	24	17	13	14	6
Database Management	22	12	16	13	5
Computer Training	23	8	11	11	7
Help Desk	23	5	16	13	5
Video Conferencing	22	6	18	11	5
Equipment Maintenance	20	9	15	17	7
Other	1	1	0	0	1

7.2 MIS Staffing and Budgets

In 2010, 46 SMHAs had a total of 1,075.3 full-time equivalent (FTE) staff working on information management functions for mental health. The staff included 876.8 FTEs who worked within the SMHA and 198.5 FTEs who worked in another agency on mental health IT. States averaged 23 FTEs for mental health information functions (the median state had 9 FTEs), with a minimum of 2 FTEs to a maximum of 300 FTEs.

Thirty-five SMHAs expended over $158 million to support the mental health-related information management functions. States averaged expenditures of $4.5 million (the median state expenditures were $616,594), ranging from a high of $81.8 million in New York to a low of $89,680 in New Hampshire. The funding sources for these functions included state government (79 percent), federal government (6 percent), and other sources (15 percent).

7.3 Type of Mental Health Information Collected by SMHAs

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

7.3.1 Client-Level Data

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

Forty-seven SMHAs maintained client-level data for consumers served in community mental health settings. Of these, 38 SMHAs received unique client information for all community programs, whereas 9 SMHAs received client data from only some providers. For example, the South Dakota SMHA received client-level data only from providers receiving funding from the SMHA, and the Tennessee SMHA received client-level data only for clients enrolled in the Behavioral Health Safety Net.

7.3.1.1 Frequency of Client-Level Data Submissions and Updates

Local mental health service providers submitted data to the SMHA at a variety of time intervals. Sixteen SMHAs received data from providers monthly, 13 received data instantaneously through direct interface between the providers and the SMHA, 8 received data daily, and 4 received data weekly.

SMHAs required local providers to update client-level elements at specified times. Twenty-seven SMHAs received client-level information at admission, 29 received updates at discharge, and 19 received updates annually.

7.3.2 Sources of Mental Health Data

SMHAs received client-level or aggregate client data from a variety of sources. Thirty-five SMHAs received client data directly from local providers. Data received directly from local providers were often sent at the client level; however, eight SMHAs received aggregate data from local

providers. Ten SMHAs obtained client-level data at the client level directly from local county/city mental health government agencies, whereas one SMHA received aggregate data from these entities. In many states, a Medicaid managed care organization (MCO) waiver covered some behavioral health services. Twelve SMHAs received client-level data from MCOs, whereas 19 SMHAs received data in the form of Medicaid-paid claims with additional data to supplement reporting.

Thirty-six SMHAs conducted data audits or reviews to verify information submitted by community mental health providers. These data audits included onsite data checks and reviews of service or medical records. For example, in Kentucky, the Department of Behavioral Health, Developmental and Intellectual Disabilities utilized its automated data edits to verify accuracy, timeliness, and completeness of monthly client-level data submissions from community mental health centers. The department's Internal Data Users Group regularly reviewed aggregate data for quality of data elements collected.

7.3.3 Claims/Encounter Data

Most SMHAs received claims/encounter data that included descriptions of the transactions between the provider and client or those between a provider and another provider/entity for the benefit of the client. Forty-eight (48) SMHAs received claims/encounter data as well as aggregated provider reports. Of the 48 SMHAs, 42 received client-level claims/encounter data and 5 received a combination of client-level claims/encounter data and aggregated provider reports. One SMHA (New Mexico) received only aggregated provider reports.

Thirty-four SMHAs received client-level claims/encounter data for all individual encounters, whereas 14 did not receive all mental health claims/encounter data. Among the 14 SMHAs that did not receive all mental health claims/encounter data, only encounters for specific services were collected. These included inpatient/residential (8 SMHAs), crisis services (6 SMHAs), partial hospitalization (4 SMHAs), case management (10 SMHAs), support services (3 SMHAs), treatment services (9 SMHAs), and medication (7 SMHAs). Five SMHAs received claims/encounter data only for services for which the SMHA paid.

Table 55 shows the number of states that collected specific claims/encounter data file information. As depicted in table 55, although states received dates of service and type of service information, the specific codes used for types of service varied. Similarly, most SMHAs (40), received mental health diagnosis information in the claims/encounter record, but states differed in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) versus the International Classification of Diseases (ICD) diagnosis coding. Only 13 SMHAs received information about whether the service was for a person with a serious mental illness (SMI) or serious emotional disturbance (SED). The costs of services were available to slightly more than half the SMHAs (27). Thirty-five SMHAs could link service type in their claims/encounter data with Medicaid and/or other agency data.

