Grading the States

A Report on America's Health Care System for Serious Mental Illness

Executive Summary

2006

The National Alliance on Mental Illness

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NAMI: The National Alliance on Mental Illness

Grading the States: A Report on America's Health Care System for Serious Mental Illness,
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NAMI is the National Alliance on Mental Illness, the largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. A nationwide organization founded in 1979, NAMI has become the nation's voice on mental illness, with affiliates in every state and in more than 1,100 local communities across the country.

NAMI is dedicated to the eradication of mental illnesses and to the improvement of the quality of life of all who are affected by these diseases.

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Letter from NAMI Executive Director

We live in a time where people with serious mental illness are at increased risk. State systems are under tremendous financial strain. As this report goes to press, actions that are being considered in Congress are likely to do more harm than good. Sadly, the promise of community mental health remains unfulfilled.

In 1990, NAMI released its last state ratings report. It described a system of services that, despite enormous expenditure of resources, was not "even minimally acceptable." It detailed great regional and state variations in the existing system of care. Sixteen years later, mental illnesses cause more disability than any other class of medical illness in America. Recent reports from the U.S. Surgeon General, President Bush's New Freedom Commission, and the Institute of Medicine describe well a "system in shambles" and the "chasm" between promise and performance.

Simply put, treatment works, if you can get it. But in America today, it is clear that many people living with the most serious and persistent mental illnesses are not provided with the essential treatment they need. As a result, they are allowed to falter to the point of crisis The outcome of this neglect and lack of will by policymakers remains often horrendous. The number of people with serious mental illness incarcerated in jails and prisons is on the rise. Emergency room use is increasing. The availability of housing is being threatened. Increasingly, access to effective treatments is being limited by many state governments.

This 2006 report, *Grading the States: A Report on America's Health Care System for Serious Mental Illness*, has number of audiences. NAMI intends the report to be a consumers' guide to public services for adults with serious mental illness. We hope it will provide elected policymakers with a specific agenda for action. We also intend for this report to promote a dialogue among all stakeholders about what is and what is not working in the mental health system.

> Mental illnesses cause more disability than any other class of medical illness in America.

This report looks closely at the investment over time that states have made in their public mental health systems serving adults with serious mental illness. Consistency of vision and political will are key factors driving good systems of care. In 2006, the leadership necessary to drive and sustain system development comes from an array of sources that include a state's mental health authority, Medicaid bureau, the governor's office, legislative leadership, and county officials. We have worked to understand how decisions made by each of these entities have influenced the development of a state's mental health system.

Striving for fairness, comprehensiveness, and transparency, we have surveyed consumers and family members, subject-area experts, researchers, administrators, and clinicians, and then focused on those areas we believe matter most to people with serious mental illnesses and their families.

We thank the Stanley Foundation for its funding and ongoing support of this survey. We also thank the State Mental Health Authorities for their willingness to share information with this project. And we thank Dr. E. Fuller Torrey for the vision provided in the 1986, 1988, and 1990 state rating reports. Without those groundbreaking reports, this one would not exist.

It is our strong sense that if we are to move forward, we must routinely engage in assessing the mental health care systems in every state. It is our intention with this report, and future reports, to stimulate dialogue about what is and what is not working in America. We look forward to releasing the follow-up to this report several years hence. We encourage State Mental Health Authorities to reply and we will print their responses on our Web site, to continue the essential dialogue of advancing our shared system. Your comments will allow us to strengthen such surveys. We hope that our publication of these reports at regular intervals will over time drive the creation of service systems in all states that are not "patchwork relics," but ones of hope, opportunity, and recovery.

Michael J. Fitzpatrick
Executive Director
National Alliance on Mental Illness

Executive Summary

This report is the first comprehensive survey and grading of state adult public mental healthcare systems conducted in more than 15 years. Public systems serve people with serious mental illnesses—such as schizophrenia, bipolar illness, and major depression—who have the lowest incomes.

The report confirms in state-by-state detail what President Bush's New Freedom Commission on Mental Health called a fragmented "system in shambles."

Nationally, the system is in trouble. Its grade is no better than a D.

Too many state systems are failing

Only five states receive a B: Connecticut, Maine, Ohio, South Carolina, and Wisconsin.

Seventeen states receive Cs, 19 states get Ds, and eight get Fs. That's without the pluses and minuses.

Those states that are failing are: Iowa, Idaho, Illinois, Kansas, Kentucky, Montana, North Dakota, and South Dakota.

Nationally, the system is in trouble. Its grade is no better than a D.

This report includes tables that indicate each state's overall grade as well as its grade in each of four categories: Infrastructure, Information Access, Services, and Recovery.

Each state grade is based in part on a "take-home test," in which survey questions were submitted to state mental health agencies during October and November 2005. All but two states responded. Colorado and New York declined. They have been graded "U" for "Unresponsive."

NAMI wishes to commend Alabama, Louisiana, and Mississippi for their participation, which came in the wake of the twin catastrophes of Hurricanes Katrina and Rita.

Based on the surveys and publicly available information, states were scored on 39 criteria. Consumer and family advocates also provided information through interviews that contributed to state narratives.

The "Consumer and Family Test Drive" represents a unique, innovative measurement. Access to services depends on access to information. NAMI therefore had consumers and family members navigate the Web sites and telephone systems of the state mental health agency in each state and rate their accessibility according to how easily one could obtain basic information.

To some degree, this exercise was like a "pop quiz." Over 80 percent of the states scored less than 50 percent of the total points.

In one case, an agency employee told a consumer: "No, I will not help you."

Those states that received excellent Test Drive scores were Indiana, Michigan, Ohio, South Carolina, and Tennessee.

Those that received the lowest Test Drive scores were Alabama, Arkansas, Missouri, New Mexico, and South Dakota.

For each state, grades in each category and scoring of the 39 criteria appear in the "State Narratives" section of the report.

The narratives provide context. Common themes

emerge. In every case, they relate to choices. None are predestined. Some reflect choices made by governors and legislatures, sometimes without full appreciation of the nature of serious mental illnesses.

The report offers several basic policy recommendations:

- Increase funding tied to performance and outcomes
- Invest in proven. cost-effective practices (i.e., evidence -based practices)
- Improve data collection
- Increase access to information
- Involve consumers and families in all aspects of the system
- Eliminate discrimination

Each state narrative also includes a list of specific "Innovations" and "Urgent Needs" to help advocates and policymakers further define agendas for action. An overall list of innovations provides an opportunity for states to learn from one another. Just a few include:

- California's Proposition 63 to finance mental health services
- Low-income housing financed by real estate transaction fees in Illinois
- A telephone triage system in jails financed through DWI fines in Kentucky
- A public-private joint venture in Massachusetts to replace a mental health center
- A prescription feedback system in Missouri that has reduced hospitalizations and unnecessary poly-pharmacy
- A purchasing collaborative in New Mexico

Creative action is needed. Progress is needed. As the grade distribution in the report demonstrates, the United States still has a long way to go to achieve a "New Freedom" for people living with serious mental illness—a freedom based on recovery and dignity.

NAMI wishes to commend Alabama, Louisiana, and Mississippi for their participation, which came in the wake of the twin catastrophes of Hurricanes Katrina and Rita.

Acknowledgements and Authors

We would like to thank the state mental health commissioners and their staffs for responding to the extensive NAMI survey and furnishing information on their states' systems of care. In this time of expanding responsibility, these dedicated workers continue to impress us with their devotion to helping the less fortunate lead fulfilling lives.

Along with the commissioners and their staffs, we would like to thank the many NAMI leaders who provided fact checking and background information that support the findings of this report.

Information for the statistical data incorporated into this report was gathered from the organizations of the National Association of State Mental Health Program Directors, the National Institute of Mental Health, and the Substance Abuse and Mental Health Services Administration.

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To ensure the report's objectivity, we sought and received help in scoring the data compiled by the state mental health commissioners. We would like to acknowledge the individuals who contributed countless hours to deciphering and comparing data on each of the individual state responses: Anand Pandya, M.D., psychiatrist and chair of the NAMI Board of Directors Policy Committee; Elizabeth Edgar, a family member, social worker, and former mental health administrator; Marty Raaymakers, chair of the NAMI Consumer Council; and Jack Gorman, M.D., psychiatrist and chair of NAMI's Scientific Council.

Michael Cohen, MA, CAGS, and Abby Winzeler, of NAMI New Hampshire, designed and executed the Consumer and Family Test Drive portion of this report. A group of local volunteers, including Caroline Bacon, Dan Danisewski, and Janine Lapete, participated in "test-driving" each state's system.

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Introduction

The National Alliance on Mental Illness (NAMI) presents this state-by state "report card" on adult mental health care systems in the public sector in order to measure closely the continuing crisis in what President Bush's New Freedom Commission on Mental Health has labeled a "system in shambles."

The report is intended as a starting point. It is intended to provide a common baseline that will help the states share, learn, and build from individual lessons and innovations and will help them measure progress in future years. We hope it will give policymakers ideas to use in improving their states' mental healthcare systems. We also hope it will give consumer and family advocates information and the tools they need to shape agendas for change and hold policymakers accountable.

In appointing the New Freedom Commission in 2002, President Bush challenged the nation:

> "Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care. They deserve a healthcare system that treats their illness with the same urgency as a physical illness…
>
> "Today, new drugs and therapies have vastly improved the outlook for millions of Americans with the most serious mental illnesses, and for millions more with less severe illnesses. The treatment success rates for schizophrenia and clinical depression are comparable to those for heart disease. That's good news in America, and we must encourage more and more Americans to understand, and to seek more treatment."

NAMI members represent people with serious mental illnesses and their families. We are the "customers" whom state agencies serve. The perspective of this report is ultimately that of the people for whom the criteria, overall, may make the difference between recovery or premature death.

Today, that promise is stalled and at risk. The mental healthcare system faces continuing financial crisis as well as a need to catch up with advances in science and with proven, cost-effective treatment practices.

The report focuses on state adult systems of care. It does not address systems that serve children and adolescents, older adults, and veterans. That focus, however, should not be interpreted as a disregard for the importance and urgency of their distinctive needs. Much of this report focuses on State Mental Health Authorities (SMHAs), which provided much of the information for the grading process. However, the grade applies not to each SMHA, but to the total system in each state. The nation's overall system is complex and organizationally fragmented. It involves both the federal and state governments; counties and cities; and other public sectors such as the education, social welfare, and criminal justice systems. It is affected by private-sector trends involving medical professions, hospitals, and insurance. It also is financed

from many funding streams—a fact which sometimes results in competing priorities and conflicts beyond the control of any one agency.

That said, SMHAs play the most critical role in organizing, coordinating, and implementing statewide systems of services. Their leadership and accountability are vital. At the state level, it is their responsibility and obligation to push the agenda for change.

Methodology

Three landmark documents guide the report's overall vision:

- The U.S. Surgeon General's Report on Mental Health (1999)
- The report of the President's New Freedom Commission on Mental Health: *Achieving the Promise: Transforming Mental Healthcare in America* (2003)
- *Improving the Quality of Health Care for Mental and Substance Abuse Conditions*, by the Institute of Medicine of the National Academy of Sciences (2005)

> Nationally, because of a range of barriers, less than one third of adults with diagnosable mental illnesses receive treatment.

"Evidence-based practices" (EBPs), as based on those promoted by the U.S. Department of Health & Human Services (HHS) Substance Abuse & Mental Health Services Administration (SAMHSA), are those in which treatment methods have been measured against outcomes. These EBPs also provide a foundation for the report. They include Assertive Community Treatment (ACT), integrated dual diagnosis treatment (IDDT) for co-occurring disorders, illness management and recovery, supported employment, and family psycho-education.

Each state's progress toward a proven, cost-effective system of mental healthcare is indicated by a letter grade of A, B, C, D, or F. These are discussed in individual narratives in Section II of the report. Each grade is calculated from 39 specific criteria organized in four categories:

- Infrastructure
- Information Access
- Services
- Recovery Supports

Specific scores for each of the 39 criteria for each state appear in tables accompanying each state narrative.

The national grade was calculated as an average of the state grades, both overall and by category. In addition, the reader can quickly compare state systems by referring to tables in the report that list states grouped by grade and that list all states' scores for each of the 39 criteria.

The evaluation of existing state systems relied on four principal sources:

- Written responses from state mental health agencies to detailed questionnaires submitted in October—December 2005. To some degree, the questionnaires resembled "take-home tests" in contributing to each state's final grade. Colorado and New York were the only states to decline to participate in the survey, for which they have been graded "U" for "Unresponsive."

- Public information, such as state community mental health services block grant applications, agency reports, Web site content, and newspaper articles.

- A "Consumer and Family Test Drive" of every state agency's Web site and telephone routing system for information accessibility—which was then incorporated into the scoring system with a weight of 10 percent. To some degree, the test represented a "pop quiz."

- Interviews conducted with consumer and family advocates, which provided additional information for the state narratives.

A more detailed explanation of the scoring methodology can be found later in this section as well as in the Appendix. A discussion of the Consumer and Family Test Drive can also be found in the Appendix.

Information constantly changes. We have worked to make the report as accurate and up-to-date as possible. We also worked with states to address concerns or clarifications to improve the report during the research process. We look forward to receiving additional written comments and refining the methodology over time. It is important to see the grades as a *baseline* or *starting point* for the future.

Keep in mind also that NAMI members represent people with serious mental illnesses and their families. We are the "customers" whom state agencies serve. The perspective of this report is ultimately that of the people for whom the criteria, overall, may make the difference between recovery or premature death.

Common Trends

The state narratives that appear in Section II can be read individually or as a compilation in which common themes emerge. It is not enough to say that a state receives a "D" or a "B" without having some context for the obstacles it faces or efforts it makes. Several themes are worth noting here.

State Budget Crises

Most states have cut spending. Some have frozen spending. Some have given modest or small increases to mental health services. In New Jersey, in the face of a $4 billion deficit, Acting Gov. Richard Codey provided a $40 million increase in mental health services and $200 million for a housing trust fund for people with special needs that will construct 10,000 units over 10 years. In 2005, former Gov. Mark Warner of Virginia proposed a $460 million investment in the state mental healthcare system out of a state budget surplus of $1 billion.

Budgets represent choices.

In many cases, the budget squeeze has been over Medicaid. Overall, the public sector pays for more than 50 percent of mental health services. Medicaid, in turn, pays for 50 percent of the services that the states administer. In human terms, that translates to approximately 5 million people.

Nationally, because of a range of barriers, less than one-third of adults with diagnosable mental illnesses receive treatment. Worry about cost is one reason. For people on Medicaid, approximately 60 percent also identify as a barrier "the inability to obtain an appointment soon enough because of an insufficient supply of services." For much of the discussion in this report, that one fact—whether it applies to inpatient hospital care or outpatient community services—is centrally relevant. The system does not reach most people who need help. Nor does it encourage them.

Today, states are moving to contain Medicaid costs. In Tennessee, the state dropped approximately 200,000 adults generally from Tenncare, and imposed restrictions on benefits for an additional 400,000. Other states, such as Florida, are imposing co-payments, limits on the number of prescriptions per month, restricted formularies, "fail first" policies. and prior authorizations for medications.

Restrictions also represent choices. They are not mandatory. They are not predestined. They are choices made by governors and legislatures, often made without full appreciation of the nature of serious mental illnesses, psychiatric medications, or proven, cost-effective practices.

The long-run costs of Medicaid "reforms" often run higher than short-term savings. Costs are only shifted elsewhere. Cuts shift costs to hospital emergency departments.... Inadequate treatment leads to relapses. Relapses lead to hospitalizations. Medicaid "reforms" come with a price.

Cost-Shifting: Penny Wise, Pound Foolish

States have to make tough choices—but these have to be smart choices, too. Everyone benefits when people with mental illness are able to live productive lives. On the other hand, the long-run costs of Medicaid "reforms" often run higher than short-term savings. Costs are only shifted elsewhere.

Cuts shift costs to hospital emergency departments. Most of the states in this report are experiencing problems in emergency rooms. In a 2004 national survey, 60 percent of emergency physicians reported that an upsurge in people with mental illness seeking treatment in community emergency departments was negatively affecting patient care, causing longer wait times, and affecting everyone's access to lifesaving treatment. Two-thirds of responding physicians attributed the recent escalation to state healthcare budget cutbacks and the decreasing number of psychiatric beds for consumers in crisis.

Inadequate treatment leads to relapses. Relapses lead to hospitalizations. Medicaid "reforms" come with a price.

Inadequate treatment can also lead to jail or prison. Almost 20 percent of individuals incarcerated today in

the corrections system have serious mental illnesses. "First responders" in times of psychiatric crisis often are police. In states such as Ohio, leaders in the criminal justice system are playing an important role in working with SMHAs or local communities to achieve reforms in the mental healthcare system. "Decriminalization" of mental illness involves police Crisis Intervention Teams (CITs),. mental health courts and other jail diversion programs. But those innovations cannot work without the availability of community-based services.

Cost-shifting also is involved in the debate over state mental health insurance parity. About a dozen states, like Michigan, have not passed parity laws. Others have only limited versions. Failure to adopt such measures costs states money. These measures are important in helping to stem the flow of people with private insurance into the public system. Simply put, when middle class families lack mental health benefits under private insurance plans, they often are forced to spend down assets and enter the public system—or go without treatment. They end up in emergency rooms, hospitalized, or worse. Lack of parity comes with a price.

The Crisis of Capacity

"Deinstitutionalization," in which treatment began shifting out of state hospitals in the 1960s, was the result of better medications and a better understanding that the best outcomes for individuals with serious mental illnesses occurred when they remained "connected" to home communities. The failure of that transition was the result of a failure to invest adequately in community services.

Every mental health system requires carefully balanced levels of care. That continuum of care includes state hospitals, short-term acute inpatient and intermediate care facilities, crisis centers, and outpatient services like Assertive Community Treatment (ACT), supported housing, and independent living options.

When community services are not available, the entire system backs up. Long waiting lists reduce access. People languish in hospital beds because they can't be placed elsewhere, or can't be discharged because outpatient services aren't immediately available. Overcrowding and shortages arise. Closures, reductions, or conversions in private hospitals and other private facilities aggravate these problems in the public system.

In state after state, shortages are occurring. The problem is one of overall capacity, hinging on community services. In many cases, states are repeating the mistakes of the past—closing, consolidating, or reducing state hospitals before sufficient community services are in place.

Evidence-Based Practices

Concern for outcomes—through proven, cost-effective treatment—should drive transformation of the mental healthcare system. The goal of treatment is shifting beyond prevention of further deterioration in a person's condition, and beyond maintenance, to the fullest possible level of recovery.

Evidence-based practices (EBPs) focus on outcomes. Adoption of EBPs varies widely among the states, within states and among providers. Many states are neither modernizing their systems of care, nor getting "the biggest bang for their buck." Gaps also exist in systematic collection of data to broaden the evidence base, especially by measuring outcomes relative to a range of factors. How well treatment works is often related to housing, income support, and employment-related activities in the community.

Concern for outcomes—through proven, cost-effective treatment—should drive transformation of the mental healthcare system.

Information Accessibility and Participation

Agency transparency, information accessibility, and opportunities for consumer and family participation vary widely among the states. In a world where access to information is usually a prerequisite to care, a stunning result of our "Consumer and Family Test Drive" was the finding that 80 percent of all states did not score even half the total possible points on the survey. This indicates that SMHAs are not communicating basic information to their customers.

New Beginnings

Today's crises occur at a time of transition. The goal of advancing both knowledge and recognition of a greater range of needs is shaping a new vision of a mental healthcare system, one that is flexible, adaptable, and

better-suited to serve the people for whom it is intended. Themes of transformation therefore also are reflected in the state narratives, including discussions of recovery principles, consumer and family driven choices, cultural competence, the information age, workforce development, and the need for distinctly rural strategies. Transformation is not an easy challenge.

For an outline of a high-quality system as the standard for this report and future progress, please refer to the article following this introduction, "Standards for a Quslity Mental Health System: A Vision of Recovery." It includes the following components:

- Comprehensive services and supports
- Integrated systems
- Sufficient funding
- Consumer and family driven systems
- Safe and respectful treatment environments
- Accessible information for consumers and family members
- Access to acute care and long-term care treatment
- Cultural competence
- Health promotion and mortality reduction
- Adequate mental health workforce

Although the grades of the state systems are in most cases disappointing, NAMI takes encouragement from the level of creativity which many states are exhibiting in trying to address the challenges of the current environment.

Innovations and Urgent Needs

Each state narrative includes a list of "Innovations" being undertaken in the states. "Urgent needs" also are identified, based on NAMI's analysis.

One purpose of this report is to stimulate discussion of different ways that common issues can be addressed. There is much that states—and advocates—can learn from one another. Although the grades of the state systems are in most cases disappointing, NAMI takes encouragement from the level of creativity which many states are exhibiting in trying to address the challenges of the current environment. For example:

- California's Proposition 63 to finance mental health services
- Low-income housing financed by real estate transaction fees in Illinois
- A telephone triage system in jails financed through DWI fines in Kentucky
- A public-private joint venture in Massachusetts to replace a mental health center
- A prescription feedback system in Missouri that has reduced hospitalizations and unnecessary poly-pharmacy.
- A purchasing collaborative in New Mexico.

A longer list of "Innovations," compiled from the state narratives, is also included in this report's first section.

We hope the report will provide a springboard for action by both advocates and policymakers. As the grade distribution in the report demonstrates, we still have a long way to go to achieve a "New Freedom"—based on recovery and individual dignity—for people living with serious mental illness.

Standards for a Quality Mental Health System: A Vision of Recovery

The starting point for conducting a comprehensive evaluation of state mental health services is to define what a good public mental health system looks like. This section of the report outlines the standards NAMI used to conduct this evaluation.

In setting forth these standards, we acknowledge that no State Mental Health Authority (SMHA) has unilateral control over all elements of mental health services in its state. In a number of states, responsibility for administering community mental health services is vested at county levels, with the state responsible for such functions as running hospitals, setting standards for community services, setting rates, and monitoring provider performance.

Today, it is widely understood that a diagnosis of a serious mental illness need not relegate a person to a lifetime of suffering or dependency.

Moreover, multiple state agencies, not just the SMHA, affect in some way the provision of mental health services. These agencies include corrections, housing, vocational rehabilitation, Medicaid, and others.

Despite these factors, our assumption in conducting this evaluation is that the SMHA plays the most critical role in organizing and implementing the statewide system of services and coordinating the various funding streams that help support these services. As the state agency directly responsible for mental health services, the SMHA therefore ultimately must be held accountable for how these services are organized and delivered.

Based on NAMI's review, we have determined that high quality state mental health systems are characterized by the following 10 elements.

1. Comprehensive services and support
2. Integrated systems
3. Sufficient funding
4. Consumer- and family-driven systems
5. Safe and respectful treatment environments
6. Accessible information for consumers and family members
7. Access to acute care and long-term care treatment
8. Cultural competence
9. Health promotion and mortality reduction
10. Adequate mental health workforce

1. Comprehensive Services and Supports

Today, it is widely understood that a diagnosis of a serious mental illness need not relegate a person to a lifetime of suffering or dependency. With appropriate services and supports, people with serious mental illnesses can and do recover and lead lives that are productive and meaningful. Moreover, the term "recovery" does not mean simply relieving or controlling medical symptoms.

It focuses more broadly on the process of restoring "self-esteem and identify and on attaining meaningful roles in society." Recovery also does not necessarily refer to "curing" mental illness, but rather describes a process of restoring consumers' independence, self-sufficiency, dignity, and personal fulfillment.

Serious mental illnesses affect people in a wide variety of ways. Therefore, the specific services needed and the intensity of those services will vary from person to person. However, a high quality mental health system should, at a minimum, include the following services.

> Housing is the cornerstone of recovery for people with serious mental illnesses.

A. Affordable and supportive housing.

Housing is the cornerstone of recovery for people with serious mental illnesses. Without stable housing, it is very difficult for consumers to benefit from other services. Supportive housing is an approach that combines affordable housing with supportive services to help people with serious mental illnesses achieve stable and productive lives. Supportive housing has proven effective in alleviating homelessness and aiding recovery.

Unfortunately, supportive housing options are in short supply in most parts of the country due to federal cuts in vital programs such as Section 8 and Section 811, and the prohibitive costs of housing. Nationally, the average monthly cost of a one-bedroom rental apartment exceeds the total amount of monthly income under Supplemental Security Income (SSI). Thus, even though SMHAs may not be directly responsible for funding housing programs, NAMI believes that it is very important for these agencies to be integrally involved in strategies to develop supportive housing opportunities for consumers at both state and local levels.

B. Access to medications.

Significant progress has been made in the past several decades in discovering medications that alleviate and help to control the most profound symptoms of serious mental illnesses such as schizophrenia, bipolar disorder, and major depression. Medication decisions are best made on an individualized basis, taking into consideration factors such as consumers' past treatment history, side effect profiles, and other clinical concerns. A high quality mental health system should include full access to approved psychiatric medications and should enable clinicians, in partnership with consumers, to make informed medication decisions tailored to the individual. The system also should include mechanisms for providing physicians with feedback about prescribing patterns and ongoing education about best practices.

C. Assertive Community Treatment (ACT).

ACT is the most studied and widely adopted model for addressing the needs of people with serious mental illnesses who require multiple services at a high intensity and level of support. ACT programs are characterized by inclusion of all key service components (mental health, substance abuse, etc.) under one administrative entity; low staff-to-client ratios; services that are available on a 24-hour, seven-day-a-week basis; a client-centered program philosophy that encourages the provision of services at whatever location that client prefers; and a mobile crisis management capability. While relatively expensive, ACT programs have a track record of success in reducing far costlier hospitalizations and other adverse consequences of lack of treatment.

> While relatively expensive, ACT programs have a track record of success in reducing far costlier hospitalizations and other adverse consequences of lack of treatment.

D. Integrated Dual Diagnosis Treatment (IDDT).

IDDT is an evidence-based program designed for people with co-occurring mental illnesses and substance abuse disorders. It is characterized by both mental health and substance abuse treatment provided at the same time and in one setting. Research results demonstrate that integrated approaches to mental health and substance abuse treatment are more effective and produce better outcomes than non-integrated approaches.

E. Illness Management and Recovery.

Illness management programs are intended to educate consumers about their mental illness so they may make informed decisions and generally manage the course of their illness effectively. These programs generally are conducted by professionals and are distinguished from illness-self-management programs which are conducted by peers. While these programs provide strategies for minimizing symptoms and preventing relapse, many go further and try to help recipients achieve personal goals and recovery. Research conducted on these programs provides promising indications that they are successful in increasing consumer knowledge and fostering recovery.

Jails and prisons have become de facto psychiatric treatment facilities.

F. Family psychoeducation.

Family psychoeducation programs are designed to educate and inform family members about the mental illness of a loved one and to participate in a meaningful and informed way, in partnership with consumers and providers, in helping to prevent relapse and to foster recovery. Studies show a reduction in relapse and re-hospitalization rates among consumers whose families have participated in family psychoeducation programs.

G. Supported Employment.

Supported employment is an evidence-based approach to helping consumers find and maintain competitive employment. Unlike the traditional approach to vocational rehabilitation, which involved job training and subsequent job placement, supported employment follows a "place and train" model. People with mental illnesses are helped to find a suitable job and are provided with job coaching and related services designed to help them keep it. Research on supported employment demonstrates its effectiveness in improving employment outcomes for consumers.

H. Jail Diversion.

Jails and prisons have become de facto psychiatric treatment facilities. It is conservatively estimated that 16 percent of all inmates—more than 300,000 people—in U.S. jails and prisons suffer from serious mental illnesses. Jail diversion programs are collaborations between criminal justice and mental health systems designed to link individuals (primarily non-violent offenders diagnosed with serious mental illnesses or co-occurring mental illness and substance abuse disorders) with appropriate services instead of incarceration. Jail diversion strategies include pre-booking diversion initiated prior to arrest, and post-booking diversion, which is initiated following arrest and is often under the ongoing supervision of courts.

I. Peer Services and Supports.

The provision of services by peers is a growing trend in the mental health field. These services include case management, drop-in centers and clubhouses, outreach programs and consumer-run businesses. The benefits of these services are two-fold: first, they provide meaningful work for consumers employed as peer specialists and peer counselors, and second, there is emerging evidence that peer services produce positive outcomes. In recognition of this, peer specialists are now included as part of recommended staffing for ACT teams.

J. Crisis Intervention Services.

A quality mental health system must have mechanisms in place to respond in a timely and compassionate manner to people with serious mental illnesses in crisis. Too often, these responsibilities are left to law enforcement. Mobile crisis intervention services should be available on a 24-hour, seven-day-a-week basis. Acute care hospital beds and/or crisis residential services must be available for individuals identified as needing that level of service.

The provision of services by peers is a growing trend in the mental health field.

The list set forth above represents NAMI's judgment about what constitutes the essential elements of high quality mental health services. It is by no means an exhaustive list. Other services that should be available include psychiatric rehabilitation, clubhouses or drop-in centers, and supported education.

2. Integrated Systems.

To achieve recovery, people with serious mental illnesses require multiple services, ranging from psychiatric treatment to housing to rehabilitative services. Typically, these services are furnished by different providers accessing different sources of funding, and therefore operating under different rules. The result is a mental health system that, in the words of President Bush's New Freedom Commission on Mental Health, "looks more like a maze than a coordinated system of care."

Complex, uncoordinated mental health service systems serve no one's interest—not providers, not families, and certainly not consumers. One important element of quality in a mental health system is the extent to which the various services required by individual consumers—and the funds used to pay for these services—are provided in the most user-friendly manner possible. This requires close collaboration among the systems responsible for providing the various services.

One method being tried involves integrating diverse funding streams into one general fund. However, even without blended funding, it is possible to coordinate services to design effective service systems at local levels. Coordination must occur, for example, between SMHAs and regional or local mental health systems and providers to facilitate seamless transitions from inpatient to outpatient services. And, coordination also must occur among the myriad state agencies offering services for people with serious mental illnesses.

As the entity most knowledgeable about the services consumers need and how best to deliver them, SMHAs should be at the center of these integration efforts. Moreover, SMHAs should be aware of all services for consumers, even those for which they are not directly responsible. For example, SMHAs should be involved in the design of jail diversion or supportive housing initiatives, even though they may not be directly responsible for funding these services. Similarly, SMHAs should be aware of where these programs and services exist at local levels.

There is increasing awareness that short-term savings accrued through cuts in public mental health funding lead to increased long-term public costs associated with hospitalizations, incarcerations, and other costly consequences of lack of treatment.

3. Sufficient Funding

In recent years, many states faced with budget deficits have cut mental health services funding and/or increasingly relied on Medicaid to pay for community mental health services. Today, Medicaid is the largest single payer of public mental health services. Since Congress has recently enacted cuts to the federal portion of Medicaid, burdens on states are likely to increase even more.

Continuing disparities in mental health coverage in health insurance is also a factor. Although 36 states have enacted parity laws, the lack of a federal parity law is an impediment to achieving true equity in coverage of mental illnesses in private health insurance. And, costs not picked up by private insurance frequently are shifted to state mental health systems.

There is increasing awareness that short-term savings accrued through cuts in public mental health funding lead to increased long-term public costs associated with hospitalizations, incarcerations, and other costly consequences of lack of treatment. NAMI's research for this project reveals that a few states have increased mental health funding in recent years, even in the face of overall budget deficits.

Funding is not the only solution. Funds allocated for services that don't work or systems that don't effectively coordinate mental health services are wasteful and inefficient. However, the provision of high quality mental health services cannot be achieved without adequate funding. The sad reality today is that few states are funding public mental health services at levels sufficient to enable all or even most who need those services to receive them.

4. Consumer and Family Driven

Historically, consumers have had little involvement in the services they receive or the settings in which they receive them. Some consumers continue to have negative experiences with the treatment system, which deters many from continuing to participate in services. Families, too, often have been discounted as having any role to play despite the fact that, in many cases, families function in a primary caregiving role.

In recent years, there has been some progress in creating systems that are responsive to the concerns of consumers and family members. For example, successful efforts in many states to reduce the use of restraints and limit consumers' seclusion in hospitals can be directly traced to the efforts of consumer advocates.

A system that is truly consumer- and family-driven is characterized by meaningful involvement of consumers and families in the design, implementation and evaluation of services. Consumers and family members should be regarded as true partners in this enterprise, not as mere advisors whose feedback can be ultimately discounted. Mental health systems should operate in a transparent manner, welcoming and supporting monitoring and feedback from consumers and family members. One promising development in a few states is the emergence of consumer and family teams responsible for monitoring the quality of psychiatric treatment facilities and other mental health services.