Table 55: Data Elements Collected by SMHAs in Claims/Encounter Data Files

Data Elements	States
Client Identifier	47
Date(s) of service	48
Type of Service	48
CPT Codes	34
HCPCS Codes	33
UB82/92 Codes	11
State's Own Coding	16
Other Service Codes	3
Place of Service	37
Cost of Service	27
Duration of Service	41
Adjusted Cost of Service (Net Value)	13
Clinician/Provider	36
Diagnosis	40
DSM	23
ICD	30
SMI/SED Status	13
Other Diagnosis Codes	2
Clinician Provider Medicaid Identification	24
Other	5

CPT = Current Procedural Terminology.
HCPCS = Healthcare Common Procedure Coding System.
UB = Uniform Billing.

7.3.4 Medications/Pharmacy Information

Most SMHAs helped provide medications to persons with mental illnesses, paid for by SMHA funds or Medicaid. Thirty-five SMHAs maintained information about the use of psychiatric medications. Of these, 31 percent maintained information on Medicaid and SMHA-paid prescriptions, 34 percent on Medicaid-paid prescriptions only, 14 percent on SMHA-paid prescriptions only, and 20 percent maintained this information on other prescriptions.

SMHAs maintained a variety of information about medications, including the number of prescriptions (28 SMHAs); the types of medication, quantity of drugs prescribed, and data of prescriptions (29 SMHAs); medications delivered or purchased (21 SMHAs); and payments for medications (16 SMHAs).

Thirty-one SMHAs received medication information at the client level that could be linked to other client service-use data. In 24 SMHAs, this included detailed information about each prescription, and in five SMHAs, summary-level medication information was available for individual clients. Six SMHAs received aggregate information about medications.

SMHAs used electronic pharmacy/medication ordering systems to improve care. Thirty SMHAs implemented an electronic pharmacy/medications ordering system for their state psychiatric hospitals. Four SMHAs implemented an electronic pharmacy/medication ordering system for their community mental health system.

Electronic Medication Administration Record (eMAR) systems track the actual administration of medications to consumers. Fifteen SMHAs implemented an eMAR system in their state psychiatric hospitals, and two implemented such a system in their community mental health system.

7.3.5 Client Outcomes

The SMHA used its information management functions to prepare information for the SMHA's leadership, state legislatures, Mental Health Block Grant plans, and others on the effectiveness and appropriateness of mental health services offered in their states. A variety of stakeholders were involved in selecting client-outcome measures in each state. These stakeholders included mental health consumers (31 SMHAs), family members (26 SMHAs), mental health planning councils (31 SMHAs), researchers (24 SMHAs), community mental health providers (34 SMHAs), SMHA administrators (36 SMHAs), and others (7 SMHAs).

Most SMHAs monitored a variety of client-outcome measures. The client outcome measured by the most states was consumer perception of care, which was most commonly measured using the Mental Health Statistics Improvement Program Consumer Survey. Assessments of other frequently measured client outcomes included client functioning, family involvement/satisfaction, and client employment (see table 56).

Client outcomes were measured as part of a statewide client-outcome monitoring system in 31 states. In 22 states, the SMHA had or was implementing an SMHA-developed outcomes measurement system, whereas 5 SMHAs used a commercially developed outcomes measurement system, and 4 used a system that was a combination of a SMHA-developed system and a commercial system. In 10 SMHAs, the client-outcome system provided clinicians with real-time information about mental health consumers' status, such as functioning or symptoms scales.

Table 56: Number of SMHAs Monitoring Client-Outcome Measures

Client-Outcome Measures	Community Mental Health	State Hospitals
Perception of care	47	47
Functioning	44	35
Family involvement/satisfaction	44	29
Change in employment	46	35
Change in living situation	45	34
Client symptoms	39	32
Strength-based measures	39	33
Recovery/resilience	38	34
Other outcome measures	15	17

7.4 Linking SMHA Client Data With Other State Agency Databases

In order to facilitate a more comprehensive understanding of the services consumers received, SMHAs worked with their state Medicaid and other state agencies (OSAs). Forty-two SMHAs had access to the state Medicaid-paid claims files. Thirty-two directly received and analyzed mental health services paid for by Medicaid. Sixteen states established a central data warehouse, run by a separate state agency, which combined SMHA data with Medicaid data. Sixteen SMHAs utilized another mechanism for linking Medicaid-paid claims data files with SMHA mental health data, whereas in nine states, Medicaid-paid claims data were not linked to mental health data by any group within the state.

Of the SMHAs that linked Medicaid paid claims files with SMHA client data, 10 linked data on a monthly basis, 6 linked data annually, 3 linked data quarterly, and 2 linked data semiannually. SMHAs used these linked Medicaid and SMHA data for analysis of mental health services (38), policy analysis and/or administrative purposes (33 SMHAs), and identification of fraud and abuse (14).

Fourteen SMHAs worked with their state's Medicaid agency to combine the two data systems, and nine of these worked to utilize the federal Centers for Medicare and Medicaid Services Medicaid Information Technology Architecture (MITA). For example, Indiana worked on a Request for Services for MITA (Medicaid Management Information System) development and planned for full implementation by 2014.

In addition to linking mental health client data with Medicaid, 26 SMHAs linked data with several OSA data systems. SMHAs most frequently linked their data system with alcohol and drug abuse data systems (see table 57).

Table 57: Number of SMHAs Linking SMHA Data Systems With OSAs

OSA	Update Frequency		Purpose		Agency Responsible for Linking Data		
	Regularly	Special Projects	Analysis of MH Services	Identify Fraud & Abuse	SMHA	OSA*	Other Agency**
Alcohol and drug abuse	20	13	30	3	23	8	9
Criminal justice	6	16	19	0	15	0	4
Public health	4	12	14	1	11	3	4
Employment/vocational rehabilitation	5	10	11	0	8	2	4
Child welfare	9	0	0	10	4	2	2
Juvenile justice	2	15	15	0	12	1	4
Education	2	2	4	0	1	1	2

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

7.5 Electronic Health Records

"Electronic health records will provide major technological innovation to our current healthcare system by allowing doctors to work together to make sure patients get the right care at the right time and want to be clear that in all our Health IT investment, patient privacy is our top priority" (Secretary Kathleen Sebelius, 2010).

SMHAs actively implemented health information technology and expended resources on the implementation of electronic health records (EHRs) within mental health facilities. SMHAs also worked on participating in health information exchanges (HIEs) that shared EHR information between health providers and physicians. Additionally, SMHAs shared personal health records (PHRs) that allowed consumers to access elements of their medical records and allowed the sharing of that information with persons chosen by the consumers.

7.5.1 Implementation of EHRs

Thirty-eight SMHAs either already operated an EHR or were installing an EHR system in either their state psychiatric hospital or community mental health system. Thirteen of these SMHAs operated EHRs in both the state psychiatric hospitals and community mental health system. Sixteen SMHAs already operated EHRs in their state psychiatric hospitals, 15 were considering the implementation of EHRs, and 13 were installing EHRs (see figure 42).

Within the community mental health service setting, in 25 states, local mental health service providers already operated EHRs; in 11 states, the community service providers were installing EHRs; and in 5 states, community providers were considering the implementation of EHRs (see figure 43).