5. Safe and Respectful Treatment Environments.

As discussed above, many consumers have had painful experiences with the treatment system. These experiences—such as being put into restraints or seclusion, suffering abuse and assault, or encountering a general disregard of one's concerns while in a treatment facility —reduce trust and willingness to participate in future treatment. Inpatient psychiatric treatment facilities and community treatment or residential programs are unsafe and even dangerous in some parts of the country.

As any consumer of healthcare services would expect, people with serious mental illnesses should be treated with dignity and respect while in inpatient or community treatment programs. Adequate staffing must be maintained and program staff should receive training on crisis de-escalation techniques in order to avoid the use of restraints or seclusion. Consumer complaints of abuse and neglect should be investigated promptly, the findings shared with the consumer, and steps taken to remedy any problems that are identified. All deaths or serious injuries that occur in psychiatric treatment programs must be reported and investigated.

6. Accessible Information for Consumers and Family Members.

Being diagnosed with mental illness is a traumatic and unsettling experience for consumers and their families. At such times, accurate information about the specific diagnosis, treatment options and community resources is vitally important. Unfortunately, this information is frequently unavailable.

NAMI believes that SMHAs play a critical role in disseminating information to the public about mental illnesses and where people diagnosed with these illnesses can go for help. As reliance on the Internet increases, this information should be available on the SMHA website. Moreover, SMHAs should develop written materials and resources and provide training to their employees about how to respond effectively to inquiries from the public.

> Families, too, often have been discounted as having any role to play despite the fact that, in many cases, families function in a primary caregiving role.

7. Access to Acute and Long-Term Care Treatment.

As efforts to transform state mental health systems from institutional to community-based care continue, adequate resources must be maintained for the provision of acute or long-term psychiatric treatment for those who need it. These resources should include acute care beds, group homes or other 24-hour residential programs for people who require continuous care on a long-term basis. The use of nursing homes or unlicensed and unregulated board and care homes to address the needs of previously institutionalized individuals is not appropriate.

8. Cultural Competence

Communities throughout the country are becoming more diverse, with a rich mix of racial and ethnic groups. Mental health services should be designed and delivered in a culturally competent manner. A number of states have made significant strides in developing culturally competent services, some of which are highlighted in this report. Awareness of the need for cultural and language competence should be incorporated in all aspects of mental health planning and service delivery, including staff recruitment, staff training, development of resource materials, and service delivery.

9. Health Promotion and Mortality Reduction

Studies have shown that people with schizophrenia and other serious mental illnesses have a higher risk of medical disorders such as diabetes, hypertension, and heart disease than people without mental illnesses. There are a number of possible contributing factors, including high rates of smoking among people with mental illnesses, reduced physical activity and fitness levels, and the side effects of psychiatric medications. NAMI believes that a high quality mental health system must promote the overall health of those it serves through the integration of primary medical care with psychiatric treatment. Health-promoting activities such as exercise, smoking-cessation programs, and dietary education must be offered and data about medical risk factors and health mortality rates collected.

10. Adequate and Qualified Mental Health Workforce

There is a significant shortage of qualified mental health personnel across the country. This shortage pervades all aspects of the field, from psychiatrists to caseworkers and other direct service personnel. NAMI believes that SMHAs should work in partnership with other relevant agencies and institutions (e.g., universities) on initiatives to ensure an adequate supply of qualified mental health personnel. These initiatives should consider strategies such as educational subsidies, loan forgiveness programs, continuing education, competitive salary and benefit structures, and inclusion of consumers and family members within the mental health workforce.

Policy Recommendations

1. Increase funding tied to performance and outcomes.

In recent years, most states either have reduced funding of services for people with serious mental illnesses or have level-funded these programs. The impact of inadequate funding has been devastating—we now see overflowing emergency rooms with no place for people to go, increased numbers of people with serious mental illnesses in jails and prisons, and large numbers of people without access to desperately needed services.

State legislators and policymakers must realize that cuts to vital services for people with serious mental illnesses raise rather than reduce overall costs to society. These cuts affect systems in a very negative way. Corrections systems, indigent care systems, emergency medicine, or homeless service providers are left to pick up the pieces.

State legislators and policymakers must realize that cuts to vital services for people with serious mental illnesses raise rather than reduce overall costs to society.

At the same time, NAMI understands and supports the importance of linking public-sector mental health expenditures with positive outcomes. Thus, we believe that states should be able to demonstrate that mental health services funded through Medicaid, the Federal Mental Health Services Block Grant, or state dollars achieve positive outcomes such as reduced symptoms, increased independence, employment, housing, and increased consumer satisfaction. States also should be able to show that these expenditures reduce negative outcomes such as hospitalizations, homelessness, criminal justice involvement, and suicides.

If a state mental health system is unable to demonstrate the positive impact of the services it funds, legislators and policymakers are justified in raising questions about the value of the funding. We believe that the federal government, through the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Mental Health (NIMH), and other agencies administering services and programs that affect people with serious mental illnesses, should provide technical assistance to ensure that such funds are being used appropriately and achieving positive outcomes.

As a last resort, non-performance by a mental health system may be a justifiable reason to reallocate mental health funds to other systems and programs that bear the burdens of failed mental health policies and services, such as jail diversion programs, homeless shelters, and emergency rooms.

2. Invest in evidence-based and emerging best practices.

In the section of this report entitled "Standards for a Quality Mental Health System—A Vision for Recovery" we have described the elements of what we believe constitute high-quality services for people with serious mental illness. Unfortunately, the research we conducted in preparing this report revealed that the services discussed in that section are in short supply, or even non-existent, in many parts of the country.

This is not acceptable. If services with an established research base of demonstrated effectiveness are not translated into practice, the cynicism of policymakers may be justified. On a more positive note, SAMHSA and the National Association of State Mental Health Program Directors (NASMHPD) are engaging in efforts to promote the widespread adoption of evidence-based and emerging best practices. And state mental health authorities in some states are taking leadership in working with other agencies and systems on jail diversion, supported housing, employment, and other critical services.

NAMI understands and supports the importance of linking public-sector mental health expenditures with positive outcomes.

3. Improve data collection, reporting, and transparency of information.

In preparing this report, we tried to find existing data that would help give advocates and consumers information about state mental health systems and how well they were performing. We found very little. The data that exist are not designed to allow easy state comparisons and are not linked to consumer outcomes.

SAMHSA, as the agency with responsibility for oversight of mental health services, must develop uniform outcomes measures and insist that states provide data on these measures as part of their block grant reporting requirements. This information should be accessible and transparent and be used to guide the development of priorities by state legislators and policymakers.

Our research for this report also revealed that state mental health authorities are, by and large, not doing well in providing easily accessible information about mental illnesses and mental health resources to their customers—consumers and family members. This is another area that requires significant improvement. In this day of enhanced information technology, it is reasonable to expect states to fulfill their fundamental obligation to provide easily accessible and understandable information about the services they provide.

4. Involve consumers and families in all aspects of the system.

Although lip service is given to the importance of consumer- and family-driven systems, we found very few examples where this important principle actually is being translated into practice. The examples we did find are exemplary and should be replicated in all states.

For example, in recognition of growing evidence about the effectiveness of peer services and supports, Georgia is the first state that reimburses certified peer counselors in its Medicaid program. Other states should follow Georgia's lead.

Another example is the use of independent, third-party, consumer- and family-monitoring teams used to conduct inspections and monitor conditions in psychiatric treatment facilities. These teams have proven effective in the past in states such as Delaware, New Hampshire, Oklahoma, and Pennsylvania. All states should similarly involve consumers and family members in oversight and monitoring activities.

States are required under the Federal Public Health Services Act to include consumers and family members on state mental health planning councils. We strongly believe that the involvement of consumers and family members must extend significantly beyond an advisory function. Unfortunately, on an overall basis, involvement of consumers and families in various aspects of the mental health system (planning, implementation, and evaluation) is token at best. Some states and systems apparently find it difficult to break away from outdated, paternalistic attitudes toward the people they are charged with serving.

The federal Medicare program also contains provisions that discriminate against people with mental illness.

5. Eliminate discrimination.

People with serious mental illness encounter stigma and discrimination in all aspects of their lives. Overcoming this discrimination requires not only community education, but also the change of certain federal policies that reinforce this discrimination.

For example, Congress continues to sanction discrimination against people with serious mental illness by failing to enact a federal law requiring that mental illnesses be covered on a par with all other medical disorders in health insurance policies.

> SAMHSA, as the agency with responsibility for oversight of mental health services, must develop uniform outcomes measures and insist that states provide data on these measures as part of their block grant reporting requirements.

The federal Medicaid program contains a provision that similarly encourages discrimination toward people with serious mental illness. Since its inception, there has been a provision in federal law prohibiting the use of federal Medicaid dollars to pay for services in an "institution for mental disease" (IMD), defined as a facility with 16 or more beds, at least 50 percent of which are used for psychiatric treatment. This provision serves as a barrier not only to reimbursing care in psychiatric hospitals, but also to implementing Medicaid-reimbursable home- and community-based waivers of the kind that have been very helpful in facilitating recovery among people with developmental disabilities, and other Medicaid populations.

Finally, the federal Medicare program also contains provisions that discriminate against people with mental illness. For example, while Medicare covers 80 percent of the costs of outpatient treatment for traditional medical disorders, it covers only 50 percent of the costs of outpatient psychiatric treatment.

NAMI calls upon Congress and the President to set an example for the rest of the nation by moving swiftly to change these discriminatory policies. Outdated laws that reinforce stigma and faulty assumptions about mental illnesses should not be allowed to continue.

Innovations

A Sample of State Innovations and Best Practices, as viewed by NAMI

During the development of this report, programs and policies emerged that represented sound examples of innovation and commitment to providing high-quality services to people living with mental illness. They are shining examples of high quality. The following list is not comprehensive, but it demonstrates the pioneering approach that is necessary to change fundamentally America's mental health system. There is an urgent call for our nation to take steps to make these programs the norm—not the exception.

Financing

- Proposition 63—Voters recognize need to creatively fund services. (California)
- Combining multiple funding sources to streamline care and decision-making. The jury is out, but the effort will teach others. (New Mexico)
- Local municipalities taking the lead to address mental health concern in their communities through special tax districts or unique bond proposals. (Arizona and Colorado)

Housing

- Tremendous progress in developing housing, which rose from almost none in NAMI's 1990 report to among the best today. (Tennessee)
- Transaction fees on real estate transactions to promote rental housing assistance. (Illinois)
- Passage of legislation that dedicates $200 million to create 10,000 units of new supported housing in the next 10 years. (New Jersey)
- Initiative to develop more than 36,000 supportive housing units. (New York)
- Cooperative ("Bridges") program between the state mental health authority and the housing finance agency to provide $650,000 in housing subsidies for people with serious mental illnesses. (Minnesota)

Five states received excellent scores in our survey for their work in employment.

Restraint and Seclusion Reduction

- The leadership of the National Association of State Mental Health Program Directors (NASMHPD) drives a national culture change.
- Significant reductions in use of restraint and seclusion in a forensic setting at North Texas Hospital (Texas) and Taylor Hardin Secure Medical Facility. (Alabama)
- Regulations enacted in 2006 to codify a preventive approach and discourage the use of restraint and seclusion in all facilities, both acute and tate-run. (Massachusetts)

Jail Diversion

- A culture of jail diversion that penetrates almost the entire state. (Ohio)
- Legislation mandating a telephonic triage system to screen jail inmates for mental illness and to provide linkages to treatment. (Kentucky)

- Extensive post-booking jail diversion programs in arraignment courts. (Connecticut)
- TAMAR (Trauma, Addictions, Mental Health, and Recovery) Project for the treatment of female consumers in detention centers. The program also helps their children. (Maryland)

- Prison education program run by NAMI Indiana and supported by the state DMHA and Department of Corrections to educate prison guards and staff about serious mental illnesses. (Indiana)
- Mandatory jail diversion strategies for every county authorized through HB 2292. (Texas)
- Statewide implementation of police crisis intervention training (CIT). (Georgia and Texas)

Employment/Vocational Success

- Five states received excellent scores in NAMI's survey for their work in employment. (Connecticut, Maine, Missouri, New Mexico, and Vermont)
- A rural state is dedicated to employment opportunities, reporting an impressive 41 percent employment rate for consumers. (South Dakota)

Disaster Response

- Quick response and triage to continue service provision and ensure safety of consumers during and after Hurricane Katrina. (Mississippi, Louisiana, Alabama, and Texas)
- Mutual aid support from many states across the country.

Academic/State Collaboration

- Partnerships with SMHAs and universities to establish centers promoting the implementation of EBPs. (Ohio, Hawaii, and Indiana)
- Collaboration to promote the mental healthcare workforce with Yale University. (Connecticut)

Creative Use of Public Land

- Public/private collaboration to rebuild a community mental health center. (Massachusetts)
- Reinvestment of funds from the sale of a state hospital to create increased housing options for individuals with mental illnesses through the Community Mental Health Housing Fund. (Oregon)
- Establishment of the Alaska Mental Health Trust Authority to generate revenue for the state's mental health services. (Alaska)

Mortality Studies

- NASMHPD medical directors are investing in this important issue as a priority.

One state reinvested funds from the sale of a state hospital to create increased housing options for individuals with mental illness.

Multicultural Outreach

- State leadership to encourage and monitor county-based efforts to ensure culturally competent care. (California)
- Efforts to ensure the mental health workforce has appropriate linguistic skills, and that materials are properly translated. (Arizona)
- Establishment of subcommittees—specifically on ethnic/cultural minorities and sexual minorities—to focus on the impact that legislation, public policies, and practices have on the treatment of multicultural and/or minority groups in institutional, residential, and community settings. (Washington)

Co-Occurring Systems Change

- Development of a consumer- and family-driven process to evaluate every level of the system to integrate services for co-occurring disorders. (Oklahoma)
- Leadership to integrate treatment for substance abuse and mental illness, resulting in statewide adoption of integrated dual disorder treatment. (Delaware)
- State-funded program to incorporate mental health treatment principles into a traditional 12-step model, "Double Trouble in Recovery." (Georgia)

Capacity Response

- Using the state's authority to generate new inpatient beds to address a profound need among the population. (Arkansas)

Best Information

- Several states score as top performers on NAMI's Consumer/Family Test Drive. (Tennessee, Ohio, Indiana, South Carolina, and Michigan)
- Several states provide most accessible SMHA Web sites. (South Carolina, Alaska, Minnesota, New York, Tennessee, Texas, Massachusetts, Michigan, Oregon, and California.)
- Web site publication of a report containing data comparing performance in the provision of mental health services with neighboring states. (Nevada)

Parity Laws

- Model parity law that includes substance abuse. (Connecticut, Maryland, Minnesota, Vermont, and Oregon—to take effect in 2007)
- Inclusion of mental health parity in a statewide program to expand health insurance to uninsured populations. (Maine)

Clinical Approaches to Medication Access

- Program to provide clinical feedback to doctors on prescribing patterns that save money and improve outcomes. (Missouri)

Peer Support/Peer Run Programs

- A culture infused with recovery principles. (Vermont)
- Policies to promote recovery and ensure that it is a part of the state's mission and treatment planning. (Connecticut)
- Medicaid reimbursement of certified peer counselors. (Georgia)

Health Promotion

- Development of a program that provides identification and intervention for diabetes, hypertension, and other cardiac risk factors among individuals with serious mental illnesses. (New Hampshire)

Community System of Care

- Comprehensive systems of care with demonstrated linkage between service providers and integrated service approaches. (Vermont and Wisconsin)

Engaging Rural Constituents

- Use of audiovisual technology to eliminate long-haul vehicle transport for persons in need of emergency orders of detention. (Oklahoma)
- "Deliberate and Deliberative" approach to system redesign to improve local service capacity and access within specific budgetary constraints. (Nebraska)

A Brief Overview of Methodology

Grading the States is a "report card" that assesses each state's mental healthcare system, measured relative to three landmark documents:

- U.S. Surgeon General. (1999). *Report on Mental Health.*
- President's New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Healthcare in America.*
- Institute of Medicine of the National Academy of Sciences. (2005). *Improving the Quality of Health Care for Mental and Substance Abuse Conditions.*

The report also is based consciously on the perspective of people with serious mental illness and their families. We are the customers whom the state systems are designed to serve.

Disseminated through the federal government's "Science to Service Initiative," the five evidence-based practices promoted by the Center for Mental Health Services (CMHS) have been used as a standard throughout much of the assessment, along with other recovery-oriented service and treatment measures. Each state's progress toward a proven, cost-effective system is indicated by a letter grade of A, B, C, D, or F, based on information from four sources, and scored from 39 specific criteria representing four categories: Infrastructure, Information Access, Services, and Recovery Supports.

Sources

1. State Mental Health Authority (SMHA) Self-Reported Questionnaire

SMHAs were surveyed through a questionnaire submitted and returned during October-December 2005. Colorado and New York declined to respond. Although narrative discussions are included for these two states, they have been graded simply as "U" for "unresponsive."

2. Public Information

Information also was obtained from public sources, such as official documents, including SMHA Community Mental Health Services Block Grant Applications to SAMHSA, state agency reports, reports from the Department of Justice, newspaper articles, and other sources.

3. Consumer and Family Test Drive

Access to services depends on access to information. In order to capture the perspectives of consumers and family members about access to basic information, a Consumer and Family Test Drive (CFTD) was developed. For details regarding the methodology for this score source, see the appendix of this report. In addition to serving as a source of information, the CFTD results were included as part of the criteria and were weighted 10 points (10 percent) in the numerical scoring, in recognition of the important role that access to information plays in the mental health system.

4. Interviews

Consumer and family advocates were interviewed on several occasions concerning their state systems. Other knowledgeable sources, such as legal and mental health policy experts, also were consulted.

Criteria and Scoring

Four individuals were selected to serve as masked scorers based on their diverse professional and personal backgrounds:

- Anand Pandya, M.D., chair, NAMI National Board of Directors Policy Committee
- Marty Raaymakers, chair, NAMI National Consumer Council
- Elizabeth Edgar, NAMI senior policy analyst, family member, social worker
- Jack Gorman, M.D., chair, NAMI Scientific Advisory Council

The 39 individual criteria used in the scoring process were weighted by relative importance. Where a perfect score is 100, the distribution is as follows:

Infrastructure:	18
Info Access:	16
Services:	44
Support/Recovery:	22

Each question received a 2, 3, or 4 point valuation. For details regarding methodology of the values and scoring, please refer to the appendix of this report.

Criteria were evaluated through a combination of masked and unmasked scoring (where "masked" indicates that the identity of the respondent was unknown, and "unmasked" indicates that the identity of the respondent was known), as follows:

Masked scoring	71%
Unmasked scoring	
CF Test Drive	10%
Other	19%

Based on the information gathered and the masked and unmasked scoring, grades were determined for the four categories, with the final grade representing an overall assessment of the state system. We graded the states on a scale of 0 to 100. More information about our grading scale may be found on NAMI's Web site.

State Grades

B	Connecticut
	Ohio
B -	Maine
	South Carolina
	Wisconsin
C +	Maryland
	Michigan
	Minnesota
	Oregon
C	California
	District of Columbia
	Hawaii
	New Jersey
	Rhode Island
	Texas
C -	Delaware
	Florida
	Massachusetts
	Missouri
	New Mexico
	Tennessee
	Vermont
D +	Arizona
	North Carolina
	Pennsylvania
D	Alaska
	Alabama
	Georgia
	Mississippi
	Nebraska
	New Hampshire
	Oklahoma
	Utah
	Virginia
	Washington
	West Virginia
	Wyoming
D -	Arkansas
	Indiana
	Louisiana
	Nevada
F	Iowa
	Idaho
	Illinois
	Kansas
	Kentucky
	Montana
	North Dakota
	South Dakota
U	Colorado
	New York

National Report Card

United States of America

Grade: D

Category Grades	
Infrastructure	D
Information Access	D
Services	D+
Recovery Supports	C-

"For too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery. Today's mental health care system is a patchwork relic-the result of disjointed reforms and policies. Instead of ready access to quality care, the system presents barriers that all too often add to the burden of mental illnesses for individuals, their families, and our communities.

"The time has long passed for yet another piecemeal approach to mental health reform. Instead, the Commission recommends a fundamental transformation of the Nation's approach to mental health care. This transformation must ensure that mental health services and supports actively facilitate recovery, and build resilience to face life's challenges. Too often, today's system simply manages symptoms and accepts long-term disability."

--Letter of July 22, 2003 from Michael J. Hogan, chairman of the New Freedom Commission on Mental Health, to President George W. Bush, transmitting the commission final report, Achieving the Promise: Transforming Mental Health Care in America.

State Narratives and Score Cards

Alabama

Grade: D

Category Grades

Infrastructure	**C**
Information Access	**F**
Services	**D**
Recovery Supports	**D-**

Spending, Income, & Rankings

PC Spending/Rank	$60.95	38
PC Income	$25,006	41
Total MH Spending/Rank	$274 *(in millions)*	25
Suicide Rank		28 *(tied with Wisconsin)*

Recent Innovations

- Jail diversion programs and prison reforms
- Outreach to people with mental illness who are deaf
- Elimination of restraints and seclusion at Taylor Hardin

Alabama is a state trying very hard to move in the right direction, but poverty and historical bureaucratic inertia make progress slow. In the words of one advocate: "We are the 'make me' state. We do what you inspect, not what you expect."

The current status of services for people with serious mental illnesses in Alabama is inextricably linked to the case of *Wyatt v. Sawyer*, a class action lawsuit originally filed in 1972 that was finally settled in 2000—more than 30 years later. As if the long, tortured history of the lawsuit isn't enough, problems facing the state also are symbolized by the fact that the majority of probate judges who hear civil commitment cases in Alabama are not lawyers and have little or no mental health training.

Aimed originally at improving conditions in Alabama state hospitals for people with mental illnesses and mental retardation, the *Wyatt* case also addressed community-based services. In the end, the Alabama Department of Mental Health and Mental Retardation (DMH/MR), after many years of contentiousness as the defendant in *Wyatt*,

Urgent Needs

- Funding for community services
- More supportive housing options
- Supported employment and other recovery-oriented services

"committed to sustain and improve the reforms" stimulated by the decision.

Unfortunately, the settlement in *Wyatt* has not led to an infusion of new dollars into recovery-oriented community-based services. Thus, each county has been vested with responsibility for serving people released from the state's hospitals without additional resources to provide these services. The result has been a mixed bag at best. Left to their own resources, some counties have done well, others have not. In many parts of the state, recovery-oriented services such as employment, housing, and psychiatric rehabilitation services are non-existent.

Overall funding for mental health services has increased in recent years. However, per capita spending by the DMH/MR remains very low relative to other states, and significant gaps exist in many areas, particularly rural parts of the state.

Although conditions in Alabama's state hospitals have improved significantly, extended care and long-term care units in these hospitals are still overcrowded. These problems are compounded by the loss of an estimated 500 psychiatric beds in community hospitals.

Lack of community housing options is also a major problem. This in turn contributes to the shortage of acute and long-term inpatient beds for those who need them—because people occupying beds who are ready to move into less restrictive settings have no place to go.

To its credit, DMH/MR is engaging in efforts to increase supportive housing options. Working with the Alabama Housing Finance Authority and other housing agencies and advocates, they have developed and implemented a plan for 454 new units of housing statewide—369 of which have already been completed. Most will be occupied by DMH/MR clients.

DMH/MR is also working with the Alabama Rural Coalition for the Homeless (CRCH) on strategies to leverage federal HUD funds to provide housing for people with serious mental illnesses and others in rural areas who are homeless—or at imminent risk of homelessness.

Despite these efforts, grave concerns exist about substandard housing conditions, particularly in unlicensed boarding homes. The county public health boards are ultimately responsible for licensing the facilities, but they report that they do not have the funding to license or conduct inspections adequately. There are also concerns about the exploitation of vulnerable consumers who are enticed to sign over monthly SSI or SSDI checks in exchange for a bed in overcrowded, substandard living quarters.

In Alabama, criminalization of people with serious mental illnesses has reached epidemic proportions. From 1992 to 2000, the Alabama Department of Corrections (ADOC) was a defendant in a class action lawsuit, *Bradley v. Hightower*, which revealed inhumane and unconstitutional conditions of confinement and lack of appropriate treatment for inmates with serious mental illnesses confined in adult correctional facilities. To its credit, ADOC has since invested additional staff and financial resources into more effectively and humanely addressing inmate treatment needs. However, prisons are never optimally therapeutic environments for people with serious mental illnesses.

A multi-stakeholder effort that includes DMH/MR and NAMI Alabama is engaged in efforts to promote jail diversion and more effective community re-entry services for people with serious mental illnesses leaving prisons. Three statewide criminal justice/mental health consensus conferences have been held in recent years. A number of jail diversion programs have been established or are in the planning phase, including CIT programs in Tuscaloosa and Birmingham and mental health courts in Birmingham and Montgomery. The police department in the rural Northern Alabama community of Florence employs a community service officer who has received extensive training about mental illness and is the second responder to most calls received involving mental illness.

The state has taken positive steps in certain psychiatric treatment facilities to reduce the use of restraints and seclusion. Remarkably, the Taylor Hardin Secure Medical Facility, which serves exclusively forensic patients, has been so successful in training its staff on crisis de-escalation techniques that the use of restraints and seclusion has been virtually eliminated—so much so that in 2004, NAMI's National Consumer Council gave a special award to the facility and its director, Mr. James Reddoch, J.D., for exemplary leadership in reducing the use of restraints and seclusion and humane treatment of residents.

DMH/MR has also reached out in a progressive way to the deaf community, including training a number of interpreters on how to respond effectively to individuals with serious mental illness who are deaf. The agency also is pursuing JCAHO accreditation of all seven of Alabama's state psychiatric hospitals.

Alabama is a state with good intentions, and there are a number of positive initiatives underway to improve services for people with serious mental illnesses. However, the recent settlement of the *Wyatt* case is just a start towards the goal of developing a comprehensive community-based system for people with serious mental illnesses. Resources must be increased and good will translated into good practices if this goal is to be attained.

Score Card: ALABAMA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	1	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	1	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	1	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	0	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	1	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	0	2

Alaska

Grade: D

Category Grades

Infrastructure	**D**
Information Access	**C+**
Services	**D**
Recovery Supports	**C**

Spending, Income, & Rankings

PC Spending/Rank	$85.06	23
PC Income	$31,871	13
Total MH Spending/Rank	$54 *(in millions)*	46
Suicide Rank		2

Recent Innovations

- State hospital transformation
- Priority focus on co-occurring mental illness and substance abuse
- One of nation's first mental health courts
- Information accessibility among the best in the nation

Urgent Needs

- Funding
- EBPs, including ACT and supported housing
- Access to inpatient hospital beds outside Anchorage
- Expansion of mental health courts and jail diversion programs

Alaska is unique. Land mass, climate, and even distance from the "lower 48" continental United States are relevant in evaluating its public mental healthcare system. Its Native Alaskan population poses a special cultural challenge.

With the second-highest suicide rate in the nation, Alaska is focusing on the interplay between mental illness and substance abuse. In 2004 the Division of Behavioral Health (DBH) assumed responsibility for Medicaid planning, mental health, and substance abuse services—a foundation for an integrated system. The state also received a federal grant to increase capacity for integrated treatment, giving it priority as an evidence-based practice (EBP). Finally, it has policies in place to ensure that people with mental illnesses are not discharged from treatment because of substance abuse.

In that area, Alaska may someday become a national leader, except that today, evidence-based practices are virtually nowhere to be found. Assertive Community Treatment (ACT), illness self-management, supported housing, and integrated dual diagnosis treatment scored among the lowest of any state. There is nowhere to go but up.

Health promotion and studying causes of death are not DBH priorities, but should be, as part of its movement to align policy and funding for integrated treatment—and to learn from other changes.

The bright spot is the Alaska Psychiatric Institute in Anchorage, which used to be a shabby facility with high doctor turnover and a bad reputation. Advocates now describe API as "bright, warm, welcoming, with access to the outdoors," and adequately staffed. This transformation of a facility both physically and in personnel development is a stellar accomplishment. The state is proud to report they are working hard to reduce their currently "very limited" use of restraints and seclusion. The turnaround of the facility is worth close study.

Alaska is fortunate to have a Mental Health Trust Authority established by the state from a pre-statehood federal grant. Its role as an innovation generator may be unique and not easily replicated, but conceptually, might provide a model for other states also to consider.

Still, the need for more gears moving in the community-based service system is profound. Psychiatric emergency room services, ACT, and respite are only part of the list of services in short supply. Hospital access is a concern, especially in the outlying regions. The state understands the concept of supported housing, but there is a dire shortage, which directly impedes recovery.

Looking at numbers in the state correctional system, it is easy to see the result of gaps—more like chasms—in the mental healthcare system. The state acknowledges that "the Department of Corrections is the largest provider of institutional mental health services in the state." At any time, more than a third of inmates in state custody are estimated to suffer from mental disabilities. The state has only one mental health court and one jail diversion program, both in Anchorage.

The Anchorage court was one of the very first mental health courts in the country, and Judge Stephanie Rhoades plays a national role as an advocate both for this model, for increased illness self management programs and more community services.

Alaska has a significant commitment to consumer and family involvement; the majority of members of the state planning board are consumers and family members.

Telemedicine and workforce development are urgent needs, and the state system is working on both. The state scored well on NAMI's "Consumer and Family Test Drive" for access to information—which is a significant accomplishment and essential for such a geographically challenging state.

Score Card: ALASKA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	8	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	2	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	2	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	0	3
	21	Assertive Community Treatment (ACT) teams	0	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	1	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	1	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	1	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Arizona

Grade: D+

Category Grades

Infrastructure	**B-**
Information Access	**D-**
Services	**D**
Recovery Supports	**B+**

Spending, Income, & Rankings

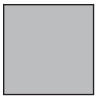
PC Spending/Rank	$126.33	8
PC Income	$25,481	39
Total MH Spending/Rank	$702 *(in millions)*	10
Suicide Rank		6

Recent Innovations

- Best-practice committee with consumer and family involvement
- Language translation services

Urgent Needs

- Findings and corrective actions in *Arnold v. Sarn* should be applied to all RBHAs
- Better hospital and transitional services
- Housing
- Resources to match population growth



Arizona is a state struggling to swim upstream in a desert.

Its urban areas, Phoenix and Tuscon, have grown by 40 percent in the last decade, making it the nation's 18th most populous state. It has a very diverse population, including a large proportion of retirees. At the same time, it is expansively rural. With an average median income in the lowest one-third of the nation, the state ranked 18th in per capita spending for mental health services in 2001.

The future of the state's mental healthcare system depends on its ability to find more effective ways to deliver quality services through a regional mental health model and to provide appropriations that at a minimum keep pace with population growth. A network of regional behavioral health authorities (RBHAs) currently provides services throughout the state, blending Medicaid and indigent support. Quality varies widely.

A 25-year-old lawsuit in Maricopa County, *Arnold v. Sarn*, exemplifies RBHA problems. Individuals with serious mental illnesses filed the suit in 1981, and it is still ongoing. Two years ago, an audit by a court monitor revealed significant deficiencies in service planning and delivery. The state and RBHA have made progress since then, such as in case management and training clinical staff in recovery principles, but major gaps in service still exist—such as in employment and substance abuse treatment.

Other RBHA problems include difficulty in getting the right medication at the right time because of prior authorization restrictions or limited formularies, enrollment protocols, and the lack of evidence-based practices such as ACT and integrated treatment.

Arizona State Hospital is located in Phoenix. In May 2006, voters in the Tucson metropolitan area will vote on a $54 million bond issue to expand University Hospital in Kino to include a psychiatric urgent care facility and a psychiatric hospital with approximately 90 beds. Timely access to inpatient care is sometimes a problem, with poor treatment planning. Advocates also report a lack of discharge and transition services.

The pressure of population growth and increases in property values makes housing a special concern. In 2004, SSI recipients would have needed to spend 112 percent of their SSI checks for a one-bedroom apartment in the state. The state provides supported housing

services in only two of the state's 15 counties, but is moving forward aggressively to address the need.

Arizona has invested in consumer and family education programs, which signals a desire to move in the right direction. Although gaps still exist in the planning process, the Arizona Department of Health Services, through the Division of Behavioral Health Services, has sponsored a Best Practices Committee that actively engages consumers and family members in the evaluation of initiatives.

Arizona has been slow to address the nuances of providing services to Native American or Latino communities, but is starting to catch up. The state requires providers to translate all materials whenever they know that either 10 percent or 3,000 of their members speak a specific language and have limited English proficiency. In other instances, translators will be provided. This is an exemplary national practice.

Within the last few years, Arizona also has made progress in developing pre- and post-arrest diversion strategies to decriminalize mental illness and to get people into treatment. Programs exist in Maricopa and Yuma Counties, with encouraging developments also in Pima and rural northern counties. One caveat: some of this progress is the result of legal actions initiated by the U.S. Department of Justice. It is a shame that a state must be forced through legal action to do what's right.

Strong, consistent, and committed leadership is needed in order to move forward proactively.

Score Card: ARIZONA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	2	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	6	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	2	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	0	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	1	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Arkansas

Grade: D-

Category Grades

Infrastructure	**F**
Information Access	**F**
Services	**D**
Recovery Supports	**D**

Spending, Income, & Rankings

PC Spending/Rank	$29.57	50
PC Income	$23,061	50
Total MH Spending/Rank	$80 *(in millions)*	44
Suicide Rank		16

Recent Innovations

- The collaboration between the University of Arkansas and state of Arkansas in expanding inpatient capacity and emergency services
- The Arkansas Mental Health Institute's training opportunities for in-state and out-of-state residents

Urgent Needs

- Data collection
- EBP implementation
- Mental healthcare services in the corrections system

Arkansas is a case of good people trying to do good—with almost nothing.

An extremely poor state, it ranked 49th nationally in per capita income in 2003. During FY 2000-2004, service delivery increased approximately 20 percent, but with no increase in the number of employees for the Department of Behavioral Health Services (DBHS).

The state's block grant report to the federal government in 2004 clearly identifies its overwhelming need: "that Evidence-Based Practices (EBP) be more widely available throughout the system."

The state also reports "difficulty in tracking implementation, including counting how many individuals are receiving EBPs." In fact, Arkansas performs poorly in collection and evaluation of system data. To its credit, DBHS acknowledges the deficiency and is taking steps to remedy it. This is an important first step for defining and setting priorities; however, the bottom line is that funding is needed to provide services, even cost-effective, evidence-based ones.

A mental health system requires different, carefully balanced levels of care, state hospitals as well as a range of community services, such as Assertive Community Treatment (ACT). When community options are not available, the system backs up. Overcrowding and shortages arise.

For several years, advocates and providers in Arkansas raised concerns about a shortage of inpatient psychiatric beds. In response, DBHS is now increasing the number at the state hospital, while the University of Arkansas is adding psychiatric beds to its teaching hospital and expanding its psychiatric emergency capacity.

The legislature is funding both initiatives. But broader investment will be needed to advance the system. For instance, there are currently only two ACT teams in the state.

DBHS delivers services through a network of community mental health centers located in 69 of the state's 75 counties, serving residents statewide. The close relationship between DBHS and the Medicaid agency is critical to the system; 60 percent of the revenue for the centers comes from Medicaid.

Arkansas must be watched closely with regard to Medicaid. To date, the state Medicaid program has demonstrated understanding and sensitivity to the needs of people living with serious mental illnesses and has

preserved open access to psychiatric medications. Nonetheless, there is pressure to impose restrictive policies. Governor Mike Huckabee, chair of the National Governors Association (NGA), is advocating at the national level for sweeping authority to be granted to the states to redesign their Medicaid systems. If he proposes radical redesigns at home, changes could follow that would weaken or eliminate some of the stronger elements of the state system.

In contrast to DBHS's earnest efforts to improve performance, the Arkansas Department of Corrections (ADC) is failing to meet the needs of individuals with serious mental illnesses. In 2004, the U.S. Department of Justice (DOJ) and ADC entered into an agreement on conditions at the Grimes and McPherson units of the state prison in Newport. The agreement was prompted by allegations of significant shortcomings in detainee health care, including mental health services. As part of the agreement, the state is required to take significant steps to enhance the quality of the prison's health services, or else face DOJ litigation. Key elements included major revisions to restraint policies, staffing, and suicide prevention procedures.

Many of the state's problems are fundamental. A person can't get access to services without services existing, nor without access to information concerning those services. Unfortunately, Arkansas received one of the lowest scores in the country in NAMI's "Consumer/ Family Test Drive" on information accessibility from DBHS.

Score Card: ARKANSAS

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services — Severe & Persistent Mental Illnesses (SPMI)	2	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	1	2
Information Access	9	Consumer & Family Test Drive (CFTD)	1	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	2	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	1	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

California

Grade: C

Category Grades

Infrastructure	**B**
Information Access	**C-**
Services	**D**
Recovery Supports	**A**

Spending, Income, & Rankings

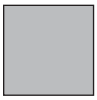
PC Spending/Rank	$109.34	14
PC Income	$32,043	10
Total MH Spending/Rank	$3,862 *(in millions)*	1
Suicide Rank		42 *(tied with Delaware)*

Recent Innovations

- Proposition 63 dedicated revenue
- Some progress in evidence-based practices
- Cultural competence
- Supportive housing

Urgent Needs

- State hospital reforms
- Statewide initiatives to decriminalize mental illness
- More ACT and other evidence-based practices



California stands at the threshold of a unique opportunity to improve services for people with serious mental illnesses. Enactment of Proposition 63, a "millionaire's tax," will provide a stable source of significant new revenue for mental health services. How much difference this will make over time remains to be seen.

Enactment of Proposition 63 (also known as the Mental Health Services Act) by referendum in 2004 stands nationally as one of the most dramatic innovations in financing mental health services, as both states and counties search for stable sources of dedicated revenue. On a county-by-county basis, planning for use of the $750 million in projected new money to be raised by the tax is currently underway, with emphasis on directing these new resources for services to unserved and underserved individuals. Clearly, it is needed —within the state, significant gaps exist in the availability and quality of treatment and services at the community level, since each county is responsible for administering its own mental health services.

California is the most populous state, with more than 35 million residents. Non-white residents comprise a significant percentage of the population; Latinos constitute the majority among residents younger than 17. Since 1991, responsibility for mental health services has been vested in the state's 58 counties and two city agencies (Berkeley and Tri-City). Simultaneously, a federal waiver resulted in the creation of California's Medi-Cal (Medicaid) program, a statewide managed mental healthcare system. In each county, a single managed behavioral health plan administers the program.

In 2003, the California Mental Health Planning Council estimated that approximately 300,000 adults with serious mental illnesses did not have access to needed services. State budget cuts haven't helped. Many indigent individuals in the state go without desperately needed mental health services simply because they don't exist.

California is increasing its emphasis on evidence-based practices (EBPs). Proposition 63 provides an opportunity to develop these programs statewide. The state is currently piloting the federal Assertive Community Treatment (ACT) model in four counties (Ventura, Los Angeles, Stanislaus, and Alameda). A number of other California counties have implemented ACT teams; however, these programs are not being monitored for adherence to the federal standard.

California's state hospitals are a major problem. Disturbing patterns of abuse and neglect recently surfaced in these hospitals, particularly at Napa State Hospital, serving the northern part of the state, and Metropolitan State, serving the Los Angeles area. The U.S. Department of Justice (DOJ) has investigated all four due to alleged civil rights violations. A preliminary letter of findings by the DOJ on June 27, 2005 asserted that the state had refused to cooperate with the investigation of Napa State, including refusal to give DOJ access to the facility until sometime in 2006. The state Department of Mental Health denies this allegation, explaining that they had simply sought to delay the DOJ inspection until an accreditation visit from the Joint Commission on Accreditation of Health Organizations (JCAHO) had been completed.

Allegations in the Napa investigation include:

- Repeated patient-on-patient assaults, resulting in at least one death and serious injuries, with failure by Napa staff to take steps to intervene or protect vulnerable individuals.
- Inadequate suicide prevention procedures, even when patients are known to be potentially suicidal, resulting in at least six successful suicides since 1999.
- Significant availability and heavy use of illegal drugs by patients, including testimony under oath by a Napa physician that Napa staff bring drugs into the facility in exchange for cash. In fall 2004, three Napa patients overdosed on amphetamines and/or cocaine. One died.
- Excessive misuse of seclusion and restraint, resulting in an investigation by the Federal Center for Medicaid and Medicare Services (CMS) that documented numerous cases of patients in physical restraints for excessive periods—sometimes for days at a time.

In 2004, California passed a law designed to reduce the use of seclusion and restraints. DMH reports that it is making progress in this area. For example, it states on its website that use of seclusion and restraints is down by 79% at Napa. However, according to the DOJ, Napa continues to employ seclusion and restraints in excess.

The proposed FY 2006/2007 budget for the Department of Mental Health includes nearly $38 million in general funds to "implement a new recovery treatment model in the state hospitals." Hopefully, these funds will be used to address the horrendous problems detailed in the investigations being conducted by the Justice Department.

In California, like other states, jails and prisons have become de facto psychiatric treatment facilities. County sheriffs and local police chiefs, such as Bernard Melekian of Pasadena, have called for alternatives to incarceration for non-violent offenders with serious mental illnesses—who, as they recognize, need treatment, not incarceration.

The DMH's response to NAMI's question about jail diversion programs stated: "California's jail diversion programs are administered locally," which is literally true. Thirteen local mental health courts have been established, including several serving juvenile offenders. The Court Transition Project, operated by the Los Angeles County Department of Mental Health, has received national attention as an exemplary program. The DMH must take a more active leadership role in promoting jail diversion as an integral component of a recovery-oriented public mental health system.

On the positive side, DMH is working to make sure that the most vulnerable individuals don't fall through the cracks—such as by increasing supportive housing options for people who are either homeless or at risk of homelessness. These efforts are critically important, as homelessness has reached epidemic proportions in some of California's major cities.

Under the leadership of DMH, county mental health agencies in many parts of the state have adopted cultural competence as an integral part of their work. The DMH has established an office of Multicultural Services which has worked hard to promote cultural competence in mental health services and provide technical assistance to counties in adopting culturally competent practices.

The state also can be applauded for increasing investment in supported employment. Programs exist in at least 22 counties. DMH believes such services also are available through the State Department of Vocational Rehabilitation in many additional counties, but could not document them.

California also supports statewide involvement of consumers and families in the planning and implementation of evidence-based practices, as well as consumer and family education. DMH's Web site also includes links to 24-hour crisis hotlines throughout the state.

California is a big state and providing it with necessary mental heath services is inevitably a big challenge. Transforming or adapting its system doesn't come easy, but for those same reasons, more is expected. We know it can do better. Proposition 63 provides an unprecedented opportunity to do so.

Score Card: CALIFORNIA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	3	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	6	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	2	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	1	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	0	3
	29	Accreditation of state hospitals/facilities	0	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Colorado

Grade: U

Category Grades

Infrastructure

Information Access

Services

Recovery Supports

Spending, Income, & Rankings

PC Spending/Rank	$66.30	33
PC Income	$32,550	9
Total MH Spending/Rank	$300 *(in millions)*	23
Suicide Rank		7

Recent Innovations

- Enactment of special tax authority
- Illness self-management

Urgent Needs

- Funding
- Maintain open formulary for psychiatric medication
- Evidence-based practices
- Expanded mental health parity

Colorado was one of only two states that declined to provide specific information in response to the survey used in preparing this report. It therefore has been graded "U" for "Unresponsive."

The state's Division of Behavioral Health & Housing (DBHH), located in the Department of Health & Human Services, said that the agency "did not have time to take place in non-mandated activities at this time, as we have had significant staffing reductions in the past few years." Requests for information on expenditures related to evidence-based practice (EBP) initiatives also were met with repeated responses of "data not available."

Those statements speak volumes about the degree to which Colorado's state budget battles have hog-tied the state's mental healthcare system, impairing initiative and hampering responsiveness and accountability to consumers and families.

Drawing on generally available public information alone, the picture in Colorado is not pretty. In recent years, a national recession, declining tourism revenue, and the impact of a Taxpayers Bill of Rights (TABOR), along with other legislative measures, combined to severely restrict public services. TABOR forced the state to limit growth in government services through strict constitutional controls—and stretched an already troubled human services system even thinner. Deep spending cuts in education and healthcare hurt middle and low income residents the worst.

- Emergency department admission rates for Medicaid and uninsured clients with mental health and/or substance abuse needs grew 83 percent over three years.
- In FY 2004, the state helped approximately 14,000 fewer consumers than it did three years before.
- The state reduced the number of beds in the state hospitals at a time when community services were being cut. Capacity decreased and squeezed people who were sick even more. In such cases, costs inevitably shift to emergency rooms, police, and the criminal justice system.

The good news is that as a result of the fiscal carnage, the state has suspended TABOR for five years. The

increased availability of tax dollars has made it possible for the restoration process to begin. The governor's budget provides for some increases in proposed funding for mental health services; the legislature is considering additional increases. The bad news is that for many people living with serious mental illnesses, damage already has been done.

Despite the state's fiscal woes and shrinkage in services, Governor Bill Owens held the line in one critical area—vetoing a legislative attempt in 2005 to restrict access to medications under Medicaid through "preferred drug" lists (PDLs). In a strategy to circumvent a veto this legislative session, legislators have now introduced a bill to bypass the governor and put the issue directly to Colorado citizens for a vote by referendum. Several points are relevant:

NAMI applauds the Governor's stand in 2005. Doing the right thing is not always popular or easily understood.

When it comes to psychiatric medicines, one size does not fit all, especially for the fragile Medicaid population. Side effects vary among different individuals. Some medications require weeks or months to take effect; restriction of physician-patient choices at the outset often can lead to greater suffering and costs over time.

The cost of one emergency room visit or hospitalization from one relapse can be expected to exceed significantly any per-person PDL savings. That also assumes that a person in psychiatric crisis gets help in time. The costs of suicide, homelessness, or prison are even greater.

Better, cost-effective alternatives exist. For example, the federal Center for Medicaid and Medicare Services has identified Missouri's Mental Health Medicaid Pharmacy Partnership (MHMPP) as a national model for oversight of clinical prescription processes. The innovation saved that state approximately $8 million in 2004. Equally important, MHMPP is grounded in sound clinical practice, rather than indiscriminate, restrictive formulary approaches.

In response to the budget crisis, the legislature has authorized municipalities to create special tax districts to fund mental health services. The Aurora City Council recently approved holding a public vote to create a district to raise $10 million annually. NAMI encourages communities to consider such initiatives, although it's uncertain how effective they will be in meeting the state's overall needs.

For cost-effectiveness, EBPs are essential. Unfortunately, DMH did not respond to requests for information in this area, but advocates report that DMH convened a working group in 2004 to develop a plan to generate provider support for EBPs. The state should insist on EBPs in its contracts with providers.

Lack of financial support for community-based mental health services continues to have devastating impacts on other systems that pick up the slack for underfunded services. Unless the state begins to make a financial investment in a mental health system to help people with serious mental illnesses move toward recovery, they will merely continue to shift the costs to taxpayers through other sectors, including the criminal justice system. In approximately 10 years, the number of people with mental illnesses incarcerated in Colorado's state prisons increased by a factor of 10—to approximately 2,400 in 2002.

The short-sightedness of failing to invest in an effective mental healthcare system is not only cruel, but sadly at odds with the pioneering vistas of the Rocky Mountain State. Advocates report optimism over recent developments and attention by key legislators; time will tell if the state can claim national leadership in developing a sound mental health system.

Score Card: COLORADO

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	U	3
	2	Demonstrated innovation	U	2
	3	Health disparities program	U	2
	4	Studies regarding causes of death	U	2
	5	Workforce development & strategic plan	U	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	U	2
Information Access	9	Consumer & Family Test Drive (CFTD)	4	10
	10	Consumer & Family (CF) monitoring teams	U	2
	11	Written mandate ensuring CF input	U	2
	12	CF involvement in EBP implementation	U	2
Services	13	No outpatient mental health co-pays	U	3
	14	No restrictions for antipsychotic medications	U	3
	15	No restrictions on prescriptions per month	U	3
	16	Benefit-service identification program	U	2
	17	Interagency cooperation between SMHA & Medicaid	U	2
	18	Wraparound coverage for benzodiazepines	U	2
	19	Feedback to doctors on prescribing patterns	U	2
	20	Integrated dual diagnosis treatment policies	U	3
	21	Assertive Community Treatment (ACT) teams	U	3
	22	Written ACT fidelity standards	U	2
	23	Family psychoeducation - SAMHSA model	U	2
	24	Illness management & recovery - SAMHSA model	U	2
	25	Jail diversion programs	U	3
	26	Restoration of benefits post-incarceration	U	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	U	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	U	2
Recovery Supports	31	Supported employment	U	3
	32	SMHA-Division of Vocational Rehab	U	2
	33	Supported housing	U	4
	34	Efforts to reduce waiting lists for residential services	U	3
	35	Housing services coordinator	U	2
	36	Written plan for long-term housing needs	U	2
	37	Co-occurring disorders--No Wrong Door	U	2
	38	Financial-logistical support Family-to-Family education program	U	2
	39	Financial-logistical support Peer-to-Peer education program	U	2

Connecticut

Grade: B

Category Grades

Infrastructure	**A**
Information Access	**C+**
Services	**C+**
Recovery Supports	**B+**

Spending, Income, & Rankings

PC Spending/Rank	$151.03	5
PC Income	$40,990	2
Total MH Spending/Rank	$525 *(in millions)*	15
Suicide Rank		47

Recent Innovations

- Recovery as a vision and goal, prior to the President's New Freedom Commission
- Corporation for Supportive Housing, a joint private/public partnership
- Mental Health Jail Diversion specialists in all arraignment courts
- Training institute with Yale

Urgent Needs

- Aggressive examination and solution to the nursing home crisis
- Housing
- Fidelity to ACT
- Resolve quality and safety concerns at CVH

Connecticut is recognized nationally for explicit promotion of a recovery model of care which focuses on individual strengths and enhancement of the ability to function. The vision is commendable, but the state is not yet fully engaged in making it a reality. It can do better.

Credit for the vision belongs to Commissioner Thomas Kirk, Jr., who issued a policy statement in 2002 that recovery was to become the overall goal of the Department of Mental Health and Addiction Services (DMHAS). Consumer and family advocates in the state generally find his leadership to be open and respectful of their involvement, but question whether the policy statement will actually translate into better services—and most of all, outcomes.

One innovation has been the creation of a training institute with Yale University for mental health workers. DMHAS includes requirements in its contracts that program staff be competent in recovery models—but the approach has not yet taken hold at the grassroots, nor been applied comprehensively. The state has increased funding for vocational support and developed pilot consumer-run programs, but the latter so far have been only that, small pilots, with no apparent plans to reproduce or expand them.

Over the past few years, the state has moved to improve cultural competency within the system, which in turn influences treatment effectiveness. The state has promoted cultural competency. It currently plans to increase bilingual and bicultural personnel to reduce culturally-specific barriers to treatment.

Long emergency room wait times for hospitalizations are a problem. Additional inpatient adult hospital beds are not the solution, but the state also should not reduce the supply. They are still the only intermediate level of inpatient care. The core problem is lack of ready access to outpatient care, along with shortages in decent, safe, affordable housing and effective outreach and crisis intervention services. Some state hospital beds have been made available through a new fund that last year served 42 people by supporting tailored discharge plans for people requiring intensive services who otherwise could not have left the hospital.

Grave concerns over the quality and safety of Connecticut Valley Hospital have recently surfaced. The

state's largest psychiatric facility is being investigated by the US Department of Justice for concerns about safety and the use of restraint and seclusion. Additionally, the Judge David Bazelon Center has initiated a review of whether people with serious psychiatric illnesses are inappropriately admitted to locked nursing home beds in Connecticut. Issues in both settings require urgent action.

Twenty-nine Assertive Community Treatment (ACT) teams are available statewide, but previously have not met federal standards. The state is moving now to improve fidelity to standards in order to obtain Medicaid funds for the service.

Housing is a problem. As a small state with the country's highest average per capita income, safe, decent, affordable housing for people with serious mental illnesses often is limited. The state has worked to address the problem. Approximately 2,300 units of supported housing have been added since the 1990s, and another 500 are anticipated. The state also has worked to make creation of smaller group homes easier through zoning exemptions, but ultimately, in order to meet overall needs, more investment by the legislature is needed.

There has been an increase of approximately 40 percent in the number of people with serious mental illnesses who have been placed in nursing homes. DMHA is considering the use of a state Medicaid waiver to move younger adults into more appropriate settings in the community. The state needs to move forward quickly to do so.

Criminalization of people with serious mental illnesses is also a problem. Based on information provided by the Connecticut Department of Corrections, Connecticut's adult prison population of people identified with a moderate to serious mental illness has gone from 2,200 in 2000 to 3,700 in 2005, from 12 percent of the total prison population to nearly 20 percent. Pre-booking crisis intervention teams (CIT) have been started in several towns with the help of federal grant funds. Jail diversion programs exist in all 20 arraignment courts in the state, but only about 40 percent of people with serious mental illnesses can be diverted, in large part due to lack of community housing and services.

Connecticut is one of seven states to receive a SAMSHA Transformation Grant. It has an excellent opportunity to examine how it can build on its successes and address some of the more disturbing trends related to incarceration and inappropriate nursing home placements.

Connecticut is moving forward and compares favorably to other states. But the state must not become complacent or content to stay in place. Many people still are not getting the help they need. One in five Americans experience mental illness at some point in their lives. Every person in the state is potentially vulnerable to a swift reversal of fortune. If it happens, the state needs a mental healthcare system that is ready, willing, and able to help them truly recover.

Score Card: CONNECTICUT

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	3	3
	6	Insurance parity for mental illness	2	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	9	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	3	3
	22	Written ACT fidelity standards	1	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	3	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	0	3
	29	Accreditation of state hospitals/facilities	0	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	3	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Delaware

Grade: C-

Category Grades

Infrastructure	**B**
Information Access	**D-**
Services	**D+**
Recovery Supports	**C+**

Spending, Income, & Rankings

PC Spending/Rank	$81.40	24
PC Income	$31,151	15
Total MH Spending/Rank	$66 *(in millions)*	45
Suicide Rank		42 *(tied with California)*

Recent Innovations

- Housing
- Growing collaborations with law enforcement
- Integrated treatment of mental illness and substance abuse

Urgent Needs

- Transparent outcome data on the change from CTTs to CCCPs
- Increased access to medications
- An end to police transport of people in psychiatric distress

"The Diamond State" is not a diamond in the rough so much as a diamond going through rough times. Delaware faces problems that one would not expect to find in a small state with only three counties.

Within the Department of Health and Social Services, the state's Division of Substance Abuse and Mental Health (DSAMH) administers community-based services through four community mental health centers, as well as four community continuum of care programs (CCCPs). For more intensive care, the state has the Delaware Psychiatric Center (DPC) in New Castle.

Introduction of the CCCPs in 2004 dramatically changed the system. Traditionally, people with serious mental illnesses had received intensive services from continuous treatment teams (CTTs) based on the national Assertive Community Treatment (ACT) model. As part of a restructuring, DSAMH collapsed nine CTTs into the CCCPs. DSAMH reports that ACT teams are still embedded within each program, but advocates report decreased availability.

Advocates are concerned that the state is either not measuring the impact of the changes, or withholding information that may be less than flattering. According to one advocate, CCCPs are "gutted" versions of CTTs, with too large of a caseload to provide appropriate intensive services.

Other concerns exist:

- In January 2005, DHSS imposed changes in Medicaid regulations that restricted access to medications through a variety of means: medication co-pays, a preferred drug list, step therapy ("fail first"), and prior authorization for clients with more than 15 medications per month. The state's House of Representatives recognized the adverse impact on individuals needing psychiatric medications and unanimously passed a bill to ease some of the restrictions, but the bill stalled in the Senate. In response to the legislative pressure, DHSS announced minor changes in the regulations —but the overall result still has been reduced access.
- Individuals in psychiatric crisis are routinely

transported in handcuffs by police, rather than by medical staff in ambulances. The result is additional trauma and unnecessary stigmatization, as well as increased pressures on already-overbudened law enforcement resources. Advocates have raised the issue before the legislature.

- According to advocates, DSAMH is seeking to narrow the state's involuntary commitment law, making it one of the most restrictive in the nation. One of its effects would be to keep those people in most desperate need of treatment out of the public system.
- A federal appeals court has upheld rulings in favor of a former DPC psychiatrist who lost his job after speaking out about problems at the hospital. The court found that the leadership of DSAMH "acted at least recklessly or callously, if not intentionally or maliciously" by not renewing the psychiatrist's contract after he wrote a series of memos in 2000 citing patient safety concerns, staffing shortages, and overcrowding of the hospital.

On the positive side, Delaware has moved to implement an evidence-based, integrated treatment model for co-occurring mental illness and substance abuse. There currently are 22 such programs across the state.

Housing is an area of strength. The state provides consumers with a continuum of options. DSAMH supports a variety of group homes, supervised apartments, and rental subsidy programs. For ten years, NAMI Delaware also has provided housing using HUD Section 811 funds.

Nonetheless, the maintenance of stable housing for consumers relies on community support services—one more reason for DSAMH to evaluate closely the switch from CTT to CCCP. Analysis needs to include effects on housing status to ensure that people do not fall through the cracks.

A significant development is a growing partnership between law enforcement and mental health advocates. The Delaware State Troopers and New Castle County are moving to increase training about mental illnesses. The State Troopers have developed a Crisis Intervention Team (CIT), and the county recently passed a resolution encouraging the police departments to explore implementing CIT.

To continue the trend, NAMI encourages the state to review mental health services for inmates at the state prison to ensure that adequate, humane treatment is provided.

Score Card: DELAWARE

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	4	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	2	3
	16	Benefit-service identification program	0	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	3	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	2	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	0	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Washington, D.C.

Grade: C

Category Grades

Infrastructure	B-
Information Access	C-
Services	C-
Recovery Supports	B+

Spending, Income, & Rankings

PC Spending/Rank	$414.08	1
PC Income	$45,898	1
Total MH Spending/Rank	$232 *(in millions)*	27
Suicide Rank		51

Recent Innovations

- DMH structural changes under court order
- Development of community system DMH Training Institute

Urgent Needs

- Information Accessibility
- New hospital construction on schedule
- Reinvestment of St. Elizabeth assets "in trust" for mental health care system
- Ensure EBP model standards and recovery orientation
- Housing

Washington, D.C.'s current level of achievement in mental healthcare is the result of court-ordered changes that are being dictated to the system. The real test comes when the District has to proceed on its own.

It is too early to tell when—or whether—the District will live up to the high standards set by the court. It is important for advocates to monitor the changes and continue pressing for reform.

The key to understanding the District's system is the 1974 court case *Dixon, et al. v. Williams*. In that case, a group of individuals civilly committed to the city's sole public hospital, St. Elizabeth's, sought community services as alternatives to hospital treatment. As a result of the case, the federal and District governments in 1980 agreed to a consent order and implementation plan to ensure that treatment occurred in the least restrictive setting possible.

Throughout the 1980s and 1990s, the court maintained close oversight of the mental health system. After the District repeatedly failed to meet its court-ordered obligations, a court-ordered Receiver was appointed in 1997 to oversee the system and ensure the development of community services in compliance with the *Dixon* case rulings.

In 2001, the city reached a major milestone with the adoption of a Transitional Receiver's Court-Ordered Plan (the Plan) that is intended to be the blueprint for eventual resolution of the *Dixon* case. The plan established specific "exit criteria" that must be met in order to close the case.

Nearly all aspects of D.C.'s current system—even the establishment and structure of the city's Department of Mental Health (DMH)—are tied directly to the 2001 Plan. DMH has three, separate court-ordered mandates: to act as the mental health authority; to provide services, through the D.C. Core Service Agency (CSA); and to oversee the city's sole public hospital, St. Elizabeth's. In addition to acting as a service provider through the CSA, DMH also administers contracts with a variety of other service agencies across the city.

Community services are delivered primarily through an entity called the Mental Health Rehabilitation Services (MHRS) system. The *Dixon* case and the 2001 Plan placed great emphasis on leveraging as much funding as possible from Medicaid using the Medicaid

Rehabilitation Option (MRO). By tying services to Medicaid reimbursement, the DMH reports that it has created increased consistency across providers, while allowing the information to be more closely tracked by the city. However, the court monitor has noted that the city "does not appear to have a credible process in place to ensure that data collection is consistent and reliable" to measure progress toward exit criteria.

The District acknowledges that "DMH has not yet matured as a service delivery system" after undergoing such a "major paradigm shift." As DMH transforms from "largely an office- and clinic-based system" to one in which a "minimum of 50 percent" of services are delivered in non-office or -clinic settings, several barriers exist that slow the pace of reform.

- The court monitor has noted a need for stable leadership. Since October 2005, an interim director has been overseeing the department. In 2006, the incumbent mayor is stepping down.
- Construction of a new, consolidated hospital at St. Elizabeth's is over two years behind schedule, and assuming no further delays, the earliest occupancy date is in 2009. The court monitor recently expressed the "highest concern" for the hospital's clinical staffing, staff training and competence, and patient safety.
- A recent survey of 15 different DMH and provider programs revealed that approximately 60 percent of staff surveyed know little or nothing about principles of recovery.
- Over three years, $16.3 million in unpaid provider claims accumulated which resulted in a "a major crisis in cash flow for providers" in 2005. After an emergency hearing, the federal court ordered immediate payment of $8 million—which was accomplished in 48 hours. The City Council was expected to approve payment of the rest in February 2006.

DMH is required to serve all residents up to 200 percent of the poverty level, regardless of Medicaid eligibility. The cost of housing in the District is extremely high—it ranks second nationally. Monthly rent for a one-bedroom apartment is 185 percent of monthly Supplemental Security Income (SSI) payments. DMH has worked to create a continuum of housing subsidies and other options, and through its housing finance authority, the city is developing targeted affordable housing for persons with serious mental illnesses, but supply does not yet meet the overall need. Still, there is progress.

- Evidence-based practices are beginning to take root. The city has eight Assertive Community Treatment (ACT) teams—although advocates report that some fail to meet model standards.
- Six supported employment programs have been developed through partnership between DMH, Dartmouth University, and Johnson & Johnson.
- Integrated treatment for co-occurring disorders is being implemented, aided by a federal grant.
- The CSA offers a Multicultural Community Support Program to serve the city's large minority and ethnic population. DMH also has created a toll-free access helpline to immediately connect individuals in need with the city's service system.
- The city has a jail diversion program. Additional programs to decriminalize serious mental illness are being developed.
- A DMH Training Institute at Georgetown University was created under the Plan for continuing education of providers, consumers, families, and other system stakeholders.
- An Office of Multicultural Services was established by the DMH to reach out to the city's diverse population. Specifically, the DMH has developed action plans for Spanish/Latino, Asian and Pacific Islander, and other communities with limited English proficiency. To monitor implementation of these plans, DMH produces quarterly reports that address selected outcome indicators, such as translation of materials, workforce diversity, multicultural training, and outreach and community partnerships.

In the District, there is considerable distance—metaphorically speaking—between the White House and city hall. In this case, the District still has a long way to go to fulfill the vision of the President's New Freedom Commission. But it slowly is making progress.

Score Card: DISTRICT OF COLUMBIA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	3	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	7	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	3	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	2	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	0	2
	30	Olmstead Plan	1	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	1	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Florida

Grade: C-

Category Grades

Infrastructure	**F**
Information Access	**B+**
Services	**D+**
Recovery Supports	**C+**

Spending, Income, & Rankings

PC Spending/Rank	$37.99	48
PC Income	$28,907	24
Total MH Spending/Rank	$644 *(in millions)*	12
Suicide Rank		15

Recent Innovations

- Successful employment initiatives
- Promising growth in supported housing programs
- Growing penetration of jail diversion strategies

Urgent Needs

- State leadership in developing a statewide standard of care
- Assurance of protections in Medicaid reforms
- Access to prescription drugs
- Expansion of CIT programs and treatment for mental illness in jails and prisons

Florida is a big state with a big opportunity to advance its mental healthcare status. But access to services for Floridians living with mental illness has been an afterthought for too long. For the state to rightfully claim leadership in social services, it must demonstrate that leadership internally.

Today Florida is squarely in the spotlight as the nation watches efforts in Broward and Duval Counties to implement Governor Jeb Bush's Medicaid Reform Plan. Incorporating the concepts of personal responsibility and promoting healthy lifestyles, the reform offers risk-adjusted premiums that service recipients can use to purchase desired health plans from the community marketplace.

The reforms become operational in two counties this year and are expected to be implemented statewide by 2010. Florida has a history of effective Medicaid growth containment: Florida Medicaid expenses grew at a considerably lower pace than the rates of growth experienced by private insurance plans in the early 2000s. But Florida's rather daring innovations put the state's most vulnerable citizens at risk, so the state must monitor the impact of this reform effort very closely to assure that innocent people do not get hurt.