Figure 42: EHR Status in State Psychiatric Hospitals

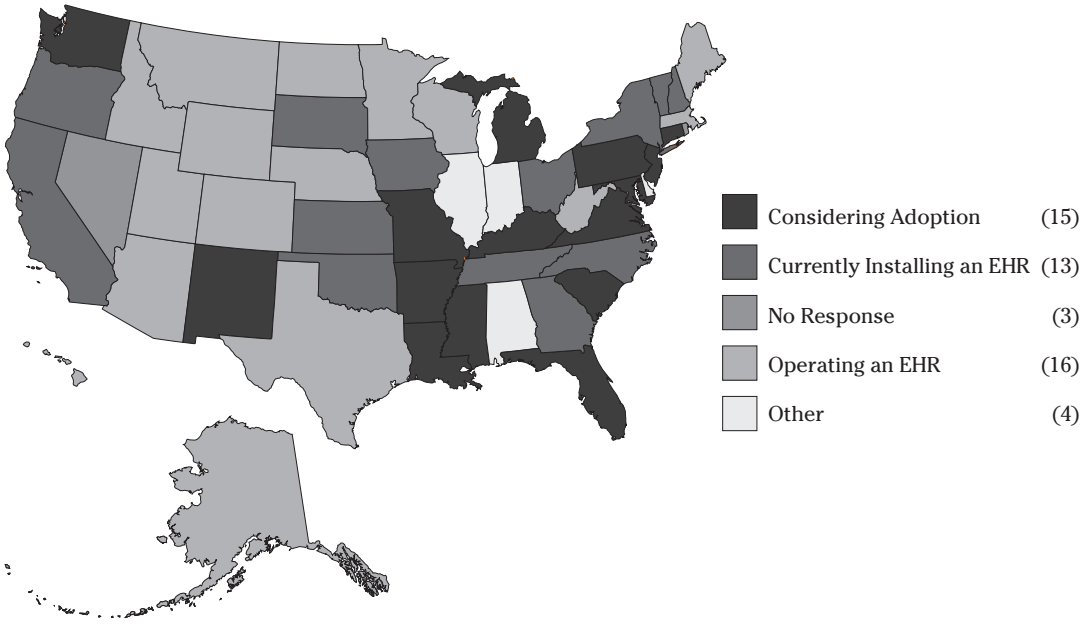
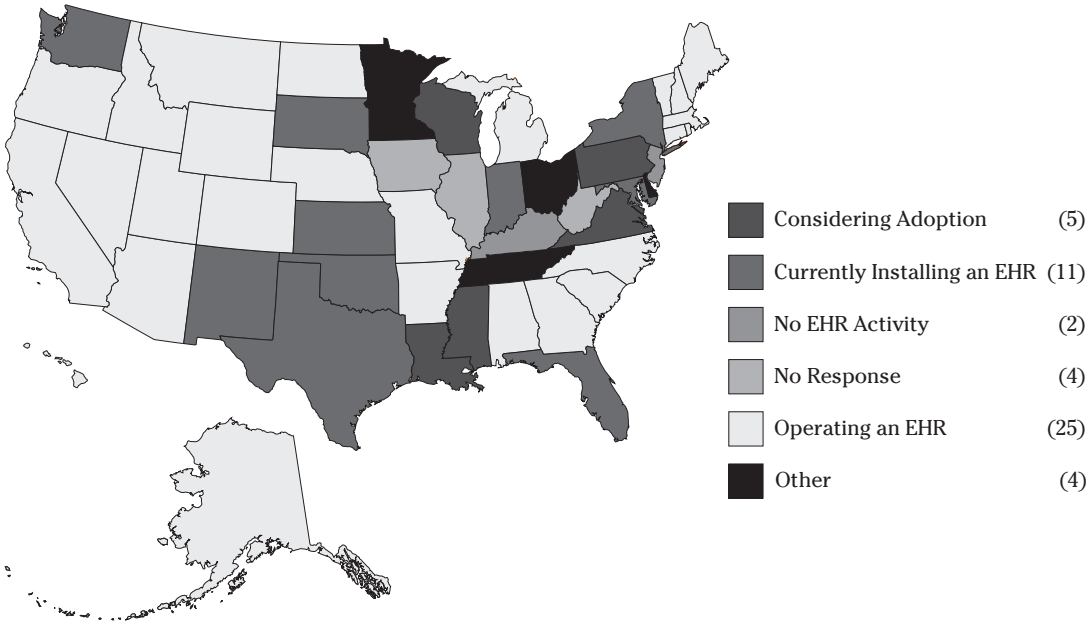


Figure 43: EHR Status in Community Mental Health Providers



7.5.2 Implementation of EHR Components

Some components of EHRs were implemented in either state psychiatric hospitals or community mental health programs, or in both. The most commonly implemented components were patient admissions, discharges, and transfers; pharmacy; billing as part of an EHR system; progress/case documentation; reporting; clinical assessments; and dietary. The least commonly implemented components were medication algorithms, exchange of client information with other providers, external consultation, and other EHR functions (see table 58).

Table 58: EHR Components Implemented in State Psychiatric Hospitals and Community Mental Health Providers

EHR Components	State Hospitals	Community Providers
	Number of States	Number of States
Patient admissions, discharges, and transfers	34	30
Pharmacy	32	19
Billing as part of EHR system	32	31
Progress/case documentation	27	30
Reporting	25	23
Clinical assessments	24	26
Treatment planning	22	29
Dietary	21	4
Scheduling	20	26
Physician order entry	17	18
Medication algorithms	9	2
External consultations	5	11
Exchange of client info with other providers	3	7
Other EHR functions	2	3

7.5.3 Sharing EHR Information

Many SMHAs had agreements that allowed the sharing of EHR information between providers to improve the coordination of mental health services. In 19 SMHAs, data-sharing agreements allowed state psychiatric hospitals within the state to share EHR information, whereas in 11 SMHAs, such agreements allowed the sharing of EHR client data between community mental health providers and state psychiatric hospitals. In six SMHAs, EHR client data were shared between community mental health service providers. The SMHAs in Alaska, Alabama, and Wisconsin had agreements that allowed the sharing of EHR client

information between state psychiatric hospitals and other general hospitals, whereas the SMHAs in Arizona, Florida, and Kansas had agreements that allowed sharing such client information between health maintenance organizations, other managed care firms, and the SMHA.

7.5.4 Benefits of Using EHRs

SMHAs reported a variety of benefits from implementing and using EHRs. The major benefits included enhanced quality assurance (19 SMHAs), improved reporting (18 SMHAs), reduced billing errors (13 SMHAs), and improved productivity (13 SMHAs). In addition, in South Carolina, the implementation and use of EHRs led to a reduction in billing administration costs.

7.5.5 Health Information Exchange

"The HITECH Act authorizes the establishment of the State Health Information Exchange Cooperative Agreement Program to advance appropriate and secure health information exchange (HIE) across the health care system. The purpose of this program is to continuously improve and expand HIE services to reach all health care providers in an effort to improve the quality and efficiency of health care. Cooperative agreement recipients will evolve and advance the necessary governance, policies, technical services, business operations, and financing mechanisms for HIE over a four-year performance period. This program will build from existing efforts to advance regional and state level HIE while moving toward nationwide interoperability" (Office of the National Coordinator for Health Information Technology, n.d.).

Thirty-two SMHAs were involved in the state's HIE Cooperative Agreements. The SMHAs' involvement in the HIE Cooperative Agreements included consultative roles (Alaska and Colorado), participation in planning (Louisiana, Maine, Oregon, Texas, and Utah), and active participation (Iowa, Michigan, Nebraska, New York, North Dakota, Ohio, Oklahoma, South Carolina, and Wisconsin). The SMHAs in Florida, Maine, and South Carolina already allowed the sharing of EHR client information with a state HIE. State psychiatric hospitals in 23 states, as well as SMHA-funded community mental health providers in 22 states, planned to participate in the HIEs being developed under the cooperative agreement.

7.6 Consumer Access to Mental Health Information

Technology was used by 39 SMHAs to help consumers find information about where and how to access mental healthcare, whereas 39 SMHAs used technology to help consumers find general information about mental illnesses. Most SMHAs (40) had initiatives to promote education about mental health treatments, services, and eligibility via state Web sites, whereas 8 SMHAs also used social networking sites such as Facebook.

7.7 Summary

SMHAs expended considerable resources in staff, time, and money to improve their mental health information systems. In 2010, 46 SMHAs had a total of 1,075.3 FTEs working on information management functions for mental health, and 35 SMHAs expended $158 million to support these functions.

All SMHAs measured the quality, outcomes, and effectiveness of their services through the collection and reporting of information about the mental health services they funded and operated. Almost all SMHAs maintained client-level data on clients served in SMHA-funded service providers.

SMHAs implemented health information technology and expended resources on the implementation of EHRs within mental health facilities. SMHAs also worked on participating in HIEs that shared EHR information between health providers and physicians. Additionally, SMHAs shared PHRs that allowed consumers to access elements of their medical records and allowed the sharing of that information with persons chosen by the consumers.

VIII. Summary

State Mental Health Agencies (SMHAs) are the state agency designated by the Governor or state legislature in each state to plan for and assure the delivery of high-quality mental health services in their state. In 2009, SMHAs oversaw the provision of services to over 6.4 million persons (over 2 percent of the population of the United States). Almost all of the persons served by the SMHAs (95 percent) received community-based mental health services, with only 2.6 percent receiving services in state psychiatric hospitals.

The organizational location of the SMHAs within state government as well as their specific service responsibilities varied. In most states, the SMHA was a division within a larger state government agency (usually a Department of Human Services). In a few states, the SMHA was an independent department where the SMHA's Commissioner reported directly to the Governor or to a mental health oversight board.