For healthy populations, the reform project appears to be a reasonable experiment to control increasing Medicaid expenditures. However, the plan can put people who have disabilities at significant risk. Because plan designs are at the discretion of competing commercial providers, it is possible that recipients will face new restrictions on access to needed medications, increased co-sharing, and reduction in benefits from the current Medicaid program. There are other possible risks. With the current Florida Medicaid plan, in a given year a person who has a significant medical emergency, such as a psychiatric hospitalization, could exhaust the premium allotment with one or just a few visits. Their choice would then be either to go without care or to enter the system at a more expensive level of service.

Florida's mental health system is organized and delivered primarily through 15 distinct districts. The state provides most of its money through Medicaid reimbursement. Counties have the option to invest additional resources to strengthen the community mental health system, and some counties, such as Orange, Broward, and Dade, have funded innovative

programs and core supports this way. But funding is spread disproportionately across the districts, creating a barrier to the development of consistent systems of care.

The state could ease pressure on its Medicaid program and community mental health services if it would advance and sign a mental health parity bill. Florida is one of a handful of states that have yet to make this important public policy commitment.

Florida boasts several examples of strong evidence-based services. However, an analysis of the locations of the programs confirms that there is great variation in the quality and quantity of services among districts. The wide variation of available services suggests that the Department of Children and Family Services has not yet fulfilled its obligation to promote a statewide system of care that is consistent in quality and availability across the state. The Florida Assertive Community Treatment (FACT) program, for example, falls short of important standards, including the failure to include vocational rehabilitation among FACT's services.

In its response to NAMI's survey, Florida listed consumer/family involvement in advisory boards as a positive example of Florida's efforts to engage stakeholders. But in interviews for this report, stakeholders suggest great inconsistency in family/consumer involvement in advisory boards: Only 25 percent of the 32 boards include family/consumer representation.

When it comes to bed availability in Florida, there are pockets of excellence, but not consistent quality of care for consumers. Reflecting a disconnect between state leadership and service provision in the districts, the state Mental Health Planning Council fails to identify access to inpatient beds as a priority for the system. According to interviews, access to state-operated hospitals is heavily rationed, and county hospitals frequently discharge patients prematurely to avoid the cost of unsubsidized inpatient hospitalization. The chronic shortfall of beds is made more problematic by inadequate discharge planning, including the failure to provide direct connections to desperately needed supported services. As a result of this shortage, many discharged patients end up in the custody of law enforcement authorities, through minor criminal offenses or civil commitment proceedings.

The Department of Justice recently closed an investigation of the G. Pierce Wood Memorial Hospital involving allegations of improper treatment and discharge planning. The complaint was closed without federal intervention, but it is indicative of the inpatient system of care within the state. The hospital closed recently, removing additional state-operated inpatient capacity—and placing more pressure on the counties and service districts.

From a statewide perspective, Florida has demonstrated leadership in the development of a comprehensive housing plan for persons with mental illness. Currently, through service districts and counties, Florida offers 62 supported housing programs throughout the state. Though this still is an inadequate number of units for the state's population, progress is evident.

By necessity, the criminal justice community has become one of the most visible mental health advocacy constituencies in Florida. Criminal justice professionals have taken steps to address the pressures of untreated mental illness by establishing eight mental health courts and developing Crisis Intervention Team (CIT) models in 12 counties and numerous communities. However, the criminal justice/mental illness crisis remains severe. The Florida Department of Corrections currently houses almost 11,000 individuals receiving treatment for mental health disorders. Among women, 40 percent of those incarcerated require mental health treatment. The problem in county and municipal jails is more pressing: An estimated 23 percent of incarcerated individuals have a mental health condition.

In contrast to its overall lack of statewide coordination, the state deserves credit for initiatives to incorporate recovery and resiliency, and consumer and family involvement, into the culture of the state system of care. The state recently established a recovery and resiliency task force to help steer the state toward the introduction of recovery-based services. Florida has also recently established an office of consumer affairs and offered meaningful involvement for consumers in the development of the state system's transformation grant application.

Florida has demonstrated national leadership in its efforts to gain competitive employment for persons with mental illness. Nearly 20 percent of adults with severe persistent mental illness are employed in the state of Florida, significantly higher than the national average.

Florida has made significant progress in aiding individuals with mental illnesses that collide with the criminal justice system, but the state's ambitious Medicaid reform program may contain risks for those with serious mental illnesses.

Score Card: FLORIDA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	8	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	0	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	0	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	0	2
	30	Olmstead Plan	1	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	1	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	1	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Georgia

Grade: D

Category Grades

Infrastructure	**D**
Information Access	**D**
Services	**D+**
Recovery Supports	**D**

Spending, Income, & Rankings

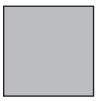
PC Spending/Rank	$49.88	44
PC Income	$27,953	28
Total MH Spending/Rank	$430 *(in millions)*	20
Suicide Rank		37 *(tied with Texas)*

Recent Innovations

- National model for certified peer specialists
- CIT training curriculum
- "Double Trouble for Recovery" for mental illness and substance abuse
- Unified transportation system for rural areas

Urgent Needs

- Funding
- Dollar-for-dollar reinvestment
- Expand ACT and other evidence-based practices
- Eliminate restricted access to medication
- Prescription feedback and education



The mental health system in Georgia is a work in progress. Several initiatives have been started that are national models of excellence. However, although many providers have moved towards evidence-based services, they are are hard to establish and even harder to maintain with shortages of adequate funding. Additionally, possible Medicaid changes in the works cloud the horizon.

As home to the Carter Center in Atlanta, which has a special focus on mental health, and former U.S. Surgeon General David Satcher at the Morehouse School of Medicine—who was responsible for the landmark Surgeon General's Report on Mental Health in 1999—the state is an important link in the national movement to transform the nation's mental healthcare system.

In 1998, the U.S. Supreme Court decision in *Olmstead v. L.C.* focused national attention on the fact that Georgia, as much as any state, continued to concentrate resources for people with serious mental illnesses and other disabilities in institutionally based care. The Court's ruling that people with disabilities have a right under the Americans with Disabilities Act to services in settings most appropriate to their needs has been the direct catalyst for a slow transition in Georgia to a system with greater emphasis on community-based care.

This transition has been hampered by cuts in general mental health funding, resulting in increased reliance on Medicaid as a predominant funding source for people with serious mental illnesses.

Georgia has reorganized its system into seven regions that correspond with seven state psychiatric hospitals—the theory being that it will facilitate seamless transitions between inpatient and community-based care. The state also has amended its Medicaid plan to allow for flexible funding of evidence-based services such as Assertive Community Treatment (ACT) and integrated treatment for co-occurring mental illness and substance abuse. The state is in the process of implementing a voluntary disease management initiative for Medicaid recipients with specific medical conditions, including schizophrenia, with the intention of both saving dollars and improving care.

The results from these steps—positive or negative—are not yet known. In the meantime, shortages of

community services remain a problem. ACT and long-term care options in the community, such as supported housing, are essential for the transition to a community-based system. In building the community system, the state needs to learn from the painful lessons of other states, approaching the transition from institutional care carefully—and reinvesting savings on a dollar-for-dollar basis. Adequate numbers of inpatient beds, community residential treatment programs, and crisis intervention services must be maintained to address acute and long-term care needs.

In January, 2006, Georgia Governor Sonny Perdue announced that he had decided to postpone implementing proposed Medicaid reforms until 2007 and that when those reforms are implemented, they will not be as far-reaching as previously anticipated. The Governor should be applauded for this wise decision. However, advocates must remain vigilant to ensure that changes that are ultimately implemented do not further impede access to services for people with serious mental illnesses.

Multiple restrictions on access to medications for Medicaid recipients with serious mental illnesses are already in place in Georgia. These changes include prior authorization for non-preferred medications and a limit of five prescriptions per month for adult Medicaid recipients, unless a pharmacist rules them "medically necessary."

Restrictions of this kind are misguided. Limiting access to medications for people with serious mental illnesses can lead to significant increases in other costs such as hospitalizations and incarceration in correctional facilities. They ignore several unique concerns involving psychiatric medications, including the length of time often needed for them to take effect, and the degree to which individualized side effects are part of the equation.

The state has done little to achieve greater efficiencies for Medicaid prescriptions through less onerous means such as physician feedback and education programs, which have been effective elsewhere.

In moving to build its overall system, Georgia has invested significantly in Integrated Dual Disorder Treatment (IDDT) and other services for individuals with co-occurring disorders. The state has 35 integrated treatment programs and has contracted with national experts to provide training to providers statewide. One interesting initiative is "Double Trouble in Recovery," a 12-step self-help program based in part on the Alcoholics Anonymous (AA) model, while recognizing the importance of continuing psychiatric medication as part of a treatment program.

Georgia was the first state to provide reimbursement under Medicaid for Certified Peer Specialists who work with consumers. The federal government has contracted with the state to develop a "toolkit" based on the program to disseminate throughout the nation as a best practice.

The Georgia Bureau of Investigation and NAMI Georgia are collaborating on a statewide police Crisis Intervention Team (CIT) initiative that includes a uniform training curriculum approved by the Georgia Peace Officers and Training (POST) Council and co-sponsored by the Georgia Division of Mental Health, Developmental Disabilities, and Addictive Disorders (MHDDAD). Numerous counties throughout the state have hosted the training, and some have taken the next step by designating CIT officers to respond to people with serious mental illnesses in crisis. Other jail diversion initiatives have been implemented in five Georgia counties.

The state is attempting to address the significant challenges of providing services to people with serious mental illnesses in its numerous rural counties through a variety of outreach efforts. Particularly noteworthy is the Department of Human Resource's Unified Transportation System—targeted specifically for rural regions. The system provided transportation to appointments for mental health treatment and services to approximately 5,000 mental health consumers in FY 2004.

Score Card: GEORGIA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	2	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	6	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	1	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	1	2
	38	Financial-logistical support Family-to-Family education program	0	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Hawaii

Grade: C

Category Grades

Infrastructure	**C-**
Information Access	**D**
Services	**C+**
Recovery Supports	**A**

Spending, Income, & Rankings

PC Spending/Rank	$125.38	10
PC Income	$29,350	20
Total MH Spending/Rank	$152 *(in millions)*	35
Suicide Rank		41

Recent Innovations

- Transparent action plan to build a community system
- Re-invention of the Hawaii State Hospital
- Dr. Thomas Hester's leadership to turn around a failing system

Urgent Needs

- Additional funds to build and stabilize the community system
- Solution to overcrowding at the Hawaii State Hospital

Hawaii's mental health system consistently came in dead last in previous NAMI ratings (1986, 1988, and 1990). There appeared to be few causes for hope. Everything about the situation was dire—an abysmal state hospital with disgraceful conditions, poor outpatient care, poor vocational supports, and poor housing. In the ensuing 16 years, through hard work and federal pressure, Hawaii is potentially poised to be applauded as *most improved* of any state in this report.

The Department of Justice (DOJ) entered the state in 1991 to address egregious civil rights violations of patients at the Hawaii State Hospital and has since been actively monitoring the quality of care. As a result, the Hawaii State Hospital has made a number of improvements and was released from federal monitoring in December 2004. In lifting the 13 years of oversight, U.S. District Judge David Ezra called the improvements at Hawaii State Hospital "astonishing."

To ensure a continuum of services for Hawaiians with serious mental illnesses, however, the federal court has retained oversight of the state's community system of care. Hawaii's Adult Mental Health Division (AMHD) has just months until the June 30, 2006, deadline to fully implement a 2002 court-ordered community mental health plan. Clearly, this is a critical time for Hawaii's mental health system.

Although the deadline is fast approaching, the AMHD has been working for years to develop a community system under the leadership of Thomas Hester, M.D., a veteran community psychiatrist. While the speed of this process has been criticized, most notably by U.S. Magistrate Kevin Chang, change does take time. The community system is being built upon a foundation of solid plans to ensure that it is sustainable long after the court oversight leaves Hawaii's shores.

The result is currently a community mental health system that is far from perfect, but that clearly has made progress. In 2003, AMHD established a Center for Evidence-Based Practice in partnership with the University of Hawaii to advance the adoption of such important services as Assertive Community Treatment (ACT), integrated treatment for co-occurring disorders, supported employment, and illness management programs. Supported housing exists across the islands,

and the state is supporting several jail diversion programs as well. Although some of these programs are still getting off the ground, the state is working hard to advance these key community system components.

The availability of effective services is critical, but for a state like Hawaii with a majority-minority population, those services must meet the needs of the state's population. In response, AMHD has developed a three-year multicultural strategic plan to ensure that culturally competent services are infused throughout the developing community system.

Additionally, Governor Linda Lingle's discussion of her mother's mental illness has helped debunk stigma in the state during this important transition time for the mental health system. In 2003, during legislative debate around insurance parity, Governor Lingle testified in favor of the legislation and spoke of her family experience. As Governor Lingle so aptly stated, "It just doesn't make any sense why we would have to come and even testify on something like this. It's a sickness. It's an illness. You don't come and testify for diabetes or high blood pressure." Governor Lingle's bravery and leadership on parity helped move the legislation into law and brought mental illness into the open for Hawaiians.

Even though Hawaii's system is on the right leadership track, change also takes money. The Hawaii legislature has supported the mental health system over the past few years, with an increase in funds from fiscal year 2003 to 2005 of almost $35 million. Now is the time for the state to demonstrate its commitment to the mental health system in this final stretch before the June 30, 2006, deadline.

In early 2006, AMHD requested an emergency appropriation from the legislature of approximately $10 million, a request still in debate at the time this report went to press. The additional funds are needed in the short term to help the system comply with the court deadline, and are also necessary for the long term. The funds will also be used to meet the growing need for services as increasing numbers of individuals access the developing community system.

But, even with an influx of additional funds, there is still much work to be done in Hawaii's system, as noted by Mr. Chang's July 2005 report. A recent spate of 16 deaths, including six by suicide, among individuals receiving state mental health services was cited as one major concern. In his report, Mr. Chang said that the deaths reflected system dysfunction and a lack of judgment in the AMHD's response. And, despite the turnaround at Hawaii State Hospital, the challenge now is overcapacity, due to an increasing forensic population and a community system that does not yet possess the resources to provide appropriate services for individuals discharged from inpatient care. As a result, the state has contracted with another mental health provider (Kahi Mohala) for an additional 40 beds, at an annual cost of $10 million.

Clearly, Hawaii has not yet fully arrived. With the help of the federal court, the leadership of the state system, and the involvement of consumers and family members in the state, however, Hawaii's mental health system has a chance to address these problems and continue the tremendous progress made by the state since 1991.

Score Card: HAWAII

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	6	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	0	2
	20	Integrated dual diagnosis treatment policies	3	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Idaho

Grade: F

Category Grades

Infrastructure	**D-**
Information Access	**F**
Services	**D**
Recovery Supports	**F**

Spending, Income, & Rankings

PC Spending/Rank	$33.69	49
PC Income	$24,601	46
Total MH Spending/Rank	$46 *(in millions)*	51
Suicide Rate/Rank		9

Recent Innovations

- First Lady Patricia Kempthorne speaking out about her depression to reduce stigma
- Mental health courts
- ACT teams

Urgent Needs

- Funding
- Evidence-based practices, including integrated treatment and supported employment
- JCAHO accreditation of State Hospital North
- Housing
- Comprehensive plan to address workforce shortage

Idaho is one of the worst states in the nation when it comes to the adult public mental healthcare system. Leadership, commitment, and investment in the system are all low. The state has one of the lowest per capita spending rates on mental health services in the nation.

Governor Dirk Kempthorne recently proposed a Medicaid waiver to the federal government, in order to make significant changes in the state program. From background materials available in early February 2006, including the governor's concept paper, it appears that adults with serious mental illness will continue to receive the same benefits—but further information and analysis will be needed to fully assess the implications of what is a major reform initiative.

"Adult" is also an especially important distinction in talking about Idaho's system.

First Lady Patricia Kempthorne, wife of the governor, has devoted herself to mental health and substance abuse issues, but focusing primarily on the needs of children. She chairs the Governor's Coordinating Council for Families and Children—and has publicly spoken out about her own experience with depression. What can't be measured, except over time, is the degree to which she may have helped to reduce stigma—and opened the state's political community to broader dialogue on mental illness.

The Division of Family and Community Services (DFCS), located within the state's Department of Health and Welfare, is responsible for mental health services. Seven Regional Mental Health Authorities (RMHAs) provide community mental health services, and two state hospitals—North and South—provide inpatient care.

Low funding levels have been stretched even thinner by the state's large population growth over the past 15 years. New challenges include an increasing concentration of people of Latino heritage in the southern part of the state, and increasing population in cities and towns.

There is an astonishing shortage of mental health professionals in the state. According to the state's FY 2005 federal block grant application, there are only approximately *nine* psychiatrists, nurse practitioners, and physician's assistants across the *entire* state to supplement other clinical staff. The federal Health Resources and Services Administration (HRSA) has des-

ignated the state a Healthcare Professional Shortage Area (HPSA), but the state reports it has not undertaken a workforce assessment or designed a strategic plan to meet the need.

It only gets worse:

- Assertive Community Treatment (ACT) programs are the only evidence-based practice (EBP) in the state. ACT teams operate in all seven regions, but only four are fully staffed and able to meet model standards.
- No integrated treatment exists for individuals with co-occurring mental illness and substance abuse.
- No supported employment program.
- No supported housing services or plan to address long-term housing needs.
- Despite repeated recommendations from the State Planning Council on Mental Health (SPCMH), Idaho also has not pursued accreditation for State Hospital North from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- The state reports no *Olmstead* compliance plan to assure that individuals currently in institutions receive care in an appropriate setting.
- Workforce shortages affect access to inpatient care in the two state hospitals. Advocates report that beds lie empty because of a lack of staff.

The SPCMH has urged the state to create more opportunities for direct consumer and family involvement in policy and programs—including monitoring teams—but one of the few mechanisms for inclusion is representation on RMHA oversight boards.

Finally, the state legislature's continuing failure to pass mental health insurance parity stands as a symbol of apathy and shortsightedness—failing both to remove stigma and discrimination and to recognize the potential burden of mental illness on middle class families, and the eventual cost to taxpayers, when such families are forced to spend down assets and enter the public system.

Now for the good news (there is always some).

Partnerships between the legislature and criminal justice system are helping drive reforms. Mental health courts are spreading across the state, and judges involved with the courts have been advocates for increased funding for ACT teams to ensure community services for individuals they see in court.

To help reach the estimated one-third of the state's population that live in rural and mountainous areas, DFCS also is creatively using regional field offices, technology, and mobile treatment teams.

Nonetheless, Idaho has a long way to go before it even approaches the vision of a recovery-oriented system.

Score Card: IDAHO

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	3	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	1	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	0	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	1	2
	30	Olmstead Plan	0	2
Recovery Supports	31	Supported employment	0	3
	32	SMHA-Division of Vocational Rehab	1	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	1	2
	39	Financial-logistical support Peer-to-Peer education program	1	2

Illinois

Grade: F

Category Grades

Infrastructure	**D-**
Information Access	**F**
Services	**F**
Recovery Supports	**D**

Spending, Income, & Rankings

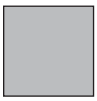
PC Spending/Rank	$66.12	34
PC Income	$31,987	11
Total MH Spending/Rank	$835 *(in millions)*	7
Suicide Rank		44

Recent Innovations

- Real estate transaction fees to fund rental assistance programs

Urgent Needs

- Balanced hospital and community service capacity
- Broad implementation of evidence-based practices
- Stronger collaboration to promote employment opportunities
- Jail diversion strategies, including re-entry programs



The Land of Lincoln is a complex state. Old Abe suffered from depression. If he were alive today, the quality of his care would depend on where in Illinois he resided.

The Mental Health & Developmental Disability Service Division (MHDDSD) is located within the state Human Services Department. Mental health services are delivered through six Comprehensive Service Community Networks (CSCNs), which provide consolidated planning and coordination for inpatient and community-based services. Advocates report great disparities in the quality of services among the service regions.

The state has been moving slowly away from a grant model of contracting community services to a fee-for-service model. Because of criticism from providers and a consultant's report by Parker, Dennison & Associates that deemed the system unprepared to absorb the change due to structural and capacity limitations, the state has delayed implementation of the approach for another year. A fee-for-service approach is potentially important for incentives to broaden evidence-based practices (EBPs), as well as enhancing accountability.

In its 2005 federal block grant report, the state Mental Health Planning Council gives priority to implementation of EBPs. The state has a long way to go, but is making progress in that area. It recently convened a task force on the challenge, and a plan is in place. A payment model that rewards providers for using evidence-based practices and addresses consumer treatment needs would expedite the progress toward this key transformation need.

In October 2005, the Office of Inspector General for the U.S. Department of Health and Human Services began a review of Illinois community mental health services funded by Medicaid. The scope of the review predates administrative procedures adopted by the state to strengthen billing protocols. No findings have been issued, and any concern at this time is only speculative, but the review needs to be watched cautiously. At least one other state found itself having to reimburse the federal government a large amount for past expenditures—which added an unanticipated cost to the state budget, requiring large program cuts.

Rather interestingly, MHDDSD's "culture" sometimes is raised in discussing general needs. Research during this report tended to confirm descriptions of the agency as

being at times lackadaisical, and at other times confusing or difficult to deal with. In particular, during NAMI's "Consumer and Family Test Drive" of information accessibility, raters complained about MHDDSD's telephone responsiveness perhaps more than in any other state. One person called and never reached a live person, even after being connected to multiple voicemails. Another called one line seven times, but always found it busy.

Worst of all, one person called and after identifying himself as a consumer was told by an agency employee: "No, I will not help you."

Only five states scored lower than Illinois on the "test drive": Alabama, Arkansas, Missouri, New Mexico, and South Dakota.

If access to information is a problem, access to services usually isn't far behind. Employment training for people with serious mental illnesses is a major problem in the state—even though it is often critically important to recovery.

Although many consumers want to work, the state acknowledges that it is not doing enough to help them. The state's Department for Rehabilitative Services only accepted 25 percent of referrals for training from the mental health provider network and successfully found work for only 11 percent of those accepted. No formal agreement exists between the mental health and vocational rehabilitation agencies, which suggests that lack of shared priorities and bureaucratic inaction are compromising opportunities for recovery.

Over 15 years, admissions to state psychiatric hospitals have declined approximately 60 percent, and the state has reduced inpatient capacity proportionally. Unfortunately, advocates report the state has gone too far, too quickly. The system is out of balance. Availability of local inpatient care options through the CSCNs have not kept up with expectations. Replacing institutional care with community-based services should still be the goal, but when community services are lacking, access to state hospitals must be preserved for those in psychiatric crisis.

Recently, the Illinois Medicaid program implemented preferred drug lists for psychotropic medications. Open access to mental health medications is a critical issue, and restrictions to access risk severe consequences. Advocates were successful in negotiating a four-month grandfathering window that has allowed physicians to complete prior authorization requests—hopefully avoiding wholesale medication changes that might be imposed on consumers in otherwise stable treatment regimes. The state also deserves credit for eliminating co-pays for antipsychotic medications; however, consumers who take medication for co-occurring conditions will still be affected.

The state deserves special credit for taking an innovative step to address the housing needs of people living with mental illnesses. In 2005, the legislature designated a share of transaction fees on all real-estate transactions be reinvested through rental assistance programs. The new investment in low-income housing will help many Illinois residents, including those with mental illnesses.

Strong action is needed in addressing problems within the criminal justice system.

In July 2005, an agreement was reached between the state and plaintiffs represented by the MacArthur Justice Center to improve the quality of mental health services provided in the state's SuperMax prisons. Meanwhile, a class action lawsuit is pending against the Cook County Jail in Chicago. As of 2003, the jail housed an estimated 1,500 people with chronic mental health conditions and was discharging 100 people per month—without connecting them to community services.

Currently, the state lists only two active mental health courts. Kane County recently has taken the innovative step of assigning a $10 fee on all guilty judgments or grants of supervision in the 16th Judicial Circuit in order to fund a new mental health court.

The state also is behind the curve relative to many other states in establishing police Crisis Intervention Teams (CIT).

For a large state, Illinois is nowhere near meeting its potential. There are pockets of excellence and tremendous resources. But somehow it simply hasn't pulled itself together. To move forward, political leadership and long-term commitment will be required.

Score Card: ILLINOIS

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	1	2
Information Access	9	Consumer & Family Test Drive (CFTD)	2	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	1	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	1	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	0	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	0	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	1	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	1	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	0	2

Indiana

Grade: D-

Category Grades

Infrastructure	**F**
Information Access	**C+**
Services	**D**
Recovery Supports	**F**

Spending, Income, & Rankings

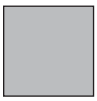
PC Spending/Rank	$72.37	28
PC Income	$27,328	36
Total MH Spending/Rank	$448 *(in millions)*	19
Suicide Rank		24

Recent Innovations

- Commitment to transformation
- Implementation of ACT in partnership with universities
- Prison education program

Urgent Needs

- Caution on scope and speed of changes
- Greater transparency
- Consumer and family participation in decisions
- Waiting list reduction for community services



Indiana is a state in transition.

The election of a new governor in 2004 led to a change in leadership in the state's Division of Mental Health and Addiction (DMHA). The state now has a new vision, seeking dramatic change in the public mental healthcare system. And given the system's failing grade in this report, a new vision for the future is sorely needed.

Advocates hope that the changes will be for the better, but are concerned about the scope and speed of changes being pursued, especially within the state's hospital system. Overly ambitious strategies have backfired in some states. Still, change is needed. In 2005 in response to NAMI's questionnaire, DMHA reported no innovations in the past three years.

Perhaps the area slated to change most quickly is the state hospital system. DMHA plans to transfer three of the six state hospitals—Evansville, Madison, and Richmond—to local, non-profit entities. Some call the process "privatization." DMHA calls it "localization." No matter which word is used, the process is moving at great speed, with the first transfer to occur as early as summer of 2006.

The state insists the initiative is intended to enhance quality of care rather than manage costs, but the devil is in the details. In the past year, the superintendents of five of the state hospitals have been forced out. The most recent one to leave was quoted upon leaving as saying that shaking up the system should not mean sacrificing quality of care.

The state's Medicaid agency is also being closely scrutinized. That agency, along with the DMHA, is located within the state's Family and Social Services Administration (FSSA). After the 2004 election, FSSA Secretary Mitch Roob lambasted the agency in a press release, stating that even though Medicaid funds nearly one-third of the total mental health budget, the agency has "no accounting system and no systematic budgeting process." An audit revealed a host of other problems. The state's Medicaid program also has no medical director or clinical oversight.

Waiting lists for community services are a problem. Sources at DMHA report that there typically are about 100 people waiting for services at any one time, but the information is hard to track, due to antiquated computer

systems. The state Mental Health Planning Council has called on DMHA to obtain waiting list information from CMHCs, which is a logical first step.

Yet, the state may be poised to turn a corner. Despite an unsuccessful application for a federal Transformation State Incentive Grant (TSIG), DMHA is moving forward to transform the system anyway. A Transformation Work Group is shepherding the process. It has defined several initiatives for immediate action:

- changes in the state hospital system
- better management of contract relationships with providers
- better cross-agency collaborations
- greater consumer and family participation
- measurement of outcomes

It's an ambitious agenda. The state deserves credit for embarking on major transformation while working within a limited budget—so long as insufficient investment of resources doesn't prove its undoing. Consumer and family participation, and public transparency, also are essential for transformation to succeed.

One bright spot in the state's current system is Assertive Community Treatment (ACT). Since 2000, 26 teams have taken root with the assistance of the state-funded ACT Technical Assistance Center at Indiana University-Purdue University Indianapolis. The state has made ACT a Medicaid-reimbursable service, and tied provider reimbursement to model standards set by the Center. NAMI commends the practice; it also should be applied to other evidence-based practices.

Also noteworthy is NAMI Indiana's prison education program, supported by DMHA and the Department of Corrections. Trainers teach guards and staff at state prisons about serious mental illnesses and prepare them for better interactions with inmates. Early indications show that the program has led to a significant reduction in the use of force against inmates at one prison.

Collaboration between the DMHA, advocates, and the criminal justice system in the Fort Wayne area has also produced successful local programs. Overall, Ft. Wayne's commitment as a community and its services may be worth study—perhaps a case study—as a national model for successful community action.

Score Card: INDIANA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	0	3
	2	Demonstrated innovation	0	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	10	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	1	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	1	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	0	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Iowa

Grade: F

Category Grades

Infrastructure	**F**
Information Access	**F**
Services	**D**
Recovery Supports	**F**

Spending, Income, & Rankings

PC Spending/Rank	$73.70	27
PC Income	$27,575	34
Total MH Spending/Rank	$217 *(in millions)*	29
Suicide Rank		35 *(tied with South Carolina)*

Recent Innovations

- Mental health parity law
- Created a multi-stakeholder taskforce to implement evidence-based practices (EBPs)

Urgent Needs

- Remove legal settlement rules
- Statewide dissemination of EBPs
- A uniform data collection system
- Rural services
- More options to address acute or emergency treatment needs

Iowa is a prime example of what President Bush's New Freedom Commission on Mental Health meant when it reported that the nation's mental healthcare system is "fragmented and in disarray." It must be among the most convoluted mental health systems in the country.

For individuals on Medicaid, Magellan Inc. provides mental health and substance abuse services. For individuals who are not Medicaid eligible, the state's 99 counties provide services, through a combination of state funds and county funds, derived primarily from local taxes.

Iowa's counties also follow a policy known as "legal settlement" which requires that individuals be county residents, and free of the need for mental health services for at least a year before their new county is responsible for paying. These restrictions often lead to inordinate, potentially catastrophic delays in getting services when they are needed.

Although Iowa's counties are required to collect data, there is no statewide system through which this information can be shared. As a result, Iowa is among a minority of states that cannot provide an unduplicated count of whom they actually serve. The state is working to upgrade its data collection system and hopes to have the capacity to provide unduplicated counts by the end of 2006. That will be an important, fundamental step forward. It is hard to design an effective service-delivery system without first knowing the number of the people for whom you are responsible.

Surprisingly, the state mental health authority, called the Division of Mental Health and Developmental Disabilities (DMHDD), does not appear to be actively engaged in strategies to expand access to services for people with serious mental illnesses who live in rural areas of the state. Among its many attributes, as presidential candidates discover early in party primary campaigns every four years, Iowa is rural—89 of its 99 counties are classified as such. Any presidential candidate can not be a serious contender without addressing the distinctive needs that flow from this fact. In some respects, Iowa might be the perfect stage for a well-focused comprehensive debate over mental healthcare policy, as the 2006 and 2008 elections approach.

Iowa also appears to be lagging in its implementation of evidence-based practices (EBPs). To its credit, the DMHD is forthright about the need for better progress and has established a statewide Technical Assistance Center for Evidence-Based Practices to promote their expansion. DMHD has identified Assertive Community Treatment (ACT) as one of its top priorities. Currently, four programs exist—in Des Moines, Cedar Rapids, Iowa City, and Fort Dodge.

Unfortunately, employment and housing, two critical components of recovery, do not appear to be prominent on DMHD's radar screen. Although the state reports that supported employment services are available to people with serious mental illnesses in 91 of 99 counties, DMHD does not seem to be involved with them through funding or coordination with Iowa Vocational Rehabilitation Services. DMHD also was unable to provide any information about supportive housing in Iowa, and does not employ, as many states do, a person responsible for coordinating housing services for people with serious mental illnesses.

In his 2006 State of the State address, Iowa Governor Thomas Vilsack took credit for significant accomplishments in the 2005 legislative session that benefited people living with mental illness. He referenced the important milestone of enacting mental health parity legislation, a hard-won victory in a state that was home to some of the most assertive anti-parity lobbying in the country.

Iowa is experiencing significant problems with an overall lack of inpatient psychiatric beds for people with acute treatment needs. Nationwide, many community hospitals have gotten out of the business of operating psychiatric units—increasing the burden on state hospitals. The few community hospitals that continue to operate inpatient psychiatric units are overwhelmed by demand and do not have enough beds to meet that demand. For example, in Des Moines there are virtually no hospital beds available for people with acute or long-term care needs.

As acute care beds in community hospitals decrease, the number of state hospital beds decrease as well, worsening the crisis. There are only four state hospitals in Iowa right now that can serve patients with serious mental illnesses, a low number when you consider the geographic size of Iowa.

Iowa's mental health system is in serious trouble. The state needs to move forward with a bold restructuring of its mental health system, which should include removal of legal settlement rules and increased access to mental health services that work for Iowa's residents with serious mental illnesses.