The majority of SMHAs (30 states) were responsible for behavioral health services, combining substance abuse and mental health services into a single state agency. In addition, several states also included intellectual disability services, and in 11 states, all 3 disability responsibilities (mental health, substance abuse, and intellectual disabilities) were combined into 1 agency.

SMHAs also differed regarding the specific set of mental health conditions and age groups for which they were responsible:

- All state governments operated psychiatric inpatient beds, but not all states assigned this responsibility to the SMHA. In 44 states, the SMHA oversaw state-operated psychiatric inpatient beds; however, separate agencies in Colorado, New Hampshire, New Mexico, North Carolina, and South Dakota were responsible for the provision of state-operated psychiatric inpatient services.
- Thirty-five SMHAs were responsible for providing services to both children and adolescents; however, in 11 states, the responsibility for children's services was shared between the SMHA and a separate state agency. Three states had a separate children's department responsible for services including child welfare, juvenile justice, mental health, substance abuse, and other social services for children and adolescents.
- Thirty-six SMHAs were responsible for adult forensic mental health services. An additional 13 SMHAs shared this responsibility with the Department of Corrections. Only Connecticut and Wyoming had no responsibility for providing adult forensic mental health services.

- Eighteen SMHAs shared the responsibility of providing services for people with brain impairments (such as traumatic brain injuries) with another agency, whereas the SMHAs in Maryland and North Carolina had the sole responsibility for providing these services. Twenty-nine SMHAs had no responsibility for these services.
- In 33 states, the SMHA had no responsibility for the provision of services for people with organic brain syndromes or Alzheimer's disease. Sixteen SMHAs shared this responsibility with another state agency. Arkansas's SMHA had the sole responsibility for the provision of these services.

During state fiscal years (SFYs) 2009 to 2011, SMHAs were forced to address the impact of major state government revenue shortages. These shortages resulted in many SMHAs having to make reductions to their mental health services. Seventy-eight percent of responding SMHAs (35 out of 45 SMHAs) had cuts to their mental health budget during FY 2010. Over the most recently completed 2 fiscal years (FY 2009 and FY 2010), SMHAs had reductions of $1.5 billion ($664 million in reductions during FY 2009 and an additional $817 million of reductions in FY 2010). During the fall of 2010—the first few months of FY 2011—SMHAs had to make an additional $645 million in reductions (36 states reporting) and expected to make additional reductions before the fiscal year is completed.

SMHAs addressed these reductions through a variety of strategies. Most SMHAs started by making administrative reductions, such as hiring freezes, but the level of cuts required in many states required cutting direct services to consumers. Over half of the states had to reduce funds to community mental health providers, and almost half of the states made reductions to state psychiatric hospital services. Collectively, SMHAs reported closing 2,198 state psychiatric hospital beds in 25 states between 2009 and 2010, and 17 states were considering an additional 1,732 beds for closure.

In SFY 2008, SMHAs directed the expenditure of $36.7 billion (2.1 percent of total state government expenditures) for mental health services in state psychiatric hospitals; community mental health agencies; and the SMHA's research, training, and administration operations. SMHAs averaged per capita expenditures of $121 (the median was $109). Sixty-two percent of SMHA-controlled revenues came from state government sources.

The funding sources SMHAs rely on have shifted over time. Since FY 1981, state general funds have grown from $4.6 billion to $16 billion in FY 2008, an annual average increase of 4.7 percent. Medicaid, however, has increased at a much faster rate, an annual average rate of 11.7 percent, from $0.9 billion in FY 1981 to $17.1 billion in FY 2008.

Every SMHA funded community mental health services; however, SMHAs varied widely in how they organized and financed this community mental health system. Most SMHAs (39) funded private not-for-profit community providers, but many (19) states—particularly the large population states—funded city and/or county governments that were responsible for the delivery of community mental health services. A few SMHAs (14) operated community mental health provider agencies with state employees. SMHAs also used a wide mixture of financing sources and payment arrangements to cover mental health services.

In 2009, 95 percent (6.1 million) of the 6.4 million consumers, served by the 58 state and territorial SMHAs, received community-based mental health services. Consumers of all ages received services in community settings. Of the different age groups served, consumers ages 21 to 64 made up the majority (64 percent), followed by children aged 0 to 17 (27 percent), young adults aged 18 to 20 (5 percent), and elderly aged 65 and over (4 percent).

Every state operated some psychiatric inpatient beds, most of which were located in a specialty state psychiatric hospital. In 2009, state-operated psychiatric hospitals served 2.6 percent of all mental health consumers who received services provided by the SMHA, or 167,002 individuals, throughout the year. At the start of 2009, 45,468 persons were residents in state psychiatric hospitals. These state psychiatric hospitals had expenditures of $10.3 billion, or 28 percent of all SMHA-controlled expenditures in FY 2008. In 2010, 49 SMHAs operated or funded 216 state psychiatric hospitals (operated and staffed, or funded by, the SMHA) that provided specialized inpatient psychiatric care. Rhode Island was the only state that did not have a stand-alone state psychiatric hospital; however, Rhode Island's SMHA operated psychiatric beds within the state's general hospital.

During 2010, SMHAs were working on each of the SAMHSA-identified eight major strategic initiatives for behavioral health. SMHAs were addressing all eight of these areas—Health Reform; Prevention of Substance Abuse and Mental Illness; Housing and Homelessness; Military Families; Trauma and Justice; Health Information Technology; Data, Quality, and Outcomes; and Public Awareness and Support.

Glossary

ACA	Patient Protection and Affordable Care Act
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADHS	Arizona Department of Health Services
AIDS	Acquired immunodeficiency syndrome
APA	American Psychiatric Association
APRN	Advanced practice registered nurse
ASO	Administrative services organization
BMI	Body Mass Index
BSFT	Brief Strategic Family Therapy
CBT	Cognitive Behavioral Therapy
CEO	Chief Executive Officer
CMHC	Community mental health center
CMHS	Center for Mental Health Services
CPSST	Cognitive Problem-Solving Skills Training
CPT	Current Procedural Terminology
CS	Clinical specialist
CVD	Cardiovascular disease
DBHS	Division of Behavioral Health Services
DCF	Department of Children and Families
DD	Developmental disabilities
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III-R	Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised

EBP	Evidence-based practice
EHR	Electronic health record
eMAR	Electronic Medication Administration Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FFS	Fee-for-service
FFT	Functional Family Therapy
FPL	Federal Poverty Level
FQHC	Federally qualified health center
FTE	Full-time equivalent
FY	Fiscal year
GBMI	Guilty but mentally ill
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HHS	U.S. Department of Health and Human Services
HIE	Health information exchange
HIV	Human immunodeficiency syndrome
HMO	Health maintenance organization
HUD	Department of Housing and Urban Development
ICD	International Classification of Diseases
ICF	Intermediate care facilities
ICF-MI	Intermediate care facilities for persons with mental illness
IMD	Institution for Mental Disease
IPT	Interpersonal Psychotherapy
IT	Information technology
IY	Incredible Years
LOS	Length of stay

M.S.W.	Master of Social Work
MC	Managed care
MCO	Managed care organization
MH	Mental health
MHBG	Mental Health Block Grant
MHPAEA	Mental Health Parity and Addiction Equity Act
MIS	Management Information Systems
MITA	Medicaid Information Technology Architecture
MR	Mental retardation
MR/DD	Mental Retardation/Developmental Disabilities
MST	Multisystemic Therapy
NA	Not applicable
NASBO	National Association of State Budget Directors
NASMHPD	National Association of State Mental Health Program Directors
NGA	National Governors Association
NGRI	Not guilty by reason of insanity
NP	Nurse practitioner
NR	Not reported; no response
NRI	National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc.
ODMH	Ohio Department of Mental Health
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OSA	Other state agency
PATCH	Psychogeriatric Assessment and Treatment in City Housing

PATH	Project for Assistance in Transition from Homelessness
PCIT	Parent-Child Interaction Therapy
PHR	Personal health record
PMT	Parent Management Training
PTSD	Posttraumatic stress disorder
RAP	Reintegration Action Plan
SA	Substance abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious emotional disturbances
SFY	State fiscal year
SHA	State Health Authority
SMHA	State Mental Health Agency
SMI	Serious mental illnesses
SNF	Skilled nursing facility
SPS	State Mental Health Agency Profiling System
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TBI	Traumatic brain injuries
TF-CBT	Trauma-Focused Cognitive Behavioral Therapy
TMAP	Texas Medication Algorithm Project
UB	Uniform Billing
URS	Uniform Reporting System
WET	Workforce education and training
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association

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