Score Card: IOWA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	0	3
	2	Demonstrated innovation	0	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	0	2
Information Access	9	Consumer & Family Test Drive (CFTD)	4	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	1	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	0	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	0	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	0	2
	39	Financial-logistical support Peer-to-Peer education program	0	2

Kansas

Grade: F

Category Grades

Infrastructure	**F**
Information Access	**F**
Services	**D-**
Recovery Supports	**B**

Spending, Income, & Rankings

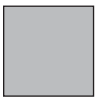
PC Spending/Rank	$75.22	26
PC Income	$28,422	27
Total MH Spending/Rank	$204 *(in millions)*	31
Suicide Rank		21

Recent Innovations

- Dedication at the state level to system transformation and evidence-based practices implementation
- Academic partnerships to advance service development and delivery

Urgent Needs

- Increased flexibility from the state to listen to the concerns of consumers and families
- Implementation of ACT Teams
- Jail diversion programs



Kansas looks good, but the glow is superficial. The state has strategic plans, reports, updates, and information on its Web site that buzz words like "recovery," "self-determination," and "wellness" in all the right places. Good intentions exist, but rhetoric often doesn't match reality.

The Department of Social and Rehabilitation Services (SRS) directs mental health care in the state, and there are indications that SRS has embraced the vision of President Bush's New Freedom Commission and the need for system transformation. It has created a five-year strategic plan and invested in data collection mechanisms—along with other initiatives. While the planning process was remarkably open, consumers and families feel that SRS has been inflexible, and has a history of asking for their input and then ignoring it. The result is a plan with little consumer and family ownership or support.

The state has piloted evidence-based practices (EBPs) such as supported employment and integrated dual diagnosis treatment. Partnerships with Dartmouth College and the University of Kansas have helped guide these programs. It remains to be seen whether these pilots will be the precursor of statewide implementation. However, as these practices spread, they must be closely monitored to ensure that they meet the evidence-based standards.

What is strange is that Kansas has no Assertive Community Treatment (ACT) programs—one of the oldest and most effective EBPs, and one that is critical to any comprehensive mental health system.

SRS has shown very little interest in ACT, investing instead in a less intensive case management model, called Strengths, developed in partnership with the University of Kansas School of Social Welfare. Although the program provides standardized training for case management and has some research to support its effectiveness, it is not a substitute for ACT, especially for individuals needing highly intensive services. Other states, such as Oklahoma, have had success in using ACT and Strengths together, providing a powerful and flexible combination that meets the needs of highly vulnerable individuals.

Advocates report that the availability, quality, and timeliness of crisis services are inconsistent from one Community Mental Health Center (CMHC) to

another and have been described as "inadequate." There is a need for increased numbers of clinically trained staff at CMHCs to ensure that consumers receive a higher quality treatment.

Access to acute inpatient treatment is also a problem. State hospitals are frequently at or above their capacity. NAMI Kansas supports the position of the Association of Community Mental Health Centers (ACMHC) of Kansas to create a system of regional, state-operated inpatient facilities to supplement the state's three mental hospitals. This proposal would help increase the state's capacity while at the same time providing services close to a consumer's home community. However, it is worth noting that even with state hospitals stretched beyond capacity, there has been a significant reduction in the use of seclusion and restraints.

Kansas is behind the curve in the decriminalization of mental illnesses. The state has looked into training for jail diversion, but there seems to be no sense of urgency, in spite of the costs of treatment that otherwise are shifted onto the criminal justice system. NAMI Kansas is working to establish a Memphis Model Crisis Intervention Team (CIT) with police in the greater Kansas City area, which may help spur interest statewide.

SRS has demonstrated some creativity in addressing the needs of people in rural areas (25 percent of the state's population) and the state's growing multicultural diversity. Limited block grant funds have been used to fund pilot projects at CMHCs for culturally competent initiatives. Infrastructure for telemedicine exists in most CMHCs and the state psychiatric hospitals, but it is underutilized and inconsistent, potentially because of concerns around privacy and lack of training for consumers and providers using this service.

Finally, it is worth noting the state's goal of involving consumers in services, particularly through 20 Consumer Run Organizations (CROs) that receive state funding. CROs serve as the go-to network for the state in policy and service planning and also provide self-help and peer support programs across the state. But consumers say the system could be better, with greater emphasis on education and recovery and increased incorporation of their concerns into the planning process for the mental health system.

Kansas is not the only state in which such complaints have been raised, but it is part of a troubling theme.

Score Card: KANSAS

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	2	3
	2	Demonstrated innovation	1	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	1	2
Information Access	9	Consumer & Family Test Drive (CFTD)	3	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	0	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	1	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	0	3
	22	Written ACT fidelity standards	1	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	0	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Kentucky

Grade: F

Category Grades

Infrastructure	**D-**
Information Access	**F**
Services	**F**
Recovery Supports	**C-**

Spending, Income, & Rankings

PC Spending/Rank	$51.27	42
PC Income	$24,925	42
Total MH Spending/Rank	$210 *(in millions)*	30
Suicide Rank		19

Recent Innovations

- Housing support
- Expanding Crisis Intervention Team (CIT) programs
- Louisville mental health court
- Training on mental illness and suicide prevention for jails
- Jail telephone triage system

Urgent Needs

- Funding
- Statewide implementation of evidence-based practices (EBP)
- Exempt people with mental illnesses from changes in Medicaid
- Protect access to medications
- Inpatient hospital beds

Fifteen years ago, Kentucky had the potential for developing one of the best mental healthcare systems in the nation—and a reputation for innovation. Unfortunately, its promise never was fulfilled, due largely to the lack of adequate resources. The public community mental health system has been flat funded for more than a dozen years, leaving Kentucky in the bottom quartile of states in per capita mental health funding.

Significant, recent innovations have come in the area of criminal justice, but only after outstanding investigative reporting by the *Courier-Journal* in 2002 exposed the plight of people with serious mental illnesses locked in jails.

Economics may be one reason. Kentucky has one of the highest percentages of people living below the poverty level. Eastern Kentucky in particular is one of the poorest regions of any in the United States.

Medicaid is by far the largest payer of public mental health services in Kentucky. The Federal Center for Medicaid and Medicare Services recently approved a plan to restructure Medicaid in the state. Known as Kentucky HealthChoices, the stated intent of the plan is to contain costs while improving quality. However, as structured, the plan threatens to jeopardize access to care for many Medicaid recipients with serious mental illnesses because:

- The plan imposes a limit of four prescriptions per month. Although described as a "soft cap" which can be overridden by "medical necessity," the practical effect is to establish a barrier to needed medications for persons with the most severe mental illnesses—particularly those with multiple medical problems; and
- The plan imposes co-pay requirements on Medicaid recipients for non-emergency care in emergency rooms. While NAMI appreciates the need to decrease the burden on hospital emergency departments, shortages of appropriate community treatment and service options—plus sharp limitations in the number of physicians willing to accept Medicaid—often leave people with serious mental illnesses no choice but to turn to emergency rooms for care.

Access and quality of public mental health services vary across Kentucky. There are 14 designated mental health regions in the state. In 2005, only two regions reported having Assertive Community Treatment (ACT) teams, with a third working to develop one. The Kentucky Department of Mental Health and Mental Retardation Services (DMHMRS) acknowledges that these programs do not meet national standards. Nor does it appear that the department is exerting leadership to achieve these standards.

To its credit, DMHMRS has provided regional centers with funds for emergency services, mobile crisis services, residential crisis stabilization units, and overnight crisis beds; however, these services are effective at best only for short-term emergencies, rather than long-term treatment needs. Moreover, funding levels for emergency services in some regions have not been raised since 1996, and these services are particularly in short supply in the more populated regions of the state.

Implementation also lags statewide for integrated treatment for mental illness and substance abuse, another key evidence-based practice. Efforts in this area are hampered by lack of Medicaid funding for adults with substance abuse disorders, other than for pregnant women.

A shortage of inpatient beds is also a serious and growing problem. Since 1995, non-forensic state hospital beds have eroded steadily. Convergence with inadequate community services and the loss of psychiatric beds in community hospitals has increased the burdens on other sectors in responding to acute psychiatric crises—such as law enforcement and emergency rooms.

Following a *Courier-Journal* investigative series in 2002, the legislature appropriated $550,000 to DMHMRS to develop and implement statewide training on mental illness and suicide prevention. In 2004, the legislature passed a law mandating a statewide telephonic triage system to screen jail inmates for mental, cognitive, or substance abuse disorders—and to provide linkages to treatment. The system is funded by court costs.

In Louisville, a highly effective police Crisis Intervention Team (CIT) program and a federally funded mental health court have successfully diverted people with serious mental illnesses into treatment rather than jail. Another CIT program is located in Frankfort; others are planned in other parts of the state. NAMI has played a key role in developing these CIT programs in communities across the Commonwealth.

Governor Ernie Fletcher today deserves praise for his decision in late 2005 to allocate $5 million over two years for housing for people with serious mental illnesses who are homeless or at risk of homelessness. The Governor's intervention is timely. Housing resources throughout the state are scarce, and waiting lists for Section 8 housing vouchers are years-long in some parts of the state. However, limited funding for community mental health services, plus potential restrictions on access to treatment through the new Medicaid restructuring initiative, threaten to undermine this progress.

Score Card: KENTUCKY

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	2	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	0	3
	15	No restrictions on prescriptions per month	1	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	1	2
	18	Wraparound coverage for benzodiazepines	0	2
	19	Feedback to doctors on prescribing patterns	0	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	0	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Louisiana

Grade: D-

Category Grades

Infrastructure	**D**
Information Access	**F**
Services	**D-**
Recovery Supports	**D-**

Spending, Income, & Rankings

PC Spending/Rank	$51.34	41
PC Income	$24,780	44
Total MH Spending/Rank	$230 *(in millions)*	28
Suicide Rank		31

Recent Innovations

- Heroic response of individual providers and OMH staff on the ground in wake of hurricanes Katrina and Rita

Urgent Needs

- Restoration of OMH's budget after recent state cuts
- Increased focus on developing and funding a community-based system

Hurricanes Katrina and Rita devastated Louisiana in 2005, tilting the state's already fragile mental health system towards virtual collapse. Within this tragedy, however, resides the potential for a silver lining. As with its communities, so too the state's mental health system has an opportunity to rebuild.

In the wake of the storms, the Louisiana Office of Mental Health (OMH) has done an incredible job of deploying all available resources to deliver mental health services in a disaster zone. OMH staff responded to the storms' fury with flexibility and bravery to meet the tremendous need in for mental healthcare. And, months after the initial impact, the OMH continues to demonstrate commitment to the people of Louisiana for what will be a long recovery from the hurricanes.

NAMI would like especially to thank the OMH for participating in our questionnaire for this project at a time of such need. OMH's response demonstrated remarkable responsiveness and transparency to consumers and family members in a time of disaster. Thank you.

But, even with the Herculean efforts of those on the ground in Louisiana, the mental health system in the state has imploded.

Tremendous challenges impede service delivery. Emergency rooms, already taxed before the storms, have turned into ground zero in their aftermath. In the New Orleans area, emergency rooms are deluged with individuals needing mental health care as the city has lost over 100 psychiatric inpatient beds. As a result, ERs are clogged with individuals in need of more intensive, longer-term care, but with the city's loss of inpatient beds, there often is no where else to go for individuals in crisis. In a January 26, 2003, article, *The New York Times* documented the impact on ERs, including long waits and transfers of patients to hospitals further away that are "overwhelmed with urban psychiatric patients" they would not otherwise have seen.

The state's capacity to provide community services has been similarly battered. Louisiana's community system is a maze of three main service areas that include an additional eight regions for service delivery. Some, such as Region V around Lake Charles, receive their mental health services directly from community mental health clinics that are part of OMH. Other regions, such

as the Baton Rouge area, receive their services from contracted providers such as the Capitol Area Human Service District (Capitol Area). Coordination and consistency of services across the state, therefore, are scattershot, contributing to the system's fragmentation and perpetuating communications challenges.

Many regions have been deluged with the influx of storm evacuees. In the months since the storms, requests to Capitol Area in Baton Rouge have increased by 40 percent—rates similar to other parts of the state. Wait times to see community providers that used to be only hours or days long are now months. Providers are doing the best they can with limited resources and capacity, but the system is in grave crisis.

While supply of services has been diminished, research shows that the demand may continue to increase months after the hurricanes. The Center for Disease Control surveyed storm survivors and found that nearly half (49.8 percent) exhibit levels of emotional distress that could indicate a need for mental health services. OMH responded to these findings with the establishment of a crisis counseling program. But it is hard to imagine that a system already stressed beyond capacity before the hurricanes will be able to accommodate such large numbers of new clients.

Other storm-related complications include the hurricanes' toll on the state's mental health workforce. OMH has suffered a hemorrhage of its leadership, with recent resignations in two top-level positions: the Assistant Secretary for the OMH and its medical director. As the former head of the public mental health system in the state, Dr. Cheryl Bowers-Stevens noted in an interview with National Public Radio on January 24, 2006, that with the limited resources given to the system, she would be able to help Louisianans with mental illness more effectively in the private sector. Additionally, many of the state's providers have either not yet returned to the state, or are being stressed to the breaking point with the current demand for services, and many mid-level employees of the system are opting for early retirement, leaving an even greater leadership deficit.

And the situation promises to get even grimmer, as the state has recently imposed a 22 percent cut to the OMH budget as part of a $1.7 billion across-the-board cut applied to all state agencies. This most recent cut, and other late 2005 budget cuts to the OMH, have resulted in the elimination of 520 staff positions, a reduction in an already skeletal intermediate crisis bed supply, and the closure of 15 community clinics. Louisiana's government should remember that short-term cuts for mental health care often have unintended, long-term consequences that ripple through other state systems. These cuts will surely be felt in the jails, and streets of Louisiana as services for individuals with mental illnesses will be reduced, leaving many people in crisis with nowhere else to go.

It is important to remember that despite the current desperate situation of Louisiana's mental health system, it was near implosion even before the hurricanes touched ground. Systemic barriers to care were identified in a June 2005 report to the Governor's Health Care Reform Panel, including:

- Lack of understanding of mental health as central to overall physical health status
- Lack of process for capturing data on the need for mental health services and impact of untreated disorders
- Low treatment rates
- Insufficient awareness on the public's part as to when, how, and where to access needed mental health services
- Lack of resources to fund mental health services either through government or insurance carriers
- Insufficient infrastructure and adequately trained staff to ensure coordination across agencies and settings and to implement evidence-based practices

Additionally, Louisiana's mental health funding disproportionately flows to inpatient services at the expense of community services. While 97 percent of OMH's clients are served in the community, 60 percent of OMH's budget and 72 percent of staff support goes towards inpatient settings. A huge growth in the influx of forensic patients in state hospitals, and maintenance for the state's large inpatient facilities, accounts for some of this spending, but it is a trend that must be reversed.

Now is the time for the OMH and the state of Louisiana to meet the crisis in mental health care and seize this moment to rebuild a better system in the wake of the hurricanes than existed before.

Score Card: LOUISIANA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	2	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	2	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	2	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	2	3
	16	Benefit-service identification program	0	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	1	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	0	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	1	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	1	2
	37	Co-occurring disorders--No Wrong Door	1	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Maine

Grade: B-

Category Grades

Infrastructure	D
Information Access	C-
Services	B
Recovery Supports	A

Spending, Income, & Rankings

PC Spending/Rank	$127.92	7
PC Income	$27,373	35
Total MH Spending/Rank	$167 *(in millions)*	33
Suicide Rank		20

Recent Innovations

- Mental health parity law
- Inclusion of full mental health parity for the uninsured in Dirigo Health
- Progress in improving conditions in county jails

Urgent Needs

- Reduce long waitlists for community services
- Relieve crowding in emergency rooms
- Access to crisis and inpatient beds
- Mitigate the too-rapid implementation of managed care

Maine is a study in contradictions. On the one hand, the state has wisely invested in practices that are proven and cost-effective, such as Assertive Community Treatment (ACT) and supported employment. It has also been a leader in including mental health parity in its program to expand access to health insurance. However, budget cuts have contributed to significant gaps in services and poor outcomes. Additional cuts would reverse Maine's progress and devastate an already stretched system of mental healthcare.

Maine has taken several positive steps to improve its mental health services. Most importantly, it has invested in evidence-based practices (EBPs). It received a federal grant to expand use of these cost-effective services in the state. Both the Department of Corrections and the Department of Mental Health are focused on EBPs and are moving the Medicaid system to reimburse these services. The state has seven ACT teams, 24 supported employment programs, three Family Psychoeducation programs, and 59 programs for integrated mental illness and substance abuse treatment. The state has also developed a Peer Recovery Specialist training program.

Maine has also been a leader in the fight for insurance parity, passing one of the first state parity laws. Governor Baldacci deserves credit for including full parity in Dirigo Health, his signature program to provide health insurance to the uninsured. Many states have been shortsighted in limiting or excluding mental health care in their efforts to expand eligibility for insurance. The governor's recognition that true health insurance must include mental as well as physical healthcare should be a model for other states. Baldacci has also positioned Maine to be the first state to provide wrap-around services for the Mainers who were dual eligible for Medicare as part of the Medicare Part D rollout.

Maine has worked to reduce involvement of individuals with mental illness in the criminal justice system, which is a significant problem in the state. The Department of Behavioral and Developmental Services has developed a joint action plan with the Department of Corrections, and they have begun implementation. The state also has 11 jail diversion programs.

Despite these examples of progress, significant problems remain. Funding for mental health services has declined. Most recently, the legislature proposed slashing

$26 million from the adult and children's community mental health services. At the same time, individuals with serious mental illness in Maine are experiencing long waitlists for community services, crowded emergency rooms, involvement with the criminal justice system, and a shortage of state hospital beds, with hospitals turning away, in the first four months of 2005, 57 percent of those eligible for admission. This is a significant increase over 2004's average of 46 percent of those seeking admission.

The state mental health and Medicaid agencies are working on a transition from a cost-based, fee-for-service model to a behavioral, managed care design. It remains to be seen whether the new system for managed care can lead to cost savings without compromising quality. Significant concerns exist as to the quality of the planning and the timeline for implementation of this significant change. Advocates fear an undue emphasis on cost containment in the state in response to a study by the Muskie Institute claiming that behavioral health costs are rising much more rapidly than other healthcare costs. Although the methodology has been criticized, the report has been used by some policymakers to support cutting funds.

Budget cuts could also jeopardize the state's ability to meet its legal obligations. The Maine mental health system continues to operate under a 1990 consent decree to address deficiencies in the care of current and future patients at Augusta Mental Health Institute (AMHI). AMHI has been replaced by a new facility, but the case continues because the judge found that the state was not meeting class members' needs for community, emergency, and hospital services. The court master and others have expressed concern about the impact of managed care on the mental health system.

Maine has been a leader in both parity and employing evidence-based practices. But the state still falls short in providing an adequate mental health system. If the implementation of managed care focuses on cost cutting, the situation will get worse. For progress to continue, Maine must build upon its strengths, develop a consistent vision and the political will necessary to stop the budget cutting, and focus on filling the existing gaps in services.

Score Card: MAINE

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	7	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	3	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	3	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	3	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Maryland

Grade: C+

Category Grades

Infrastructure	**C**
Information Access	**B**
Services	**C+**
Recovery Supports	**C-**

Spending, Income, & Rankings

PC Spending/Rank	$147.08	6
PC Income	$35,444	5
Total MH Spending/Rank	$805 *(in millions)*	8
Suicide Rank		45

Recent Innovations

- TSIG use
- EBP implementation progress
- Centralized Admission and Referral Center (CARC)
- The TAMAR Project

Urgent Needs

- Restore and increase funding
- Workforce needs
- Additional inpatient capacity and acute care beds
- Affordable housing options

Maryland is an underachiever.

The state has a lot going for it, but can do better. There also are warning signs of a downward slide.

Maryland has the 4th highest per capita income in the nation and in 2002 ranked 7th in per capita spending on state-directed mental health services. The National Institute of Mental Health in Rockville and Johns Hopkins University in Baltimore are centers for cutting-edge research on serious mental illness. As the recipient of a federal Transformation State Incentive Grant (TSIG), the state is well-positioned for innovation and progress. Yet for all these advantages, the primary question seems to be whether or not the state will waste its opportunities.

In 2006, Maryland has a $1 billion budget surplus. Like Virginia, its regional neighbor and rival, Maryland should be considering renewed investment in the mental healthcare system as part of a plan for the future.

Responsibility for public mental health services rests with the archaically named Mental Hygiene Administration (MHA), housed within the state's Department of Health and Mental Hygiene. At the local level, 20 Core Service Agencies (CSAs), which are public or private agencies, are responsible for planning, managing, and monitoring services.

Beginning in 1999, as Maryland's system tried to meet a growing need for services, MHA outpaced its appropriations. As a result, the state mandated that the agency pull back spending through a series of painful cost-containment measures, in order to be in line with the budget by the end of FY 2005. MHA succeeded in bringing its budget under control, but through the paradoxical strategy of shrinking supply at a time when it faced increasing need.

It's time to reconsider.

During the past few years, the state hospital system has gone through significant changes. In 2003, the state legislature called for consolidation of inpatient care among three large state hospitals, leading to the closure of Crownsville Hospital Center and redistribution of $12 million in funds—half going to mental health services and half being applied to the state budget deficit. Despite MHA's commendable management of the closure process, the result has been high occupancy rates and pressure on new admissions.

To complicate matters, Medicid currently covers acute care in private hospitals for individuals in crisis, under what is known as an "IMD waiver." The waiver expires in 2007, and there is significant concern that the result will be even greater pressure on the state hospitals to pick up the slack.

Two private psychiatric hospitals—Chestnut Lodge and Taylor Manor—also recently have closed. Meanwhile, lack of funds for additional residential rehabilitation program (RRP) beds, commonly used for recently discharged patients, has impeded moving patients from hospitals into community settings.

The net result is that people with serious mental illnesses crowd emergency rooms across the state. In response, MHA has shown leadership by creating a Centralized Admission and Referral Center (CARC) to assist emergency rooms in finding placements in state hospitals for individuals without insurance. Although CARC is a positive step, advocates still report waits of up to three days for acute care beds.

Capacity also depends on skilled workers, and Maryland here has a significant problem. During FY 2002-2005, budget cuts eliminated almost 500 positions in state hospitals and residential treatment centers, and another 15 positions within the MHA headquarters were lost. To its credit, MHA identifies its workforce as an "acknowledged weakness." Furthermore, no system exists to review and monitor provider quality, and no comprehensive assessment and strategic plan exist to address it.

The convening of the national Annapolis Coalition on the Behavioral Health Workforce in Annapolis in May 2004 provided a powerful and ironic counterpoint to Maryland's failure to demonstrate leadership on workforce issues.

Community housing for consumers is a major need. The cost of living in the Baltimore and Washington, D.C. suburbs is higher than the national average. Individuals with serious mental illnesses often live in poverty. But Maryland also is rural. Basic access to services, including transportation, is a problem in many areas. Vast disparities exist across the state.

On the positive side, MHA has been innovative in creating the state's TAMAR Project (Trauma, Addictions, Mental Health, and Recovery) for the treatment in detention centers of female consumers with histories of substance abuse, mental illness, or trauma; the program also helps their children. TAMAR has dramatically reduced recidivism rates among this population, and it serves as a national model.

Recent legislation has helped decriminalize mental illness by suspending, rather than terminating, Medicaid benefits for individuals incarcerated for less than a year.

Maryland's community-based system is moving aggressively towards broad implementation of evidence-based practices. In particular, MHA has invested in supported employment programs, including evaluation and collaboration with the Department of Vocational Rehabilitation Services. SAMHSA grants and a partnership with the University of Maryland have helped MHA accelerate the process—although access to services is still lacking.

MHA also is moving to convert some of the state's existing mobile treatment programs to ACT teams, a needed change.

There are reasons to be hopeful about progress in mental healthcare in Maryland, but much depends on whether policymakers are willing to invest surplus dollars smartly in the system. The 2006 state elections may be an appropriate time for serious dialogue about the state's direction in helping people with serious mental illnesses. Consumers, families, and taxpayers deserve better than the status quo.

Score Card: MARYLAND

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	2	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	8	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	0	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	1	2
	39	Financial-logistical support Peer-to-Peer education program	1	2

Massachusetts

Grade: C-

Category Grades

Infrastructure	**C-**
Information Access	**F**
Services	**D+**
Recovery Supports	**B+**

Spending, Income, & Rankings

PC Spending/Rank	$106.21	15
PC Income	$37,802	4
Total MH Spending/Rank	$683 *(in millions)*	11
Suicide Rank		48

Massachusetts is home to world-class resources that could support the finest public mental healthcare systems in the nation, but unfortunately, due to tens of millions of dollars of cuts in the last five years, it falls short of its potential.

The state has many advantages. It is geographically small and relatively wealthy. It does not depend on county bureaucracies to deliver mental health services. With four medical schools, its density of psychiatrists and psychiatric residents is among the highest in the country, and it is home to many of the best psychiatric training facilities. Boston University's Center for Psychosocial Rehabilitation is a national incubator for innovation.

Historically, Massachusetts is sometimes better at innovating than in learning from others. In 1972, Wisconsin established the nation's first Assertive Community Treatment (ACT) team. Massachusetts did not launch its own statewide initiative until almost 30 years later. Memphis, Tennessee, pioneered police Crisis Intervention Teams (CIT), which are expanding nationwide, but in Massachusetts this program still needs substantial expansion. The work is just beginning.

Recent Innovations

- Medicaid "carve-out" incentives based on clinical outcomes, not on service denials
- Public-private collaboration to rebuild Massachusetts Mental Health Center
- Proposed construction of a new state hospital, while closing two old facilities
- Model regulations for minimizing use of restraint and seclusion
- Agency collaboration to help mothers with mental illnesses whose children are taken into state protective custody

Urgent Needs

- Funding and investment
- Study possible Medicaid and service delivery changes; learn from experience of states such as North Carolina
- Housing and rehabilitation supports
- Jail diversion
- Co-occurring disorder integration

Money is needed to put good ideas into practice. For over a decade, the system has been grossly underfunded, resulting in long waiting lists for case management, residential, and support services.

Today, Republican Governor Mitt Romney, a potential presidential candidate in 2008, is positioning the state to lead the nation in achieving universal healthcare coverage. The mental healthcare system could ride his coattails to higher achievement, provided it doesn't collapse under the strain of expanding too much, too fast. In practical terms, it remains uncertain what the currently proposed reforms will mean for the average person living with schizophrenia.

Commissioner Elizabeth Childs of the state Department of Mental Health, a clinical psychiatrist, is one of the state's best hopes for skillful navigation of the changes that lie ahead. Under current plans, Medicaid behavioral health services, delivered by a for-profit provider, are being integrated within the Department of Mental Health (DMH), while the entire endeavor may be restructured—potentially eliminating a behavioral "carve out" that links payments to clinical incentives, and involves consumers and families at every turn.

For all these system changes, the devil is in the details. Changes in administrative and financial structure need to be coordinated with changes in the state hospitals, as well as the urgent need for community-based services. There will be a lot of moving parts, and confusion may befall people who depend on the services. Addiction and substance abuse are getting needed attention—but non-Medicaid substance abuse services are located in a different agency—inconsistent with a unified behavioral health plan. It may be like being at Fenway Park: people will need a scorecard to follow what's happening.

The state can be commended for moving to raze two old state hospitals and build a new facility. The investment is long overdue (Worcester State was founded in 1833). Westboro State Hospital has no air conditioning, which in the summer creates a risk of hyperthermia and death for any patient taking anti-psychotic medications.

Even now, access to inpatient care is a problem. One doctor reports that it is easier to get into Harvard than to get admission to an inpatient state bed. Also, emergency rooms feel the pressure of acute bed shortages in many areas. State hospital bed closures coupled with multiple system changes and lack of community services can lead to catastrophe. North Carolina is one example that might be studied closely for comparison as Massachusetts contemplates massive system changes.

The Massachusetts Mental Health Center in Boston desperately needs to be rebuilt. The state's current plan will give Brigham and Women's Hospital a 99-year lease to the state-owned land in exchange for rebuilding the mental health center on a portion of the land. It is a creative transaction that can serve as a national model—a public-private collaboration that uses a physical asset to continue to benefit consumers; i.e., essentially, a mental healthcare "trust."

Massachusetts is commended for model regulations on the use of restraints and seclusion, which take effect in 2006. The state's reorganization of human services has promoted some excellent interagency work—such as the collaboration between DMH and the Department of Social Services (DSS) to help mothers with serious mental illnesses whose children have been removed from their homes for protective custody.

Massachusetts has a good, comprehensive inpatient services plan. It also has many good residential, supported hosing, employment, and clubhouse services—but very long waiting lists for case management and housing. To its credit, DMH is open about the shortages.

In 2002, the Massachusetts DMH developed and implemented a Cultural Competence Action Plan (CCAP) to focus the Department's mission on providing culturally competent care to consumers in the public mental health system. Goals of the plan include increased partnerships with multicultural communities, enhanced leadership to reduce health disparities, integration of cultural competence principles in the DMH workforce, and use of DMH data to study and better serve DMH clients of multicultural backgrounds. Massachusetts once led the nation in studying causes of mortality—the ultimate health disparity statistic—in the past and needs to regain its leadership, especially as multiple service changes are on the horizon.

Overall, what seems to be lacking is political will by the governor and legislature to spend what it takes to eliminate shortages, and to make financial investments to improve the crumbling facilities.

Score Card: MASSACHUSETTS

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	1	2
Information Access	9	Consumer & Family Test Drive (CFTD)	5	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	0	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Michigan

Grade: C+

Category Grades

Infrastructure	**C-**
Information Access	**B**
Services	**C+**
Recovery Supports	**C+**

Spending, Income, & Rankings

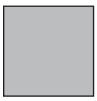
PC Spending/Rank	$97.79	17
PC Income	$28,900	25
Total MH Spending/Rank	$986 *(in millions)*	5
Suicide Rank		32 *(tied with Virginia)*

Recent Innovations

- Governor's Commission on Mental Health
- Statutory consumer participation

Urgent Needs

- Sustained leadership
- Funding for commission recommendations
- Mental health insurance parity



You cannot separate what is happening with mental health services in Michigan from what is happening with the state's economy. The state has been in a recession since 2001 and has lost several hundred thousand well-paid manufacturing jobs, a trend that hasn't stopped yet.

Despite loss of tax revenue, the state has committed to level funding for the Michigan Department of Community Health (MDCH) over the past three years. The frozen resources have been stretched more thinly every year, as the number of unemployed and uninsured persons increases.

Governor Jennifer Granholm appointed a special Mental Health Commission in 2003, which released a report in October 2004 with approximately 70 proposals for reform. Over a year later, advocates claimed that 90 percent of them have gone nowhere; only six were acted upon. The administration said that that a "working group" still is working on the rest.

One of the commission recommendations is passage of mental health insurance parity legislation—a measure that is important in helping to stem the flow of people with private insurance into the public system, as well as being central to the fight against stigma and discrimination. Simply put, when middle class families lack mental health benefits under private insurance plans, they often are forced to spend down assets and end up in the public system—or go without treatment. Either way, the cost ultimately is passed on to the state. Untreated mental illness results in more emergency room visits and hospitalizations, and in some cases, costs shifted to the criminal justice system.

In Michigan, auto industry politics are largely responsible for blocking parity. The Michigan AFL-CIO opposes parity out of concern that it will weaken collective bargaining power and benefits. This position overlooks both Michigan citizens who lack union contracts and those costs shifted to the state, as well as being based on an erroneous interpretation of the proposal—seeing it as a mandate, rather than equality between benefits offered within a single plan. To its credit, the AFL-CIO does support other Granholm commission recommendations.

Parity's fate—and that of other recommendations—hinges on leadership and political will. Advocates are concerned for the future because there soon will be no

enduring mental health champions in the state legislature. In 1992, the state enacted term limits. It usually takes years for legislators to learn the needs and often complex issues of people with serious mental illnesses. By the time they do, they are gone. In 2006, State Senator Beverly Hammerstrom, who has been one of the leaders in mental health, will have to leave.

A year before the Granholm commission, the state reorganized the mental health system so that 18 Medicaid prepaid inpatient health plans (PIHPs) were created. Using Medicaid, the state contracts with 46 community mental health service programs (CMHSPs) organized by regions. Each CMHSP provides a basic set of services mandated by the state, but each region differs in admission criteria, service array, and service accessibility for ethnic minorities and older adults.

Assertive Community Treatment (ACT) and supported employment programs have undergone "fidelity drift," so that many programs are not what their names imply. As an example, advocates report that one CMHSP-supported employment program consists of a single clubhouse custodian, who does custodial job coaching for three to four people.

To its credit, MDCH has instituted a quality improvement effort. The Improving Practices Committee is working to ensure national model standards and quality services across the state.

Michigan has notably chosen to embrace consumer involvement in mental health care and the recovery model of mental healthcare. The state has established a Recovery Council, and the hope is that some local programs will emerge to serve as models of recovery-oriented care for the rest of the state.

Since 1995, consumer representation on governing boards of local mental health agencies and on the state Mental Health Planning Council has been a statutory requirement. Advocates describe MDCH as accessible overall, with administrators who are caring, skilled, and working to do a good job with limited resources.

Despite funding problems, Michigan reports that many areas are in the process of being improved.

- Michigan recognizes that its data collection system is flawed, and is implementing changes.
- Mental health and substance abuse services have long been separate, but the state has formed several working committees looking to integrate them.
- The state trained 45 peer support specialists in 2005 and plans to train 135 in 2006.

Progress can come incrementally, but it cannot come simply by playing around the edges or without investment. The Granholm commission presented an agenda, but it will take sustained leadership and commitment—and a coming together of diverse interests—to move it forward.

Score Card: MICHIGAN

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	2	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	10	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	2	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	3	3
	21	Assertive Community Treatment (ACT) teams	3	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	1	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	0	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Minnesota

Grade: C+

Category Grades

Infrastructure	C
Information Access	B
Services	C-
Recovery Supports	A

Spending, Income, & Rankings

PC Spending/Rank	$119.07	12
PC Income	$32,702	8
Total MH Spending/Rank	$602 *(in millions)*	13
Suicide Rank		40

Recent Innovations

- Collaboration between SMHA and multiple agencies to provide services
- Evidence-based practices, particularly ACT and supported employment
- Increased supportive housing options
- CIT and mental health courts

Urgent Needs

- Funding for direct mental health services and related services, such as vocational rehabilitation
- Preserve access to medications
- Ensure adequate inpatient beds while making transition to county-run, community-based services

Minnesota has a reputation for independence and innovation and may compare well with other states, but its mental healthcare system still has problems.

During FY 2004-2005, with a budget deficit of approximately $4 billion, mental health services escaped direct cuts—but related programs, such as vocational rehabilitation, were not as lucky. In addition, for the first time, the state Medicaid program instituted prior authorization requirements and co-payments for medications. Although psychiatric medications were excluded, the state should be seen as moving toward restrictions on access to care, requiring vigilance by family and consumer advocates. Because of reduced state dollars, counties—which share responsibility for helping people with serious mental illnesses—in turn have reduced local services.

The State Mental Health Authority (SMHA) has launched an Adult Mental Health Initiative (AMHI) intended to replace regional treatment centers with 16-bed community inpatient hospitals as part of an overall transition to community-based care. Unfortunately, this initiative is taking place at a time when the lack of inpatient acute care beds in many parts of the state has reached crisis proportions. In 2004, the state reported shortages of both public and private psychiatric beds. Community hospitals have been eliminating psychiatric beds and replacing them with more lucrative medical-surgical beds. In the densely populated Minneapolis-St. Paul area, emergency rooms are overflowing with people experiencing acute psychiatric emergencies and with no place to go. Ultimately, if the conversion to a community-based system of care is to be successful, it will be very important to maintain adequate numbers of acute care beds, intermediate and long-term care beds for those who need them, and supportive housing units for people ready to re-enter the community.

As part of this conversion, the SMHA is working with adult residential treatment providers to transform into shorter-term programs providing an array of services, including crisis stabilization, integrated treatment, self-management of illness, and supported employment. These can be positive steps, as long as the needs of people requiring longer-term residential services and supports are adequately addressed.

The SMHA has worked hard to implement evidence-

based practices (EBPs). There are currently 25 Assertive Community Treatment (ACT) teams in the state. Four of them serve 18 counties in the rural southwestern area; greater statewide penetration of ACT is needed. The SMHA is also collaborating with the state agency responsible for alcohol and substance abuse services to provide training and other technical assistance for integrated mental health and substance abuse treatment for people with co-occurring disorders.

The SMHA and the Minnesota Housing Finance Agency are collaborating to run the state-funded Bridges program that provides approximately $650,000 in rental subsidies for 450 persons with serious mental illnesses in 2005. The state also has created a crisis housing fund for consumers who need financial assistance to preserve their housing while hospitalized—an exemplary program that other states should study.

The state is beginning to focus on jail diversion and alternatives to incarceration, but there is a long way to go. Mental health courts and jail diversion programs are located only in Hennepin (Minneapolis) and Ramsey (St. Paul) counties. These programs should be replicated in other parts of the state. Preliminary discussions have taken place about implementing a state prison diversion program for individuals with serious mental illnesses convicted of felonies, but this is far from becoming operational.

Increasingly, cultural competency is a necessity for the mental health system in Minnesota. A quarter of the state's federal mental health block grant allocation is targeted to Native American tribal government. The state also has a growing Laotian Hmong population.

Minnesota needs to make careful choices. It faces an equal prospect of moving upward or downward in the years ahead. It will be smart to continue to invest in the mental healthcare system, and to build on existing strengths. It may take time and money to build a good system. Unfortunately, it doesn't take long to wreck one.

Score Card: MINNESOTA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	2	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	2	3
	6	Insurance parity for mental illness	2	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	9	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	1	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Mississippi

Grade: D

Category Grades

Infrastructure	**D-**
Information Access	**B**
Services	**D-**
Recovery Supports	**C-**

Spending, Income, & Rankings

PC Spending/Rank	$93.49	18
PC Income	$22,263	51
Total MH Spending/Rank	$268 *(in millions)*	26
Suicide Rank		25 *(tied with North Carolina)*

Recent Innovations

- Response to Hurricane Katrina
- Dedicated housing staff
- Funding consumer and family education

Urgent Needs

- Fully staffed crisis centers
- Funding
- Community-based services
- Evidence-based practices

In Mississippi, people with serious mental illnesses are routinely housed in jails for the "crime" of having a mental illness. These deplorable practices have been occurring for many years.

That is the bad news. The good news is that there are finally some slight signs of progress in addressing this deplorable situation.

In response to challenges to these practices, funding was authorized in 1998 for the construction of seven mental health crisis centers to be built in rural communities to serve as alternatives to jail for people experiencing psychiatric crises. Incredibly, the new facilities then lay vacant for a number of years because no money was allocated by the legislature or the Department of Mental Health (DMH) to make them operational.

In 2004, after newspaper stories exposed the vacuum, five were opened—but only with enough funds for a capacity of eight people each, instead of the 16 for which they had been designed. The sixth center was funded in 2005. The seventh has yet to be built. Meanwhile, people with severe mental illnesses continue to be civilly committed and housed in jails, where they remain, often in solitary confinement without medical services, for weeks at a time until a psychiatric bed is found.

Nonetheless, the source of the problem is not lack of hospital beds. Nor are more hospital beds the solution. In a state with a population in 2005 of approximately 3,000,000, there are more than 1,600 state hospital beds for adults with serious mental illnesses. What is needed are community-based services. These services are in such short supply that many people ready for release remain hospitalized. The state is potentially vulnerable to lawsuits based on the Supreme Court's *Olmstead v. L.C.* decision, which requires treatment in the least restrictive, appropriate environment.

Fifteen regional mental health authorities provide community services in the state's 82 counties by relying primarily on Medicaid and federal block grant money due to minimal access to state mental health dollars. The state spends its own funds almost exclusively on hospital care. Quality and effectiveness of services among the regional mental health authorities vary greatly. Some regions provide recovery-based, consumer-driven services, while others are still clinic-based models from the 1970s. Because their resources are limited, there is an incentive

to send consumers to hospitals for care which, ironically, shifts the financial burden back onto the state.

There is discussion about the value of evidence-based community services, but no tangible effort has been made to implement them. Not a single Assertive Community Treatment (ACT) program exists in the state, even though ACT is one of the oldest, most effective evidence-based models for helping people with serious mental illnesses. For the first time in 2005, the DMH sent staff members to the national ACT conference, which indicates that the programs are being considered.

Other emerging signs of progress include the employment by the DMH of a housing coordinator who works with the regional mental health authorities to identify or develop affordable housing alternatives. Although housing is in short supply, particularly in the wake of Hurricane Katrina along the Gulf Coast, the state is moving forward to address this ongoing problem.

The DMH also has worked with the 15 regional mental health authorities to develop integrated treatment programs for people with co-occurring mental illness and substance abuse disorders. It is not clear whether these programs reflect the most effective, evidence-based model, but the essential vision is correct and, if necessary, can be refined over time.

DMH also supports peer-run education programs for consumers and family members which are essential to the recovery model.

Mississippi has a long way to go. Change is overdue. The use of jails to incarcerate people with mental illnesses who have not committed crimes is horrendous and must stop. The faint outlines of a structure are emerging that can support transformation of the system. If the governor and legislature mobilize, they have an opportunity to begin implementing the most cost-effective, proven practices that in the long run will benefit both consumers and taxpayers.

Score Card: MISSISSIPPI

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	2	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	7	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	1	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	3	3
	21	Assertive Community Treatment (ACT) teams	0	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	0	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	1	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	0	3
	32	SMHA-Division of Vocational Rehab	1	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	1	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Missouri

Grade: C-

Category Grades

Infrastructure	B
Information Access	F
Services	D+
Recovery Supports	B

Spending, Income, & Rankings

PC Spending/Rank	$67.30	31
PC Income	$27,773	31
Total MH Spending/Rank	$383 *(in millions)*	22
Suicide Rank		23

Recent Innovations

- "Procovery"
- MHMPP clinical prescribing feedback
- Suicide prevention
- Vocational collaboration
- Outcome studies

Urgent Needs

- Medicaid funding
- Community services; alternatives to hospitalization
- Housing

Missouri is a state in which the legislature has pounded the public mental healthcare system with budget cuts. At some point, cuts mean more than trimming fat or saving money; instead, they become harms, cutting muscle and bone, translating into needless suffering and early deaths.

Missouri already has passed that point.

In 2005, the state cut Medicaid eligibility to 85 percent of the poverty line. Approximately 100,000 people with disabilities lost coverage, about a third of them persons with serious mental illnesses. More cuts are expected.

The Department of Mental Health (DMH) is trying to navigate through the storm, even while leading the nation in some areas.

The state confronts shortages in housing, acute care beds, and community alternatives to hospital care. Solving these problems requires money. The key to solutions is unquestionably held by the state legislature.

In 2004, the legislature passed mental health insurance parity, an important step which demonstrated some understanding that unless middle class taxpayers have access to care, costs to the public system will increase, as families spend down assets. But greater recognition by the legislature of cost-shifting relationships is still needed. When mental health services are reduced or eliminated, emergency room visits and hospitalizations increase, and in some cases, greater costs are imposed on the criminal justice system.

Missouri's mental health care system is centralized. In a significantly rural state, centralization can lead to complexity. Missouri counties have the option of funding and delivering mental health services on their own, but only St. Louis and 13 of the state's 114 counties actually do. In the face of state budget cuts, this structure contributes to fragmentation, putting rural areas at a disadvantage.

The state uses an approach called "Procovery," a model that other states can learn from. Procovery focuses not on a return to conditions before the onset of serious mental illness, nor static maintenance, but rather on moving people forward in their lives to the highest possible level. It is pragmatic, holistic, and to some degree spiritual in its outlook.

Missouri also leads the nation in oversight of clinical prescription practices, through a voluntary program for doctors conducted by a collaboration between the

Missouri Mental Health Medicaid Pharmacy Partnership (MHMPP) and a private company called Comprehensive NeuroSciences (CNS). The program has reduced hospitalizations and unnecessary poly-pharmacy, and saved the state approximately $8 million in 2004. Equally important, MHMPP is grounded in sound clinical practice, rather than indiscriminate, restrictive formulary approaches. The federal Center for Medicaid and Medicare Services (CMSS) has identified MHMPP as a national model and the American Psychiatric Association (APA) and the Disease Management Association (DMA) gave it their Gold Award for innovation in 2005.

Other states, such as Massachusetts, have their own versions of MHMPP, but the "Show Me" state is the one that has delivered results. It is a national best practice model.

Work is a key to recovery for many consumers. DMH reports that it works with the state's Division of Vocational Rehabilitation to provide vocational services to approximately 18,500 persons. Its first plan was established in 1999 and has been continually revised, reflecting a proactive commitment.

Decriminalization of mental illness is another area of progress. In Kansas City and St. Louis, advocates see police Crisis Intervention Teams (CIT) and jail diversion programs working effectively—but ultimately, their success depends on the availability of community services.

DMH has initiated a disease management approach to mental illness which includes treatment for physical disorders—such as heart disease and diabetes—which often are interrelated.

The state has studied its suicide prevention effort and is tracking data.

Death is one harsh, but real, outcome for some consumers. The state needs to continue to study mortality among its service recipients, particularly in light of the cuts in Medicaid and services. Improving mortality data is consistent with DMH's record to date of confronting hard issues honestly, learning from them, and responding creatively. Transparency and accountability are essential to preserve the state's "show me" reputation.

Score Card: MISSOURI

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	1	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	1	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	3	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Montana

Grade: F

Category Grades

Infrastructure	**F**
Information Access	**D-**
Services	**F**
Recovery Supports	**F**

Spending, Income, & Rankings

PC Spending/Rank	$123.41	11
PC Income	$24,610	45
Total MH Spending/Rank	$113 *(in millions)*	39
Suicide Rank		3

Recent Innovations

- Regional service area plan for Medicaid
- Multi-level approach to curb alcohol abuse that connects to core mental health problems, including the nation's third-highest suicide rate

Urgent Needs

- More beds in hospital and crisis units—not jails
- Crisis Intervention Teams (CIT) and jail diversion programs
- American Indian inclusion
- Better pay for providers

Montana is a profoundly beautiful state with a strong culture of self-reliance. It also is a vast and relatively poor state, a combination that leads to chronic shortages of healthcare providers, low pay, and a constant challenge to provide quality services. The state also has a significant Native American population, posing its own set of unique challenges to the mental healthcare system.

Montana is the only state in the country that has as many Assertive Community Treatment (ACT) teams as employees of the state mental health agency (5). It also can be credited for taking steps to address structural problems within the oftentimes complicated mental health system. It has a competent data collection system. Services have recently been aligned with Medicaid spending through three regional nonprofit agencies, taking into account local decision making. On the latter initiative, the jury is still out on how well it will work.

What is appalling is the lack of adequate psychiatric hospital beds in Helena, especially when one considers the lack of day treatment programs. Consumers report long hauls in shackles in the back of police cars taking them to the distant state hospital. The practice is not only an assault on individual dignity, but a burden on sheriffs, who are themselves victims of the system's inadequacies. Statewide, there is a need for more inpatient beds—the supply of which is shrinking.

Criminalization of mental illness is tied to capacity issues. If there are not beds in hospitals, it is easier to put people where there are beds—in jails and prisons. Jail diversion programs are needed in Montana. The absence of housing options, providers, and Crisis Intervention Teams (CITs) help fill homeless shelters as well.

CIT teams in Missoula, Bozeman, Billings, Great Falls, and Helena reflect a sensible deployment and a significant achievement. From the perspective of an overall system of care, however, without beds, the CITs are like an airplane trying to fly on only a wing and a prayer. Big Sky horizons need to be broader.

Alcohol abuse and co-occurring disorders have been a major problem for Montana, causing the state to consult national experts and develop a plan to address the problem. At a larger level, the Montana legislature has made efforts toward reducing its many highway deaths by outlawing open alcohol containers in vehicles. With alcohol and depression oftentimes underlying suicide,

Montana has realized that it has to try to curb the high numbers of suicides in the state. NAMI applauds this first attempt to do just that.

Families and consumers help to get things done in the Big Sky State. It is difficult to see how progress is made at all, given the tiny infrastructure in the state. With such a small existing infrastructure, consumer and family involvement is essential to develop appropriate services. NAMI Montana's advocacy in helping support the development of ACT teams statewide, the first Crisis Intervention Training (CIT) for law enforcement officers in Helena, and consumer and provider education programs has been instrumental in creating services that really work for the people they are intended to help.

Montana's mental healthcare system has the feel of a rural "barn raising" philosophy—people working together with their limited raw materials. Yet if you are a Native American Indian consumer, you may not be connected. There has been little success in bringing this population sector to the table. While this is a challenge with a difficult history, Montana could be a leader here, given its relative success in being consumer- and family-driven.

Score Card: MONTANA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	2	3
	2	Demonstrated innovation	1	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	4	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	0	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	0	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	1	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	1	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	1	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Nebraska

Grade: D

Category Grades

Infrastructure	D-
Information Access	F
Services	D
Recovery Supports	C-

Spending, Income, & Rankings

PC Spending/Rank	$58.29	39
PC Income	$29,203	22
Total MH Spending/Rank	$101 *(in millions)*	40
Suicide Rank		27

Recent Innovations

- Methodical approach to system redesign (both Medicaid and traditional services)
- Involvement of constituents in reform efforts

Urgent Needs

- Funding
- Provider shortages
- Diversionary programs

In 2004, Nebraska's then-governor Governor Mike Johanns launched his state-of-the-state address by enumerating priorities for the state. At the top of his list was reform of the state mental health system. Johanns then worked collaboratively with Senator Jim Jensen to steer LB 1083 through the Nebraska Unicameral Legislature. The bill, signed into law in mid-April 2004, set Nebraska on a journey toward complete redesign of its mental health system.

LB 1083 seeks to change the state's health system from one based on inpatient, state-operated facilities to a system featuring community-based care and evidence-based practices (EBPs). The bill authorized creation of a division of Behavioral Health Services within the state's Health and Human Services System. All non-Medicaid state-appropriated mental health expenditures were to be directed through this new division. It established the state's first identifiable lead agency on mental health care.

The state faces significant challenges in implementing LB 1083. The legislation requires each of six regional Behavioral Health Authorities to develop specific action plans that addressed needs for inpatient services and for implementation and availability of community support programs. And, as part of the 1083 effort, two of the state's three regional hospitals—those located at Hastings and Norfolk—were to be closed or modified. Another change as a result of the legislation is that the Office of Consumer Affairs was created at the state level. This places a consumer in an administrative level position in Nebraska's Behavioral Health Division.

Only time will tell if the reforms underway in Nebraska will work. To the state's credit, these significant system changes have not been contemplated in a vacuum. The state's website provides credible evidence of efforts to engage family members, consumers, and other constituents in planning strategies. Recent changes provide some evidence that this state is making significant improvements to its system.

Rapid changes create acute challenges to the smooth implementation of any reforms. Implementing the new system will be problematic in a state that rates its behavioral health staffing shortages as "critical." The problem is so severe that 88 of the state's 93 counties are federally designated as Psychiatric Shortage Areas. Efforts to

address the gap remain rudimentary at this time and have yet to make a notable impact on the shortage.

Another factor working against successful reform is the amount of new funding generated through the legislative initiative. The proposal took about $29 million that previously was allocated to state hospitals and reinvested it in community services. New resources included $9 million in new Medicaid funds, $2 million in new housing supports, and $2.5 million in newly appropriated money for emergency psychiatric services.

The availability of new resources is paramount to the success of the transition to community services. Historically, however, many states have underfunded such transitions by assuming that redirected dollars would reach the community sooner rather than later. A review of the 2006 state block grant casts significant doubts on the state's chances of success in directing adequate funds to these services: it identifies mental health care as "chronically underfunded." And the most recent infusion of new resources was in 2001, when LB 692 added $8 million annually.

One sector that is currently grossly underfunded is the Nebraska jail diversion program. The state currently lists only one existing jail diversion program. A second jail diversion program is in the process of being implemented in Douglas County—the highest populated county in Nebraska. The initiative is being funded by local private funding. In a state with nearly 100 counties, the needs of consumers who are entangled with the criminal justice system therefore go unmet. While law enforcement was engaged successfully in the implementation of the mental health reform plan; the involvement focused on the process of civil commitment rather than diversionary strategies.

The legislature has been slow to address expansion of the state's parity benefits. The unicameral legislature did enact a good bill in 1999 that addressed people with severe mental illness and provided one of the lowest exemption thresholds in the country—15 employees. However, efforts by advocates to strengthen the bill by adding substance abuse protections have been rebuffed.

Although some of the programs in Nebraska are underfunded, reform is coming. The new reforms emphasize the development of evidence-based services to meet the needs of Nebraska consumers in communities across the state. The authors of the legislation and those involved in implementing reforms have clearly prioritized critical needs such as Assertive Community Treatment (ACT), supported employment, medication algorithms, and peer-to-peer educational models. Though not implemented fully, evidence suggests that the state is making modest inroads in these areas. New programs are developing, and there is a demonstrated ongoing commitment to SAMHSA's evidence-based models.

Concurrent with its efforts to continue the mental health reforms, Nebraska has joined other states in considering broad reforms to its Medicaid program. While other states have rushed into reform efforts, often making far-reaching policy decisions without analyzing the consequences of the implemented changes, Nebraska's unicameral and executive leadership deserve credit for addressing Medicaid through a "deliberate and deliberative" process. The state is off to a good start by emphasizing data-driven decisions, and giving priority to guarding the interests of participants.

The current reform plan calls for implementation of a medication-prescribing program similar to the partnership developed in Missouri. The proposal, while it seeks expansion of the state's preferred drug list, allows the Drug Utilization Review board to continue to exempt certain classes of medication from prior authorization. While the early indications are promising, developments must be watched closely to ensure that any such resulting program preserves access to medications.

Other promising, unique components of the proposal suggest broader use of technologies such as telemedicine within the state and disease management strategies for chronic health conditions, known as Enhanced Care Connections.

Score Card: NEBRASKA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	3	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	0	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	3	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	0	2
Recovery Supports	31	Supported employment	1	3
	32	SMHA-Division of Vocational Rehab	1	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	1	2
	39	Financial-logistical support Peer-to-Peer education program	1	2

Nevada

Grade: D-

Category Grades

Infrastructure	**F**
Information Access	**F**
Services	**D**
Recovery Supports	**D**

Spending, Income, & Rankings

PC Spending/Rank	$62.78	36
PC Income	$29,685	19
Total MH Spending/Rank	$140 *(in millions)*	37
Suicide Rank		4

Recent Innovations

- State-funded mental health courts
- Transparency, demonstrated by self-reported data posted on its website
- Efforts to reduce restraints and seclusion in hospitals
- Funding increases for emergency room and jail diversion

Urgent Needs

- Overflowing emergency rooms, particularly in Las Vegas
- Implementation of evidence-based practices and ACT programs
- Supportive housing options, especially in rural areas

Nevada offers excellent transparency into the workings of its mental health system, and provides an expanding array of high quality services, but the needs of those with mental illnesses are outpacing the capacity of facilities and services, particularly in Las Vegas. The city, commonly associated with high rollers, wealthy real estate magnates, and fun times, has become overwhelmed by growing numbers of mentally ill people in need of treatment, and lacks adequate infrastructure or funding to address those treatment needs.

To the outsider, Nevada is perceived as a wealthy state with two large population centers—Las Vegas in the South, and Reno and Carson City in the North—where 85 percent of the state's population is concentrated. In fact, most of Nevada is extremely rural, with few communities and even fewer mental health resources. In 2004, Clark County formally declared a "public health disaster" because large numbers of people with serious mental illnesses—and nowhere else to go—were occupying hospital emergency rooms in Las Vegas. Even the population centers have been ill-equipped and ill-prepared to provide high-quality treatment and services to people with serious mental illnesses.

On a positive note, the Nevada Division of Mental Health and Developmental Services is not trying to hide these problems. In fact, the Division in recent years has frankly acknowledged high levels of unmet need among people with serious mental illnesses in the state, and has engaged in a number of efforts to try to bridge these gaps.

While there are examples of excellent programs and services emerging, Nevada continues to face numerous obstacles and barriers in its efforts to develop a statewide system of high-quality services and supports. Growing numbers of people with serious mental illnesses seek treatment in the emergency rooms of Nevada's general hospitals. This increasing burden on emergency rooms, law enforcement, and other "front-line" crisis responders reflects an overall lack of programs designed to address treatment needs before they become acute emergencies. The *Las Vegas Sun* has reported that on any given day, 60 to 100 people with mental illnesses seek help, cannot get it, and end up in emergency rooms.

The Nevada legislature has approved funding for the construction of a new, 150-bed psychiatric hospital in Las Vegas, slated to open later in 2006. In view of the rapid growth in the population of Las Vegas in the 1990s, construction of a new psychiatric hospital would make sense. The potential development of a triage center in Las Vegas to provide crisis services would be helpful as well.

However, the overall lack of housing and community-based mental health services—in Las Vegas and throughout the state—contributes significantly to the growing numbers of people in emergency rooms, jails, and other crisis environments.

Although the benefits of Assertive Community Treatment (ACT) in reducing hospitalizations is well established, there currently are only three ACT teams in Nevada—two in the Las Vegas area, one in the Reno area. This is not nearly enough to address the needs of people with schizophrenia and other serious mental illnesses who reside in dense urban centers. Those groups must have access to intensive and multiple around-the-clock services.

Homelessness and lack of supported housing options also are significant problems in Nevada. The Division acknowledges that homelessness in Nevada appears to be higher than the national average, and, while the Division works with housing and homeless service providers to use federal resources such as PATH and Shelter Plus Care to address the housing needs of these individuals, it appears that these services are concentrated primarily on people who are currently homeless, not on people who are at imminent risk of homelessness if they do not receive the services they need. The Division must expand its collaborative efforts to create an array of supportive housing options for people with serious mental illnesses if these problems are to be meaningfully addressed. And these efforts must extend to the rural regions of the state. Rates of homelessness in these regions also are significantly higher than the national average.

Finally, although some efforts are being made to improve services for people in rural sections of the state, the services that are available are basic, with large gaps from region to region. Although it is clearly a challenge, the state must increase its efforts to address the needs of persons with serious mental illnesses in these rural regions by using telepsychiatry, implementing satellite clinics, providing psychiatric beds in rural hospitals, and providing services through rural community health clinics.

Despite its many problems, Nevada is making progress in improving its mental health system, thanks in no small part to strong leadership within the Division. Since FY2003, there has been a 33 percent growth in the state's mental health budget.

Budget increases have made possible the development of 98 new staff positions primarily devoted to direct services. Due to the continuing emergency room crisis in Las Vegas, it is very possible that additional staff increases will be forthcoming.

Nevada's jails, like those throughout the nation, contain a disproportionate number of inmates with serious mental illnesses. These jails are not set up or staffed to provide quality mental health treatment. Between 1999 and 2003, there were 12 suicides in the Clark County Detention Center, many of which involved inmates with serious mental illnesses and substance abuse disorders. In an effort to address this, the Nevada legislature since 2003 has provided funding for mental health courts in the state. And the Division has sunk some of its own resources into mental health court support services—specifically, $640,000 in FY2004 and FY2005 for services such as supportive living assistance and intensive service coordination. There are currently two Mental Health Courts in Nevada—one in Clark County, the other in Washoe County (Reno).

At the prodding of Nevada State Senator Randolph J. Townsend, who served on the President's New Freedom Commission on Mental Health, the Nevada legislature established a Nevada Mental Health Plan Implementation Commission in 2003, with the specific goal of developing an action plan to operationalize the recommendations of the New Freedom Commission. This plan was completed in 2004 and includes 239 recommendations for developing a more effective mental health system. The success of this commission ultimately will be determined by whether these recommendations are implemented.

The Division is engaged in ongoing efforts to reduce the use of restraints and seclusion in its psychiatric treatment facilities. And in response to a little-known but disturbing statistic that people with serious mental illnesses die of HIV infections at four times the rate of the general population, the Division was instrumental in obtaining a federal Ryan White grant to serve HIV-positive people with mental illnesses in Las Vegas.

Finally, the Division deserves praise for its willingness to be transparent and open about the performance of the mental health system it operates, including both its strengths and problem areas. This is best illustrated by a 2005 report posted on the Division's website entitled "How Nevada Stacks Up: National and Regional Comparisons of Nevada's Public Mental Health System." This report provides performance data on a number of measures and compares it with national data, as well as with data from neighboring states drawn from the Center for Mental Health Services' (CMHS) Uniform Reporting System. In some areas (e.g., the amount spent per person served, and consumer satisfaction) Nevada rates high relative to neighboring states. In others (e.g., the proportion of people with mental illnesses served, and Medicaid funding of mental health services), Nevada rates lower than most of its neighbors. Most importantly, the Division is willing to post information about these performance measures for all to see and pledges to use this data to improve services and to continue measuring its performance. This is truly an exemplary practice that should be emulated by all states.

Score Card: NEVADA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	0	2
Information Access	9	Consumer & Family Test Drive (CFTD)	3	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	0	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	1	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	0	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

New Hampshire

Grade: D

Category Grades

Infrastructure	**F**
Information Access	**C-**
Services	**D+**
Recovery Supports	**F**

Spending, Income, & Rankings

PC Spending/Rank	$117.14	13
PC Income	$32,948	7
Total MH Spending/Rank	$151 *(in millions)*	36
Suicide Rank		39

Recent Innovations

- A culture of rehabilitation and resilience
- Peer Support Agencies
- Medication prior authorization that works
- Supported employment
- Care Models for physical illnesses

Urgent Needs

- Jail diversion services
- Increased community resources—CMHCs and housing
- EBP backup plan if Medicaid support falters
- Reconnection by leadership to advocates and to Dartmouth

A front runner in the 1990 State Ratings and previous NAMI state reports, NH demonstrates how much funding can be cut in 16 years, and how impermanent even exemplary service systems can be. As New Hampshire is embarking on a series of new and potentially creative initiatives, this is a crucial time for persons living with major mental illnesses and their families. However, the history of how much has changed in the Granite State should be reviewed before looking ahead. Here are some examples of how the former national system exemplar has suffered in the ensuing years under many different leaders faced with the need to balance the budget:

- The Division of Mental Health has been downgraded from a division in Health to a bureau within Community Based and Long Term Care. Access to the leadership has become increasingly more difficult.
- Evidence-based practices (EBPs)—developed locally by Dartmouth's Psychiatric Research Center's experts—are lagging in implementation here when compared to most other states. This important program, developed by a college in New Hampshire, is taking its business elsewhere.
- The state hospital has been under increasing pressure to handle forensic clients.
- Discharges from the hospital are routinely delayed due to lack of community alternatives and housing resources.
- A bill before the legislature to add $1million to the 10 stressed Community Mental Health Centers was turned down last year, and faces stiff opposition this year.

While all is not lost, this stunning series of data points is a beginning to understanding where the system needs to go.

The mental health planners in New Hampshire are looking ahead, and have a multi-year plan to extend evidence-based practices across the state through a SAMHSA grant and changes in Medicaid funding structures. This is both realistic, because that is where the federal match for state return is, and also risky—the federal partner in this dance may or may not follow the music. The trade-off in trying for federal match money is the uncertainty that the resources will be there, as the budget deficit in Washington is not indefinitely sustainable.

New Hampshire does learn from its mistakes. In 1984 the state had decided to limit Medicaid prescriptions to three per month, which drove up hospital and emergency costs seventeenfold. This is an instance of the common error of addressing one silo—medication expenses—while ignoring another. New Hampshire now has a "soft PA" (Prior Authorization) procedure: if the doctor orders a prescription for the consumer, she gets it. This follows a consumer protection best practice regarding prior authorization for expensive and necessary medications. Many states still limit the number of medicines artificially, and this is a poor way to make medical decisions. The Granite State has a better model, rooted in experience.

The first supported employment programs were developed in New Hampshire. The multi-year expansion of EBPs is well worth watching, but is endangered by the cut in the Dartmouth contract. While New Hampshire appears static, most other states are moving ahead to expand supported employment programs and employment levels, many with consultation, training, and financial assistance from the Johnson & Johnson-Dartmouth Community Mental Health Program. Though imperfect, these models deserve special attention; there is room to expand them, and this part of the multi-year expansion of EBPs is worth watching. One of the challenges they face at this early stage of development is the organization of the departments within the mental health system; currently, the substance abuse authority is in a different department.

The consumer and family movement is alive and well here—the culture celebrated in NAMI's 1990 Report has many elements that continue to this day. Peer Support Agencies provide real help and mentoring. New Hampshire is also creatively addressing physical health risks in the population with an NIMH grant to use disease management techniques for diabetes, high blood pressure, and elevated cholesterol—an illness and management extension which may be a national model for addressing cardiovascular risk in the population.

New Hampshire hospital is a modern, physically pleasing hospital but is under tremendous system pressure—more admits, shorter stays, and more forensic patients—and maintains supportive and collaborative relationships with consumer and family members who monitor the quality of care. It is viewed as enlightened, even as by several reports the service has become more medical and less rehabilitative due to the pressures it faces. This is a very good component of the system, despite the changes around it.

More troubling spots are the state of the Community Mental Health Centers and the shortages of the housing that are needed to accompany the essential rehabilitative, clinical, and outreach services. Legislator Senator Peter Burling is quoted in the *Manchester Union Leader* of January 11, 2006, saying that, "We've been short changing the very agencies we rely on so we won't have to use government to perform the same services." The article quotes several agencies who testified they are cutting back services and creating waitlists.

The problem with attempts to save money by clipping CMHCs and the Dartmouth contract, of course, is that the state pays dearly when it has to place people with major mental illnesses in correctional settings and when it gives up Dartmouth's grant-writing capacity. There is no way to ignore the need to develop services that prevent the use of expensive and inappropriate correctional settings as care facilities of last resort.

New Hampshire's mental health system is not what it used to be—and this is no one person's fault. The key question, however, is what it will become as it commits to such heavy reliance on Medicaid matching services. There are a good many smart people in the Granite State in leadership positions. Will they get the resources they need for a safety net if Medicaid falters? What new resources will support the community safety net? These answers will likely determine how, in the end, the state spends its money—on services or corrections.

For New Hampshire, recovery is possible, and it can gain back what it has lost and move forward to a family- and consumer-driven system. But it will require an investment in adequate funding treatment and support systems. Cutting in the name of efficiency is no longer tolerable.

Score Card: NEW HAMPSHIRE

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	2	3
	2	Demonstrated innovation	1	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	6	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	0	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	1	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	0	2
	39	Financial-logistical support Peer-to-Peer education program	0	2

New Jersey

Grade: C

Category Grades

Infrastructure	**B-**
Information Access	**C+**
Services	**C**
Recovery Supports	**C**

Spending, Income, & Rankings

PC Spending/Rank	$125.60	9
PC Income	$38,383	3
Total MH Spending/Rank	$1,084 *(in millions)*	4
Suicide Rank		49 *(tied with New York)*

Recent Innovations

- Long-term special needs housing trust fund
- Funding increases for community based services and supports
- Increased investment in evidence-based practices
- Exemplary executive leadership

Urgent Needs

- Improve conditions in state hospitals, particularly Greystone
- Develop appropriate community services for people clinically ready for discharge from hospitals
- Increase evidence based practices, particularly IDDT
- Continue forward momentum stimulated by Governor Richard Codey

A governor who cares can make a huge difference.

In November 2004, New Jersey Senate Majority Leader Richard Codey became the Acting Governor of New Jersey upon the resignation of Governor James McGreevey. On his very first day in office, Governor Codey began his day with breakfast at the state's largest psychiatric hospital. Later that day, he signed his first executive order, creating a taskforce on mental health. He promised that improving services for people with mental illnesses would be one of his top priorities while in office.

During his 13 months in office, Governor Codey proved true to his word. Despite inheriting a $4 billion dollar budget deficit when he assumed office, the FY 2006 Budget approved by the New Jersey legislature contained an increase of $40 million in mental health funding for a variety of important mental health initiatives, including jail diversion, supported employment, community short-term inpatient treatment facilities, case management for individuals re-entering the community from corrections, and mental health workforce expansion. Perhaps the most important accomplishment of all, in terms of long-term impact, was the enactment of a law dedicating $200 million for a Special Needs Housing Trust Fund to create 10,000 new units of supportive housing units for people with mental illnesses and special needs.

At a time when many states are cutting mental health services, these accomplishments are remarkable—a true tribute to the determination of Governor Codey to invest new resources into services that work for people with serious mental illnesses.

This is not to say that all is rosy with New Jersey's mental health system. The Division of Mental Health Services (SMHA) has direct responsibility for operating the state's five public psychiatric hospitals. Several of these hospitals are seriously overcrowded, and services that might enable some patients to function in less restrictive settings are not available. According to the Governor's Task Force on Mental Health, "almost 50 percent (1,000 people) of New Jersey's state hospital patients are clinically ready for discharge but housing and support services are not available for these patients."

All five of New Jersey's state psychiatric hospitals are overcrowded, placing great strains both on patients and staff. Moreover, Greystone Park, the largest hospital in the state, is old and decaying. Plans have been developed to replace the current hospital with a new, state-of-the-art facility with

fewer patients while maintaining the same number of staff to improve quality of care. While this seems like a hopeful plan in concept, whether it succeeds depends upon the development of appropriate services and supports in community-based settings for those deemed no longer to require inpatient care. Is the state prepared to reinvest money saved by reducing the census of its state hospitals into community-based services and supports on a dollar-for-dollar basis?

The Division's plan to increase community-based services and ultimately decrease the numbers of individuals served in hospitals includes increased use of evidence-based practices (EBPs), such as Assertive Community Treatment (ACT), integrated case management services for individuals discharged from state or county hospitals, and the use of psychiatric units in general hospitals for individuals requiring acute inpatient care. The SMHA has taken strides in recent years to increase the availability of certain evidence-based practices. Thirty-one ACT teams currently operate in all of New Jersey's 21 counties, an impressive number on its face, but nevertheless not enough to serve all who could benefit from ACT in the densely populated Garden State. More ACT programs are needed.

A cooperative agreement exists between the SMHA and the Division of Vocational Rehabilitation to collaborate on financing supported employment services. Currently, SMHA funds help support consumer participation in 22 supported employment programs throughout the state, one in each county except for Mercer county, where there are two such programs. Here too, significant expansions are needed in the availability of supported employment programs. Fewer than 1,000 people with serious mental illnesses currently receive this vital employment support in New Jersey.

The state has lagged significantly in implementing integrated dual diagnosis treatment (IDDT) programs for the large numbers of consumers who suffer from co-occurring mental illnesses and substance abuse disorders. Citing problems with meeting specific staffing requirements, the SMHA acknowledges that only one such program exists at the present time. While funding requirements may be burdensome, IDDT has proven effective in facilitating recovery. In the long run, investing in the development of IDDT programs will decrease more costly expenditures associated with hospitalizations or incarcerations.

On a positive note, New Jersey should be applauded for its decision to provide wrap-around coverage of medications for individuals dually eligible for Medicaid and Medicare who would otherwise be required to satisfy co-pay requirements under the new Medicare Part D program. And New Jersey has, in recent years, significantly improved mental health treatment for prison inmates with serious mental illnesses, implementing an open medication formulary in prisons and contracting with the University of Medicine and Dentistry of New Jersey to provide prison mental health services. The challenge for the state is to work with counties to expand these promising practices into jail settings.

New Jersey has taken unique steps to ensure a culturally competent workforce, including enacting legislation that requires medical schools to teach these principles and physicians to attend cultural competence training before renewing state medical licenses. Additionally, the DMHS has solidified its commitment to cultural competence through the development of an Office of Multicultural Services (OMS) within the Department. The OMS oversees a variety of activities, including: liaisons with state hospitals to evaluate the needs of multicultural clients and communicate those needs to hospital CEOs; the Multicultural Services Advisory Committee, composed of providers, consumers, families, and academicians; provision of multicultural grants to minority communities; and a Technical Assistance Center at the state's University of Medicine and Dentistry that provides training in cultural competency and other DMHS priority areas.

As Governor Codey leaves office and returns to his role as Senate President, he can look back with pride at significant advances that have occurred in public sector mental health services during his watch. However, these advances are just a start. New Jersey has a long way to go to develop a truly comprehensive system of services and supports for people with serious mental illnesses. Efforts must continue to develop housing and implement evidence-based practices, while maintaining adequate numbers of inpatient beds for those who need them. Hopefully, the momentum generated under Governor Codey will continue under new governor Jon Corzine.

Score Card: NEW JERSEY

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	8	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	1	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	1	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

New Mexico

Grade: C-

Category Grades

Infrastructure	**B-**
Information Access	**F**
Services	**C**
Recovery Supports	**C+**

Spending, Income, & Rankings

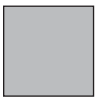
PC Spending/Rank	$28.80	51
PC Income	$24,250	47
Total MH Spending/Rank	$54 *(in millions)*	47
Suicide Rank		5

Recent Innovations

- Behavioral Health Purchasing Collaborative
- Medicaid waiver funding for peer services

Urgent Needs

- Continued decriminalization of mental illness
- Implementation of best practices



It was in Albuquerque in 2002 that President George W. Bush chose to launch the New Freedom Commission, to improve the lives of Americans living with severe mental illness by transforming the mental health care system.

The choice was appropriate.

Despite being home to U.S. Senator Pete Domenici, one of the true national champions on mental health issues, the state historically has fallen short in meeting the need of its citizens for mental health services.

The state motto is "Land of Enchantment," but the mental healthcare system is anything but enchanting. Many advocates refer to it as the "land of entrapment"—it would be funny, except that lives literally are at stake.

The good news is that New Mexico seems to have woken up. There are signs of a commitment to innovation. In 2005, the state received a federal system transformation grant. Thanks to the leadership of Governor Bill Richardson, the state also has launched an experiment known as the Behavioral Health Purchasing Collaborative (BHPC), which has the potential to become a national model. It is a needed initiative—untreated mental illness costs the state's businesses, taxpayers, and families more than $3 billion annually.

The bad news is that New Mexico has many strikes against it. The state has the fifth-highest suicide rate in the nation, and the second-lowest spending per capita for state-directed mental health services. Poverty and rural ruggedness contribute to its precarious position. Compared to other Mountain States, New Mexico has the highest percentage of uninsured citizens below the federal poverty line.

A recent settlement with the U.S. Department of Justice documented problems in the Santa Fe County jail involving inhumane conditions and inadequate medical services for inmates living with serious mental illnesses. The county agreed to improve services, including pre-admission screening and better staffing. However, advocates say that the case is only one example of a pattern of shortcomings statewide.

On the positive side, the state has made progress with a mental health court in Albuquerque and Crisis Intervention Team (CIT) programs.

New Mexico has a good history of supporting peer-operated consumer services—it was one of the first Western states to pursue the strategy. Through programs

such as the Wellness Recovery Action Plan (WRAP), the state has a strong recovery orientation. Despite the state's good intentions, however, advocates report that too much bureaucratic planning diverts resources from services.

New Mexico was the first to grant medication-prescribing privileges to psychologists. The merits of the initiative are still under debate. Other alternatives such as telemedicine were dismissed in favor of this more controversial move, but the state deserves credit for acknowledging a chronic shortage of psychiatrists and other providers. NAMI warns the state, however, to monitor and evaluate the policy carefully to ensure safety and effectiveness.

New Mexico's BHPC combines revenue from 18 state agencies into a single system. Through a management agreement with Value Options, a private managed care company, the collaborative seeks to implement evidence-based practices (EBPs) and prioritize services according to consumer and family preferences.

The jury is still out on whether the BHPC experiment will succeed. There is some cause for concern. It appears that Value Options is seeking to introduce barriers to open access for psychiatric medications—a cost-cutting strategy that is "penny wise and pound foolish." Managed care models sometimes turn into managed cost models. Experience with managed care in other states too often reveals that people's needs are sacrificed in favor of private profit incentives.

Score Card: NEW MEXICO

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	3	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	1	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	2	3
	28	Reduction in use of restraints & seclusion	0	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	3	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

New York

Grade: U

Category Grades

Infrastructure

Information Access

Services

Recovery Supports

Spending, Income, & Rankings

PC Spending/Rank	$192.07	3
PC Income	$34,725	6
Total MH Spending/Rank	$3,681 *(in millions)*	2
Suicide Rank		49 *(tied with New Jersey)*

Recent Innovations

- Progress in evidence-based practice (EBP) implementation
- Suicide prevention initiative
- Supportive housing
- Kendra's Law

Urgent Needs

- Consolidate state hospitals while maintaining overall capacity
- Statewide expansion of supportive housing and other services
- Resolve adult care home crisis
- Mental health insurance parity
- Integrated family services

New York was one of only two states that declined to respond to the survey used in preparation of this report, thereby compromising transparency and accountability. Because lack of specific information was offered for scoring the state as compared to the 48 other states and the District of Columbia that participated, the state has received a grade of "U" for "unresponsive."

The state Office of Mental Health (OMH) manages one of the largest and most complex mental health systems in the country, with 58 local government units and more than 2,500 certified mental health programs. The state is both highly urban and highly rural in nature. Delivery of quality services to people with serious mental illnesses is challenging in both environments.

In New York City and other urban centers, the need for services far exceeds the supply, contributing to high rates of homelessness and criminalization of mental illness. There are more people with serious mental illnesses incarcerated in New York City's Riker's Island jail than any psychiatric hospital in the country.

The challenge in rural areas is different but equally daunting. Obstacles such as lack of transportation and serious shortages in qualified psychiatrists, psychiatric nurses, case managers, and other mental health personnel contribute to major problems with access to services in these regions.

New York devotes significant resources to addressing these serious problems; its average per capita community mental health expenditure of $103.32 per person ranks among the highest in the country. Whether resources are utilized in the most cost-effective manner is, however, open to question.

There is a consensus among advocates statewide that New York has too many state hospitals. There are 26 hospitals, 17 of which serve primarily adults with serious mental illnesses and three of which serve forensic patients. This does not mean that there are too many hospital beds. On the contrary, decades of downsizing hospitals has created an anomaly. Although there may be too many hospitals, there are too few beds available to address the needs of people who require inpatient treatment. There are currently only 4,000 beds available statewide, and the remaining beds are threatened by misguided efforts by the state to enact legislation granting authority to civilly commit sexual predators who have completed their prison sentences to psychiatric

hospitals. Laws of this kind divert already scarce treatment resources and also potentially place vulnerable individuals with serious mental illnesses at risk.

Problems with adult care homes in New York are a major problem. A Pulitzer Prize-winning series of articles in the *New York Times* in 2003 exposed horrendous conditions in some facilities, as well as serious fraud, abuse, and victimization of residents. The state mental health system had essentially evaded responsibility for the residents—many of whom previously had been patients in state psychiatric institutions—by placing them in substandard facilities run by a different agency, the Department of Health. The state was slow to respond to this crisis.

New York is one of a minority of states that still does not require mental health insurance parity. A parity bill known as Timothy's Law nearly passed in 2005 but stalled in the State Senate. Besides being central to the elimination of the stigma and discrimination often associated with mental illness, parity is important in stemming the flow into the public system of middle class taxpayers with private insurance, who are often forced either to spend down assets or go without treatment.

Across the board, the legislature needs greater awareness of cost-shifting effects from cuts or restrictions on mental health services. Without timely, adequate services, the result is more expensive emergency visits, hospitalizations, and burdens on police and the criminal justice system.

On the positive side, OMH has developed a joint agreement with New York City to develop supportive housing. The plan will increase stable housing for approximately 5,500 people with serious mental illnesses and others affected by homelessness over the next 10 years. These 5,500 units of housing would be added to 31,000 that are either already available or in the pipeline. The challenge for New York is to implement similar programs in other parts of the state, as well as continuing to expand these services in New York City, where thousands of people with serious mental illnesses remain un-served or under-served.

Enacted in 1999, Kendra's Law also has been a source of progress, authorizing court-ordered assisted outpatient treatment for individuals with serious mental illnesses, or co-occurring mental illness and substance abuse, who are consistently non-adherent to treatment and at serious risk. Although the law has engendered divisions among advocates, a 2005 OMH report showed clear benefits in terms of reduced hospitalizations, homelessness, and arrests—as well as in treatment outcomes.

The OMH is investing significantly on a state-wide basis in evidence-based practices (EBPs), Assertive Community Treatment (ACT) teams, and family psycho-education. The state is also in the beginning stages of planning and piloting integrated mental health and substance abuse treatment, illness self-management programs, screening, and integrated family services.

The criminalization of people with serious mental illnesses is a national problem, and New York is no exception. There are several excellent jail diversion programs in the state, including Project Link in Rochester and the Nathanial Project in New York City. Six Mental Health Courts have been established in the state, including courts in the Bronx and Brooklyn serving felons with serious mental illnesses.

Suicide numbers in New York State have been very high in recent years. In response, OMH is investing significant resources in a suicide awareness, education, and prevention program that is being implemented in communities and counties throughout the state.

Overall, New York has developed some excellent services in collaboration with other agencies in certain parts of the state. However, disparities exist. The state has yet to develop a truly seamless and integrated system of care. Solutions also must be found to resolve the shameful adult care home situation.

Finally, New York deserves praise for its two state-of-the-art and nationally renowned research facilities, the Nathan Kline Institute for Psychiatric Research and the New York State Psychiatric Institute. Although there have been attempts by the state to enact cuts to these programs, funding levels have been maintained in recent years.

Unfortunately, closer analysis of specific factors in the state system is not possible without OMH's cooperation.

To the degree that transparency and responsiveness are not available directly to consumers and families—whom NAMI represents—the state's legislative oversight committees are encouraged to seek answers to the concerns reflected in this report's survey and scoring process.

Accountability is a threshold concern for the performance of any mental healthcare system.

Score Card: NEW YORK

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	U	3
	2	Demonstrated innovation	U	2
	3	Health disparities program	U	2
	4	Studies regarding causes of death	U	2
	5	Workforce development & strategic plan	U	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	U	2
Information Access	9	Consumer & Family Test Drive (CFTD)	7	10
	10	Consumer & Family (CF) monitoring teams	U	2
	11	Written mandate ensuring CF input	U	2
	12	CF involvement in EBP implementation	U	2
Services	13	No outpatient mental health co-pays	U	3
	14	No restrictions for antipsychotic medications	U	3
	15	No restrictions on prescriptions per month	U	3
	16	Benefit-service identification program	U	2
	17	Interagency cooperation between SMHA & Medicaid	U	2
	18	Wraparound coverage for benzodiazepines	U	2
	19	Feedback to doctors on prescribing patterns	U	2
	20	Integrated dual diagnosis treatment policies	U	3
	21	Assertive Community Treatment (ACT) teams	U	3
	22	Written ACT fidelity standards	U	2
	23	Family psychoeducation - SAMHSA model	U	2
	24	Illness management & recovery - SAMHSA model	U	2
	25	Jail diversion programs	U	3
	26	Restoration of benefits post-incarceration	U	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	U	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	U	2
Recovery Supports	31	Supported employment	U	3
	32	SMHA-Division of Vocational Rehab	U	2
	33	Supported housing	U	4
	34	Efforts to reduce waiting lists for residential services	U	3
	35	Housing services coordinator	U	2
	36	Written plan for long-term housing needs	U	2
	37	Co-occurring disorders--No Wrong Door	U	2
	38	Financial-logistical support Family-to-Family education program	U	2
	39	Financial-logistical support Peer-to-Peer education program	U	2

North Carolina

Grade: D+

Category Grades

Infrastructure	C-
Information Access	D
Services	D
Recovery Supports	B+

Spending, Income, & Rankings

PC Spending/Rank	$50.26	43
PC Income	$26,808	38
Total MH Spending/Rank	$417 *(in millions)*	21
Suicide Rank		25 *(tied with Mississippi)*

Recent Innovations

- Building a new state hospital to replace two antiquated facilities
- Transparency; annual five-year plans

Urgent Needs

- Funding
- Go slow, learn from changes to date
- Build more crisis services and alternatives to hospitalization
- Safety net resources and alternatives to private providers
- Passage of mental health insurance parity legislation

North Carolina is performing massive surgery on its mental health system, and the situation is critical at this time. Post-operative care will make the difference for people living with serious mental illnesses in the state.

The surgery was necessary. In 2000, the state auditor issued a report describing a system in collapse—characterized by fragmentation, lack of funding, lack of access to care, no crisis services, poor accountability, and hospitals that were failing patients. The state legislature enacted a reform plan, including voting $50 million to fund the bills. But then the national economy soured. The state chopped its budget. And the investment was withdrawn.

Meanwhile, the state has tried to move forward, essentially performing a multi-organ operation, involving state hospitals and community services, reorganization of service areas, and privatization of many aspects of care. Too much happens at once, with not enough funds and not enough support personnel. Then the bleeding starts.

Every mental health system requires carefully balanced levels of care. That includes state hospitals for longer-term inpatient care, but its primary components are crisis centers and short-term acute inpatient and intermediate care facilities in communities, as well as outpatient community services like Assertive Community Treatment (ACT), supported housing, and independent living options.

If a state starts closing or reducing hospitals without community services in place, it soon gets in trouble. If services are not available, the entire system backs up. Long waiting lists reduce access. People languish in hospital beds at one level because they can't be placed elsewhere—or discharged, if outpatient services aren't available. Overcrowding and shortages arise.

The problem is one of capacity. In human terms, a person who experiences a psychotic episode ends up discharged prematurely from the hospital before medications have had time to work. If a follow-up appointment is scheduled, no one investigates if the person never appears. According to advocates, in some areas, if a person misses three appointments at a local mental health office, they are dropped. If they turn up later, they have to go through the admission process all over again.

Dorothea Dix Hospital in Raleigh, the main state hospital, and John Umstead Hospital in Butner, North

Carolina, will be closed, to be replaced by a single new hospital in Butner. Unfortunately, advocates report that the net result will be approximately 200 fewer beds, and that community services "absolutely are not in place to deal with it."

In December 2005, a *Winston-Salem Journal* series, "Breakdown: A Crisis in Mental Health Care" examined what went wrong. The co-chair of the legislative oversight committee answered, succinctly: "The missing factor is money." That should not have come as news to anyone. The agency's five-year plan in 2001 clearly noted: "The massive disconnect between the resources needed for supports and services and resources available to provide supports and services is the most important factor in North Carolina."

Coming on top of difficulties involved in the transformation, the U.S. Department of Justice (DOJ) cited the four state hospitals in 2004 for a litany of violations:

- inadequate mental health treatment
- inappropriate use of restraint and seclusion
- inadequate nursing and medical care
- failure to ensure reasonable safety of patients
- unsafe physical plant conditions
- inadequate discharge planning

"A major cause of many of the unlawful conditions we identified stems from a fragmented, decentralized mental health system with unclear, unspecified standards of care, and an insufficient number of adequately trained professional and direct care staff to meet the needs of patients," observed DOJ. The hospitals were cited for "inadequate assessments and treatment planning, inadequate care for patients with specialized needs, inadequate psychosocial rehabilitation services, and inadequate psychopharmacological practices."

DOJ's observations also exposed the chasm between the hospitals and community services. In one case, a hospital patient was discharged simply to "self," and another to a homeless shelter.

Still, there are positive features:

- DOJ has acknowledged that NC has been "collaborative" in working to address violations at the hospitals. At Dix Hospital, DOJ found an "exemplary Clinical Research Unit and good behavioral programming on the specialty deaf service."
- Planning for the transformation is open and transparent. The state appears open to feedback and willing to learn from experience.
- Medicaid in NC has not taxed service recipients with high co-pays, medication restrictions, or other barriers to care.
- The state is exploring possibilities for using Medicaid funds to support evidence-based practices (EBPs) such as ACT.
- Development of alcohol-dedicated units will help to reduce bed demand at the state hospitals.
- Jail diversion exists in many areas of the state in pre- and post-booking services.

At this stage, one highly symbolic as well as practical step might be for the legislature to dedicate all revenue from the sale or redevelopment of state hospital land or facilities to the mental health system. A hospital closure should be seen not as a cost-cutting measure, but as a transfer and reinvestment of resources. Those resources can serve as a "trust" for people with serious mental illnesses.

Score Card: NORTH CAROLINA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	7	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	1	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	1	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	0	3
	29	Accreditation of state hospitals/facilities	0	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	1	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

North Dakota

Grade: F

Category Grades

Infrastructure	**F**
Information Access	**F**
Services	**D+**
Recovery Supports	**F**

Spending, Income, & Rankings

PC Spending/Rank	$81.06 /	25
PC Income	$27,728	33
Total MH Spending/Rank	$51 *(in millions)*	48
Suicide Rank		13

Recent Innovations

- Jail diversion programs starting to emerge in the state
- Plans to implement recovery-model training for staff and consumers

Urgent Needs

- Implementation of evidence-based practices
- Increased housing options for individuals with mental illnesses
- Better solutions for service delivery in rural areas

Living in North Dakota can feel very isolating, and when it comes to mental healthcare, perhaps North Dakota's greatest need is to integrate better with approaches found in other states across the country.

Responsibility for mental health services in North Dakota rests with the state's Department of Human Services (DHS). Within the DHS, the Division of Mental Health and Substance Abuse (DMHSA) oversees services delivered through the state's eight regional human service centers and the lone North Dakota State Hospital in Jamestown.

For individuals with serious mental illnesses, the state provides a range of options through Extended Care Treatment Units within each of the human service centers. While these Units do offer a variety of services, evidence-based practices (EBPs) are notably missing from the menu of available options in the state. North Dakota does offer supported employment services at each of the human service centers, but the state admits that it does not use the evidence-based SAMHSA model for this important service. Without adhering to standards for supported employment services, it is hard to know exactly what type of services are delivered to consumers in North Dakota and to ensure uniformity across the state for this critical service.

North Dakota also reports no Assertive Community Treatment (ACT) teams. The state's stagnation on implementing ACT contradicts an August 2004 memo from the North Dakota Mental Health Planning Council stating that ACT implementation was "feasible" in North Dakota and that one pilot program was planned for introduction in the next year. More than a year later, the state has not brought this service to fruition.

North Dakota has also failed to implement the evidence-based practice of integrated treatment for co-occurring substance abuse and mental illnesses, although one pilot is planned for 2006 in the Fargo area. In fact, the organization of the Division of Mental Health and Substance Abuse may be one of the impediments to progress in this area. According to the state's fiscal year 2005 Community Mental Health Services Block Grant Application, DMHSA functions with one director, but "two distinct tracks: one for mental health issues, the other for substance abuse issues" that "allow distinct approaches to be taken in prevention, interven-

tion, and treatment." This type of thinking is antiquated in a field where 31 percent of individuals with a serious mental illness also experience substance abuse. Even more disturbing, North Dakota has been hit hard by the growing methamphetamine epidemic, contributing to increased admissions at the state hospital for methamphetamine addiction.

And while the DMHSA indicates that there are a variety of housing options available in the state, it remains a major area of concern. For example, the state has a plan to address the long-term housing needs of individuals with serious mental illnesses, but there are no supported housing programs and no staff person within the DMHSA responsible for coordinating housing services for this population. What good is a plan, one might ask, with no one to implement it and no outcomes to show for it?

The scarcity of evidence-based practices is not the only problem facing North Dakota's mental health system. The population of this rural state is spread out over a vast land area, and 36 of the state's 53 counties are designated frontier areas, defined as fewer than seven people per square mile. To help reach these areas, staff from each of the regional human service centers travel on a regular basis to outlying communities.

In the future, the state plans to depend upon other health-care professionals (such as local public health nurses and social workers) in these communities to help fill the gap in care for these rural areas. While this plan may have some merit, the state would need to invest heavily in appropriate training for these individuals, and even then, it is no substitute for the knowledge base of psychiatrists and other specially trained mental health providers. The use of telemedicine and other interventions should be explored to supplement this plan.

Additionally, almost five percent of North Dakota's population is American Indian, and four federally recognized tribal nations lie within the state's borders. The DHS has a tribal liaison to facilitate between tribal social services and the state. This relationship has opened the lines of communication and resulted in trainings and the development of a booklet for tribal healthcare providers across the state.

On a positive note, in the Minot area, advocates are gaining traction on important programs such as Crisis Intervention Teams (CIT) to address the criminalization of individuals with mental illnesses. Additionally, human service center staff in the Fargo region are collaborating with a variety of officials to implement post-booking jail diversion strategies. This is a promising step and should be promoted with support of the DMHSA.

And, despite North Dakota's low ranking in this report, the state is making efforts to learn from others in the mental health field. Small teams from selected human service centers and the state hospital will be attending the Research Recovery Institute in Ohio to learn about a recovery-model education program for providers and consumers. This is a good first step toward climbing the ranks for North Dakota, to a better system of care.

Score Card: NORTH DAKOTA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	0	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	0	2
Information Access	9	Consumer & Family Test Drive (CFTD)	2	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	0	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	0	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	0	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	3	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	0	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	1	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	0	2
	39	Financial-logistical support Peer-to-Peer education program	1	2

Ohio

Grade: B

Category Grades

Infrastructure	**B**
Information Access	**A**
Services	**B**
Recovery Supports	**B**

Spending, Income, & Rankings

PC Spending/Rank	$62.03	37
PC Income	$28,430	26
Total MH Spending/Rank	$709 *(in millions)*	9
Suicide Rank		30

Recent Innovations

- Strong state-level leadership in various branches of government
- Consumers and family play a prominent role in the system
- Impressive implementation of EBPs, decriminalization, and criminal diversion initiatives
- Productive dialogue between advocates and criminal justice system leaders

Urgent Needs

- Gaps in funding must be closed
- Parity legislation urgently needed
- Insufficient services, especially acute shortages of beds and staff

Ohio is home to some of the strongest leaders in improving the nation's mental healthcare system, and a pace-setter for states with large county-based systems.

As the state with the electoral votes that decided the 2004 presidential election, it may be no exaggeration to say that in the field of mental health, too, as goes Ohio, so goes the nation.

The director of the Ohio Department of Mental Health (ODMH), Michael Hogan, Ph.D., is one of the nation's longest serving mental health agency heads. He served as chair of the President's New Freedom Commission on Mental Health in 2002-2003. U.S. Senator Mike DeWine and U.S. Representative Ted Strickland have nurtured the growth of mental health courts and criminal diversion programs nationally. State Supreme Court Justice Evelyn Lundberg and Corrections Director Reggie Wilkinson also have forged new policies, programs, and partnerships to change the shape of treatment in the state's criminal justice system.

In addition, consumer and family participants in policy and service decisions within the system play important leadership roles.

Unfortunately, gaps and unmet needs still exist. It is a sad commentary on public mental health systems when even a state like Ohio is still not fully able to bring treatment and recovery to people with serious mental illnesses.

Leaders alone are not enough. Quality services cost money. New funds are entering the Ohio system through a federal Transformation State Incentive Grant (TSIG) and recent budget increases. ODMH received a 3 percent increase in 2005 and again in 2006—the largest increase for any state department. In a period of intense competition for funds, it was an encouraging signal that Governor Taft and the General Assembly recognize the importance of mental health in the state's overall healthcare equation.

Looking beyond the public health system, Ohio advocates are hoping that the same vision will extend to passage of a mental health insurance parity law. Lack of parity is a strange blot on Ohio's record of national leadership, compared to the 36 other states that have passed such laws.

Parity is important in helping to stem the flow of people with private insurance into the public system—as well as being central to eliminating stigma and discrimi-

nation. When middle class families lack mental health benefits under private health insurance plans, they often spend down assets and end up in the public system, or go without treatment. Ultimately, costs are passed on to the state. More emergency room visits and hospitalizations result. In some cases, costs are shifted to the criminal justice system. The legislature's inaction on parity comes with a price.

ODMH plans to use increased funds to maintain current levels of hospital beds and staff, while offering Safety Net Emergency Funds to community service boards, based on financial hardship. Even so, the system presently is overwhelmed by not enough money or staff. There are long waitlists for services and housing. ODMH's support of 27 residency and training programs at state universities are intended to ease the workforce shortage, but by themselves, they aren't enough.

Medicaid funds many services. Federal waivers allow boards to manage provider contracts autonomously, but autonomy comes with a price—they must provide matching funds. Many boards therefore limit investment in services that are non-Medicaid reimbursable, in order to maximize federal funding. The result is minimum access to recovery-oriented services that may not be reimbursable, such as early intervention, housing, employment, consumer-run programs, and culturally competent services. In addition, recent changes in Medicaid eligibility requirements will drop nearly 20,000 adults from the rolls. Taken together, Ohio's toughest challenge will come in finding the funds to sustain services and innovations in the future.

Other states would do well to take notice of Ohio's approach to implementing evidence-based practices (EBPs) and decriminalization of mental illness. Coordinating Centers of Excellence (CCOEs) and Networks, located around the state, instill best practices through a three-phase model of engaging practitioners, providing training in specific EBPs, and offering follow-up reinforcement. The state recently made Assertive Community Treatment (ACT) a reimbursable service under Medicaid. The CCOE approach will allow the state to upgrade intensive case management services using ACT teams.

The commitment of Ohio leaders to criminal diversion and re-entry programs for people with mental illnesses is unique—these successes represent real partnerships that have brought together diverse communities and centers of power. In May 2005, the Criminal Justice CCOE, along with the Ohio Supreme Court, Capital University Law School, and NAMI Ohio, co-sponsored the first national conference on Crisis Intervention Teams (CIT) and the third national conference on Mental Illness and the Criminal Justice System, drawing participants from around the nation.

The challenge for Ohio is to apply the same kind of commitment and cohesion to other dimensions of the mental healthcare system—with the support from the legislature and other community leaders.

Score Card: OHIO

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	3	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	10	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	3	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Oklahoma

Grade: D

Category Grades

Infrastructure	**D-**
Information Access	**F**
Services	**C**
Recovery Supports	**C**

Spending, Income, & Rankings

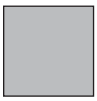
PC Spending/Rank	$39.43	46
PC Income	$25,308	40
Total MH Spending/Rank	$138 *(in millions)*	38
Suicide Rank		14

Recent Innovations

- Recovery orientation
- CIT and mental health courts
- Using technology to bridge distances
- Progress in co-occurring disorder treatment

Urgent Needs

- Continued funding increases
- Comprehensive rural strategy
- Balanced capacity between hospitals and community services
- Housing



Oklahoma is slowly progressing and turning into a light of hope for the future, provided recent trends continue. To some degree, the fact that the state receives a "D" in this "report card" may be a reflection of how bad the system was before current improvements began.

Leadership from the Oklahoma Department of Mental Health and Substance Abuse Services (DMH) and the Oklahoma Healthcare Authority (OHCA)—the state Medicaid agency—along with modest increases in funding from the legislature have been the keys to overcoming decades of neglect. The state has been moving from an antiquated mental healthcare system to one based on proven, cost-effective practices focused on recovery.

In 2005, Oklahoma was one of only seven states to receive a federal transformation grant. The state's Medicaid program also has shifted definitions of services from the support to the recovery model. One needs to look back only as far as the late 1990s to see a system that was one of the lowest funding priorities for the state legislature.

DMH Commissioner Terry Cline's leadership is credited with helping make the difference, through receptiveness to change and a commitment to improvement in the quality of services. It also helps that he has Cabinet-level status—serving as the Governor's Secretary for Health, with oversight and liaison responsibility for DMH, OHCA, and other agencies.

NAMI has recognized Oklahoma nationally for model implementation of Assertive Community Treatment (ACT), which has grown in five years from zero teams to this year's 14.

The state's mental health statistics division is also recognized nationally as innovative and comprehensive —one of the most fundamental tools for effective management that many states surprisingly overlook.

Ironically, however, Oklahoma fared poorly in NAMI's test of basic information accessibility for consumer and families. There also are more serious problems.

Since 2000, the state has closed one of two hospitals, attempting to redirect resources to community-based services. The strategy's implementation has proven chaotic and exposed state disorganization and lack of service capacity.

Every system requires balance. There is a role for state hospitals for longer-term inpatient care, along with crisis

centers and short-term acute and intermediate care facilities in communities, as well as outpatient services like ACT, supported housing, and independent living. When community services are not available, the entire system backs up. The state is now floundering to try to provide an adequate number of psychiatric beds. Many Oklahomans who need psychiatric hospitalization face four-to-six hour trips to the nearest receiving hospital. The solution lies in building overall capacity.

One of Oklahoma's most critical challenges is to develop a specific strategy for providers and services in rural areas. The system is strongest in the Oklahoma City and Tulsa metropolitan areas, where 60 percent of the state's population is located. Rural families have less access to services and fewer options—complicated by high rates of co-occurring substance abuse. Shortages of qualified staff are common. Quality of services is often low.

In some cases, technology can overcome distance. In 2005, the Northwest Center for Behavioral Health worked with NAMI Oklahoma to place video and audio Internet connections in three counties for emergency commitment hearings, staff meetings, and other needs—resulting in almost tenfold savings in time and travel costs. The program reduced stress for some patients, who previously had to be transported in handcuffs, and allowed staff to spend more time with others.

Oklahoma has one of the highest incarceration rates in the nation, and, using even the most conservative definition, 21 percent of inmates in state prisons have serious mental illnesses. For women inmates, the figure is 40 percent.

Challenges are not limited to state correctional facilities. Some of the toughest ones involve jails in rural counties. The U.S. Department of Justice (DOJ) has recently confronted the jails in Garfield and LeFlore Counties for alleged violations of patient rights to mental health treatment.

The state is moving to decriminalize mental illness by establishing police Crisis Intervention Teams (CIT), expanding mental health training opportunities for rural police agencies, and developing mental health courts to divert individuals into treatment.

Long-term housing is also a significant concern for the state. As Oklahoma moved too aggressively in the early 2000s to reduce state hospital capacity, more and more citizens with mental illness ended up in residential care homes with few supports and poor treatment availability. Predominantly scattered across the eastern half of the state, advocates report concerns about neglect in such homes; there may be inadequate incentives to support recovery in residential care homes. Housing is becoming a priority for the state, but historically, it has been a significant shortcoming.

Score Card: OKLAHOMA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	5	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	1	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	0	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Oregon

Grade: C+

Category Grades

Infrastructure	**A**
Information Access	**C-**
Services	**C**
Recovery Supports	**B**

Spending, Income, & Rankings

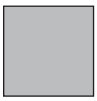
PC Spending/Rank	$56.49	40
PC Income	$27,857	30
Total MH Spending/Rank	$201 *(in millions)*	32
Suicide Rank		11 *(tied with Utah)*

Recent Innovations

- Mental health insurance parity
- ACT expansion and fidelity standards
- Community Mental Health Housing Fund
- Reinvestment of property assets in mental health care system

Urgent Needs

- Funding
- OSH remediation and new hospital master plan
- Implementation of "Blueprint for Action."



Oregon is one of those systems that may look better on paper than in actuality. There are major problems in its mental healthcare system that cannot be ignored. At the same time, the state is taking some positive steps to improve services for its residents with serious mental illnesses.

Problems at the 122-year-old Oregon State Hospital (OSH) in Salem are legion. The hospital houses 690 patients and long has struggled with inadequate staffing, poor physical conditions, overcrowding, and violence—let alone its therapeutic programs. Most residents at OSH are forensic patients, under the jurisdiction of the State's Psychiatric Security Review Board (PSRB). Empty beds for civil patients are virtually non-existent, which has a domino effect, leading to overcrowding in acute care hospitals and emergency rooms throughout the Williamette Valley.

In January 2006, after negotiations with state officials had proved fruitless, the Oregon Advocacy Center filed suit against the state, seeking a court order to increase staffing and improve safety and quality of care at the Hospital. To its credit, the state legislature acted swiftly. Meeting in emergency session, the legislature, through its Emergency Board, approved $9.2 million in new state funds to hire additional staff at the hospital, fund community placements for currently hospitalized individuals who are ready for community placements, and renovate a leased facility in Portland for individuals under civil commitment orders.

NAMI Oregon considers remediation of conditions at OSH one of its greatest priorities—along with design of a comprehensive community service system. Improving conditions at the current hospital is a step that will help for the immediate future, but the most effective long-term solution must include new inpatient and community-based alternatives both for current residents and to prevent unnecessary hospitalizations in the future. The state is expected to release a long-term master plan for the state hospital shortly, which is expected to include a recommendation for the construction of a new state hospital rather than renovating the existing antiquated and crumbling facility.

In 2004, a Governor's Mental Health Task Force issued a "Blueprint for Action" containing proposals for improvement of services for Oregonians of all ages with mental illnesses. Two of the recommendations have since

been enacted: mental health insurance parity and suspension rather than termination of Medicaid benefits upon incarceration.

Oregon's mental health parity law was enacted in 2005 after many years of effort by advocates and will take effect in 2007. When it does, it is expected to alleviate some of the burden on the public mental health system that results when families who do not have access to treatment through private insurance are forced to turn to the public system. However, it should be noted that the law only covers those who have insurance through their employers and excludes those who self-insure.

Although the Governor's Task Force was required to keep funding constraints in mind while developing recommendations, the blueprint emphasized that the system is significantly under-funded and that continuing to "defer discussion of financing is to assure that the problems will grow and become more expensive in future years." The problem became acute in 2004 when the medically needy program of Oregon's Medicaid program (the Oregon Health Plan) was eliminated, which resulted in cuts in vital services for many people with serious mental illnesses. While some who were cut off from Medicaid have since been restored, the negative effects of the cuts are still very much evidenced through gaps in services for many people.

On a positive note, Oregon is working to improve services. Most noteworthy is the state's commitment to expand access to evidence-based practices (EBPs). Twelve Oregon counties, with more than 65 percent of the state's population of people with serious mental illnesses, today offer Assertive Community Treatment (ACT) services, which meet model standards.

In 1999, the state created a Community Mental Health Housing Fund with proceeds from the sale of its old Dammasch State Hospital property. A portion of the site was reserved for community housing for people with mental illnesses. Reinvesting property assets "in trust" for consumers is an emerging, creative innovation nationally, and Oregon has helped blaze the trail.

Lane County (a large county that includes the City of Eugene) has adopted a comprehensive initiative for jail diversion and re-entry services for individuals with mental illnesses who are released from jails and prisons. It is the only Oregon county to have done so to date; however, the legislature took a step forward in 2005, requiring that Medicaid benefits for jail and prison inmates with serious mental illnesses be suspended only rather than terminated upon incarceration.

Oregon, in keeping with its pioneer spirit, is taking some innovative steps forward to improve services for people with serious mental illnesses. However, services remain fragmented or non-existent for many in the state. Advocates, mindful that small advances may be threatened the next time a state fiscal crisis occurs, must remain ever vigilant.

Score Card: OREGON

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	2	3
	6	Insurance parity for mental illness	2	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	8	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	1	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	1	2
	30	Olmstead Plan	0	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	1	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	1	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Pennsylvania

Grade: D+

Category Grades

Infrastructure	**C-**
Information Access	**D-**
Services	**C-**
Recovery Supports	**C-**

Spending, Income, & Rankings

PC Spending/Rank	$195.01	2
PC Income	$30,380	17
Total MH Spending/Rank	$2,410 *(in millions)*	3
Suicide Rank		34

Recent Innovations

- Pioneering leadership to eliminate use of restraints and seclusion
- Implementation of evidence-based practices
- PennMAPS decision making tool for physicians
- State inmate re-entry program in Allegheny County
- Co-occurring disorder workforce development

Urgent Needs

- Funding
- Comprehensive system blueprint
- Hospital land used as a trust for people with serious mental illnesses
- Better information access
- Community services; reduction of hospital waiting lists

Pennsylvania is a study in contradictions.

It has a complex mental healthcare system, serving a diverse and in many places aging population. Philadelphia, Pittsburgh, and Harrisburg are key centers, but to a significant degree, the state is county-driven, mountainous, and rural. The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSA) itself describes the state as having a "highly decentralized mental health system" in which "governance is an often confusing mix of town, city, country, and state jurisdictions." These factors also make it hard to generalize about the quality of care in the state—because so many decisions happen locally.

At times, Pennsylvania rises admirably to the vision of being the "Keystone State," exerting national influence. The state has been a pioneer in reducing the use of restraints and seclusions. Pennsylvania also is active in building capacity for treatment of co-occurring mental illness and substance abuse, winning a Co-Occurring State Incentive Grant(COSIG) and training 1,000 certified professionals in the field.

An OMHSA policy document on transformation and recovery, "A Call for Change," was developed with statewide consumer and family participation, consistent with the state's longstanding support of community support programs (CSPs).

Major changes are in progress, but lack an understandable blueprint for stakeholders. Hospital closings are a case in point. Harrisburg State Hospital was recently "closed," although 50 individuals remain within the facility under the care of another provider while other arrangements for their services can be arranged. Another closure is rumored to be coming; this seems certain, although it is uncertain which of the remaining state hospitals will be next. When the stakes are this high, people deserve a written long-term plan for their reference. As the number of state long-term psychiatric beds decreases, consumers and family members need to know well in advance the arrangement for community services or transfers to other facilities.

Every mental health system requires carefully balanced levels of care. That includes state hospitals for longer-term inpatient care, but consists primarily of crisis centers and short-term acute inpatient and intermediate care facilities in communities, as well as outpatient community services like Assertive Community

Treatment (ACT), supported housing, and independent living options.

Where community services are not available or are not sufficient to meet the need, the entire system backs up. Advocates report that waiting lists are growing and access to services is reduced. Consumers languish in hospitals beds at one level because there is a lack of available community services—or they are sometimes discharged without appropriate provisions for community care.

One way to balance the equation: have the real estate that remains after a hospital is closed remain "in trust" for people with serious mental illnesses. Proceeds from its sale, lease, or public-private redevelopment can be reinvested in the mental healthcare system.

As Pennsylvania moves into another round of hospital capacity reduction, it has an opportunity to become another keystone state in this regard. Land trusts are an opportunity for innovation.

It's also important for consumers and families to know how closures fit with proposed changes in the Medicaid system, and from a broad, statewide perspective, access to adequate care in rural areas. The state has a well-regarded Community Hospital Integration Program Project (CHIPP) to help support people in community settings after they make the transition.

Pennsylvania has made noteworthy strides in evidence-based practices (EBPs). The state has 20 ACT teams, and more in development. Although advocates report that most fail to meet national standards, approximately 10 are seeking fidelity to the EBP model. They are mainly in the Philadelphia metropolitan area. A few teams are devoted to transitional age populations—a novel application.

Pennsylvania has implemented a "PennMAPS" physician-prescribing decision making tool. Working off of the TMAP model from Texas, PennMAPS gives psychiatrists guidance on which medications to use and on improving quality of care and cost-effectiveness. It has structured and improved decision making in state facilities, but not taken root in communities, which rely on more informal provider and consumer education.

The state also is providing important support to the Pennsylvania Psychiatrist Leadership Council in order to help increase the recruitment and retention of psychiatrists for public sector and community practice.

Access to effective medication is a major concern. Under Medicaid, the state limits the number of medications a person can take each month—in spite of the fact that individuals with serious mental illnesses often have co-occurring medical conditions and side effects. Co-payments have been increased. The important issue of access to medications for people with serious mental illness is an area that advocates will continue to watch closely.

The state has an eye on improving mental healthcare within the correctional system, and there is growing interest in jail diversion programs. Allegheny County Forensic Services won the Innovations in Government Award for its state inmate re-entry program. The state is beginning to address the need to activate Medicaid benefits immediately after correctional stays. The initiative should be fast-tracked. Treatment is a key to preventing recidivism.

Going forward, Pennsylvania's transformations will require committed leadership, steady state investment, clarity of purpose—and most of all, balance. The Pennsylvania Web site was rated the worst in NAMI's Consumer and Family Test Drive. This presents a simple challenge for this prosperous state to remedy that embarrassing shortcoming. The state would do well to study North Carolina's experience to understand the risks of imbalance. Pennsylvania is a much larger and more diverse and complex state. If mistakes are made, the consequences will be proportionately greater.

Score Card: PENNSYLVANIA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	2	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	1	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	2	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	0	3
	32	SMHA-Division of Vocational Rehab	1	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	1	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Rhode Island

Grade: C

Category Grades

Infrastructure	**C-**
Information Access	**C-**
Services	**C+**
Recovery Supports	**C+**

Spending, Income, & Rankings

PC Spending/Rank	$88.75	21
PC Income	$30,302	18
Total MH Spending/Rank	$95 *(in millions)*	41
Suicide Rank		46

Recent Innovations

- EBP—ACT and supported employment penetration
- Uninsured population work

Urgent Needs

- Private sector—provider rates and supply
- Alternatives to hospitalization
- Spanish language workforce development
- Open formulary

Even in the face of a "dismal economic climate," there are many thoughtful practices and efforts happening today in Rhode Island. Rhode Island's system of care is the least like the Presidential Freedom Commission's "shambles" or a "patchwork" relic in the nation—there are points of accountability and access in eight clearly delineated catchment areas.

The state leads the nation in the development and deployment of Assertive Community Treatment (ACT) service, with 15 teams for a very small state. ACT is a Rhode Island Medicaid benefit, which is also a national model for improved access. The system is remarkably easy to understand, and the state's decision to combine its Medicaid division with the service delivery components may continue to reduce fragmentation, in one of the already least fragmented states.

The system is so easy to follow that the state can convey at a high level basic information to consumers and family members who call or use the internet. The state got a perfect curved score (top 20 percent of states) on our consumer family test drive, easily outpacing most other neighboring New England states. Rhode Island is doing something well in terms of streamlining its system and the way the state can explain it to the average person. Rhode Island is taking advantage of its history and manageable size to advance the field.

Money problems are never far from ruining the perfect day at the famed beaches here, however. The state 2004 block grant notes the following:

- "…The state budget is still under severe constraint and the public mental health operating system is still under acute pressure."
- "The system is still confronted with extremely high demand, driven in part by the almost complete unraveling of the private psychiatric healthcare system; many mental health providers will simply not accept private insurance, arguing that it costs more than they are reimbursed."
- The federal block grant cut of 6.8 percent was "the largest in the nation (Washington State was second at 3.4 percent)."

The state has some noteworthy structural advantages—it is physically tiny and has a little over a million

inhabitants, with minimal rural population. Size may help, but Rhode Island has much better evidence-based practices (EBPs) penetration than small New Hampshire, where the EBPs were developed, at Dartmouth. Rhode Island has reasonably good supported employment as well as ACT.

States need to look at their problems, gather information, and create responses. Rhode Island noted that much of the bed pressure they feel (and it is substantial) was driven by an uninsured population of young people with mental illness and substance abuse disorders. By figuring out who they were treating, the mental health providers were able to develop a program that reduced admissions in this population by devoting targeted outpatient resources to them. This is crucial, as Rhode Island runs without a free-standing state hospital—they are down to 104 continuing care beds.

A major concern in the state is the near-abandonment of the private sector, which naturally increases public demands. Reimbursement rates are low for practitioners taking insurance, so they are refusing to take it. This makes private mental healthcare increasingly a concern for the relatively well-off, and makes the concept of insurance parity a mockery. Cardiologists take insurance in Rhode Island. The link between depression and the heart fascinates researchers but does not move insurance panels here.

Recently, the Chief of Psychiatry at Eleanor Slater Hospital resigned in protest of the inappropriate placement of a sex offender who had completed his prison sentence. This raises serious questions about how the state is choosing to use its scarce mental health resources.

Mostly due to recent Hispanic immigration, Providence was recently named New England's second-largest city. Despite this growth, the cultural responsiveness and budget numbers to support programs for Hispanics in Rhode Island have not fared well in the past few years.

Federal cuts, state money woes, and providers opting out of the insurance market make for a complex blend of concerns here. Additional challenges for the Ocean state include the longest-running acting commissioner, at 18 months, and the complex dynamic of the large number of uninsured Rhode Islanders. The now-open pharmacy formulary must be preserved or—the state is at risk of losing its good score for access to the best medications.

In addition to the disappearing workforce on the private side, hospital beds and alternatives to hospitals are a problem in a state that has decided to lean so heavily on the private sector. This is a real test of leadership. Rhode Island's history suggests it will deliver and will openly show how they did it. Advocates will be watching.

Score Card: RHODE ISLAND

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	9	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	0	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	1	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	3	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	0	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	1	2

South Carolina

Grade: B-

Category Grades

Infrastructure	**B**
Information Access	**A**
Services	**D+**
Recovery Supports	**B**

Spending, Income, & Rankings

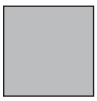
PC Spending/Rank	$67.18	32
PC Income	$24,811	43
Total MH Spending/Rank	$276 *(in millions)*	24
Suicide Rank		35 *(tied with Iowa)*

Recent Innovations

- Public-private partnerships to build capacity
- CMHC and primary healthcare facility collaborations for general healthcare services, including reciprocal agreements for "on-site staffing"
- Investment in consumer-run businesses

Urgent Needs

- Funding
- Close scrutiny of proposed Medicaid reforms
- Additional crisis care capacity
- Integrated treatment



Ask people familiar with South Carolina to rate the state's mental health system, and the answer you get is "average."

Still, the state has significant problems. Specifically, it has fared poorly in providing access to crisis and acute care treatment. Over the past several years, the South Carolina Department of Mental Health (DMH) has reduced the number of inpatient psychiatric beds it operates.

While these reductions originally represented a desire to provide more care in a community setting, in recent years the cuts have been budget-driven. DMH bed reductions went too far, leaving hospital emergency departments and local jails as the only alternative for many patients who need a state psychiatric hospital bed. Nearly 50 percent of DMH acute care beds, those intended for short stays, are now occupied by long-term patients who were displaced when the state started the process of closing the last of its long-term psychiatric hospitals.

DMH's waiting list for its forensic facility also has reached a length that is unacceptable, from both a legal and a patient care point of view. A recent surge in emergency admissions from jails (e.g., suicide risks) has decreased available beds for court-ordered, pre-trial evaluations and restorations to competency for trial.

While DMH to its credit appears to realize the shortcomings in the system, prospects for relief are uncertain. Governor Mark Sanford recently released his executive budget that funds a mere 30 percent of what the department requested. If the governor prevails, the crisis in hospital emergency rooms and jails will continue.

Since 2001, DMH has lost $30 million in funding—dropping below its 1998 level, even as the cost of programs increased by more than $45 million. Advocates support selling state-owned land near the primary state hospital and dedicating proceeds to the improvement of mental health services—but the governor instead is pushing to put them in the state's general fund.

The state also is taking aim at Medicaid.

South Carolina enjoys a federal match rate of approximately 70 percent on Medicaid expenditures, but is seeking reforms that would impose a cap on expenditures for each Medicaid beneficiary. Some analysts consider the proposals "the most radical changes ever made in a state Medicaid program." If a strict cap is adopted, the

state stands to suffer significant economic consequences—it would be prohibited from seeking additional funds in the event of a natural disaster, public health emergency, advances in medical technology and medicines, or expanding long-term care for an aging population.

Concern also exists as the state soon will be drafting reforms aimed at people with serious mental illnesses. Currently, the state plan goes beyond federal requirements to support Assertive Community Treatment (ACT) and peer specialists. There is no guarantee that these critical services will remain intact.

The state's existing Medicaid program also provides open access to medications for people diagnosed with mental illnesses—in spite of executive and legislative threats during the past two years to restrict access.

Open access is essential for effective treatment and recovery. To date South Carolina has held the line in preserving that commitment. Advocates see the issue as critical.

Despite its average reputation, South Carolina has made some commendable improvements in the system of care—which is all the more reason to protect it from radical reforms. Despite difficult budget cuts, DMH has demonstrated commitment to providing evidence-based practices (EBPs). Through agency leadership and consistent stakeholder advocacy, the state has developed and implemented ACT, supported employment programs, housing initiatives, and other programs that meet fidelity standards.

Another significant achievement was the legislature's passage of mental health insurance parity in 2005, which the governor chose to allow to become law without his signature.

Police and judges have supported better services and diversion programs for people with mental illnesses. Expansion of mental health courts and recent legislation authorizing diversion from incarceration for minor offenders with mental illness are promising developments.

DMH deserves credit for incorporating the findings of President Bush's New Freedom Commission into its operational approach—moving toward a focus on recovery and involvement of consumers and families in meaningful roles. The agency has adopted a strategic plan that lays the groundwork for significant, cost-effective improvements in the years ahead.

The wild card is whether the state's elected officials will support it.

Score Card: SOUTH CAROLINA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	10	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	0	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	1	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

South Dakota

Grade: F

Category Grades

Infrastructure	**F**
Information Access	**F**
Services	**D**
Recovery Supports	**F**

Spending, Income, & Rankings

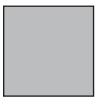
PC Spending/Rank	$65.89	35
PC Income	$27,756	32
Total MH Spending/Rank	$50 *(in millions)*	50
Suicide Rank		22

Recent Innovations

- Prescription feedback as an alternative to restricted access to medications
- Coordination between state mental health agency and correctional facilities in providing mental healthcare

Urgent Needs

- Funding
- Evidence-based practices
- Balanced community services and hospital capacity
- Provider shortages in rural communities



South Dakota ranks last in the nation in funding its mental health agency services. On a per capita basis, it ranks 35th.

There may be explanations that help to understand the status of its mental healthcare system. But it's hard to accept them. South Dakota can do better.

Geography is an understandable challenge. South Dakota is a rural frontier state, with a population density of approximately 10 people per square mile, compared to the national average of approximately 80. Most of the population is concentrated in the eastern third of the state. In rural areas, access to care is limited—a function of distance, as well as shortages of providers.

Still, other states face similar challenges.

The backbone of the state mental healthcare system is 11 community mental health centers (CMHCs) spread throughout the state, which are primarily accountable for implementation of programs and services. At the same time, the Division of Mental Health (DMH) in the Department of Human Services (DHS) plays a role in providing leadership, resources, and accountability—all of which are sometimes in short supply.

By DMH's own admission, the state is struggling to implement evidence-based practices (EBPs). Only Assertive Community Treatment (ACT) and integrated treatment for co-occurring mental illness and substance abuse are in place, and even these, according to advocates, fail to meet national standards. A response to the survey used in preparing this report suggested that no significant innovation has been implemented in the past three years, other than an indigent medication program. Progress seems to occur slowly and in very small steps.

South Dakota has one state hospital—in Yankton. Advocates report that it periodically stops taking voluntary admissions, because of a shortage of beds, and that there are long waiting lists for case management. On the other hand, the state reports progress in decreasing rates of readmission.

Every system requires balance. That includes state hospitals for longer-term inpatient care, but also requires crisis centers and short-term acute inpatient and intermediate care facilities in communities—and outpatient community services like ACT, supported housing, and independent living options. When community services are not available at one level, the system backs up. Waiting lists result.

Inadequate capacity reflects inadequate investment.

Located in the extreme southeastern part of the state, Yankton is not readily accessible as a provider for the needs of a majority of the state's citizens. Those who are hospitalized often are deprived of ready support from family and friends, which can be an important factor in recovery.

An estimated two people per week take their own lives in South Dakota. There are states in which the rate is higher, but the losses obviously hit families, friends, and communities hard. For the state's American Indians, the rate reaches "epidemic" proportions. For every fatality, the state also estimates that approximately nine people make non-fatal attempts. The state has a statewide suicide prevention strategy, but such strategies usually require support from community services within the overall mental healthcare system.

There are some positive notes.

In recent years, South Dakota has reduced the use of restraints and seclusion by approximately 50 percent.

The state also has preserved access to medication for consumers. It has maintained an open formulary for psychiatric medications and avoided limits on the number of prescriptions for Medicaid recipients. Instead, it is addressing poly-pharmacy and over-prescription concerns through a physician feedback program on prescribing habits.

The state has a mental health insurance parity law. Periodically, it is threatened by proposals to repeal health-related mandates—even though such laws primarily prohibit discrimination among benefits already offered. Any repeal would represent a step backward, rather than forward—hurting middle class families and pushing them into the public system, imposing additional costs to the state, as families are forced to spend down assets or go without care.

Overall, the future for mental healthcare in South Dakota is uncertain. Geography may be a challenge, but the state needs to prioritize and invest in evidence-based practices.

Score Card: SOUTH DAKOTA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	0	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	0	2
Information Access	9	Consumer & Family Test Drive (CFTD)	1	10
	10	Consumer & Family (CF) monitoring teams	0	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	2	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	0	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	0	2
	30	Olmstead Plan	1	2
Recovery Supports	31	Supported employment	1	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	1	4
	34	Efforts to reduce waiting lists for residential services	0	3
	35	Housing services coordinator	0	2
	36	Written plan for long-term housing needs	1	2
	37	Co-occurring disorders--No Wrong Door	1	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	1	2

Tennessee

Grade: C-

Category Grades

Infrastructure	**D**
Information Access	**A**
Services	**D**
Recovery Supports	**B**

Spending, Income, & Rankings

PC Spending/Rank	$87.22	22
PC Income	$27,016	37
Total MH Spending/Rank	$508 *(in millions)*	16
Suicide Rank		17

Recent Innovations

- Housing
- Foundation Associates integrated treatment
- Memphis CIT model
- Criminal justice liaison projects
- Peer Centers, peer education and support

Urgent Needs

- Funding
- Restore former TennCare benefits
- Open TennCare enrollment to all individuals with severe mental illness
- Open formulary for medications
- Provide funding for gaps in Medicare coverage
- Drop limit on number of prescriptions

Drastic cuts to Tennessee's Medicaid Program, TennCare, have dominated the public mental health landscape for the past year. These cuts to TennCare have caused people with severe mental illnesses to run up against sharp limitations in the treatment and services they can receive.

Since 1996, TennCare has provided services to Medicaid- and non-Medicaid-eligible individuals who are uninsured or considered uninsurable. TennCare Partners is the mental health component of TennCare. Faced with a significant budget deficit, Governor Phil Bredesen initiated reforms in 2005 that resulted in the elimination of 191,000 adults from TennCare rolls, with restrictions on coverage for an additional 396,000 persons. The legislature created a safety net for people with serious mental illnesses, so that they at least could receive basic medications and services. The Department of Mental Health and Developmental Disabilities (DMHDD) has worked diligently with providers and advocates to register adults with serious mental illness in the safety net as they were disenrolled from TennCare. However, the safety net service array and medication restrictions are limited, with the result that many individuals are left with inadequate treatment.

One bitter pill for TennCare beneficiaries is a limit of five prescriptions per month. Arbitrary limits hurt most those individuals with the most serious health problems or disabilities. People with mental illnesses often take medications for other medical problems such as hypertension, diabetes, or heart disease. Forcing doctors and consumers to choose between medications for schizophrenia and medications for other serious conditions represents malpractice by policymakers.

Another restriction that confounds logic and fairness is TennCare's new "preferred" drug list which limits the medications that can be prescribed to beneficiaries who in the future may be diagnosed with mental illnesses. Individuals with schizophrenia, bipolar disorder, or other serious mental illnesses will be required to begin treatment with low-cost "preferred" drugs. Between different patients, "preferred" drugs may not offer the same rate or degree of effectiveness, or absence of side effects. If they don't work, physicians and consumers will be required to jump through procedural hoops to get authorization for a "non-preferred" alternative—resulting in delays which from the outset may be

life-threatening. In most cases, there are no generic substitutes for psychiatric medications.

Experts who reviewed the 2005 drug formulary provisions strongly agreed that they were wrong-headed and dangerous. The TennCare Pharmacy Advisory Committee voted unanimously against the restrictions, but the governor ignored them. The sole psychiatrist on the committee, who resigned, warned: "I can't imagine a worse thing to do to mentally ill patients."

A major concern on the horizon is the apparent intention to transition to a carve-in model for TennCare behavioral health services. The mental health community has voiced strong opposition to a carve-in, fearing erosion of already inadequate behavioral health funds, additional costs of administration, and lack of service flexibility for implementing recovery and rehabilitation services. Despite this opposition, the state appears to be moving ahead with a Request for Proposals to implement the carve-in.

Trauma caused by TennCare changes was intensified with the rocky launch of the Medicare Pharmacy benefit. Even when they are listed on the rolls, low income consumers were subject to procedural barriers such as prior authorization or premium payment. One family member said, "We are tired, confused, and scared. For the past six months we have been knocking on every door. We have gotten red tape and run-around at every turn."

Sadly, the TennCare restructuring has cast a pall over what was once considered a good mental healthcare system moving in the right direction.

Tennessee has been a national leader in supportive housing. In 2000, the Department of Mental Health and Developmental Disabilities (DMHDD) established a "Creating Homes Initiative"(CHI), a partnership with local communities to provide housing options for people with serious mental illnesses. Employing seven regional facilitators throughout the state, CHI has been the catalyst for the creation or improvement of nearly 4,300 housing units.

CHI is an outstanding model that has put Tennessee near the top of states providing supported housing. It has been so successful that it spawned a "Creating Jobs Initiative" to increase employment opportunities for people with mental illnesses.

The Memphis Police Crisis Intervention Team (CIT) program has achieved national renown as a model program. Johnson County in East Tennessee recently established a second CIT program, and the state would do well to promote further replications. Tennessee has one mental health court in Davidson County (Nashville) and should establish more. Currently, there are 19 criminal justice liaison projects covering 24 of the state's 95 counties, aimed at improving coordination between the mental health and criminal justice systems—including the promotion of jail diversion.

Implementation of evidence-based practices (EBPs) in Tennessee has been slow but steady. Foundation Associates operates programs in Memphis and Nashville for co-occurring mental illnesses and substance abuse that are regarded as national models of excellence. Unfortunately, ACT programs exist only in those two cities. For a state the size of Tennessee, that is not nearly enough.

Tennessee has 49 consumer-run peer centers that implement peer recovery programs and co-occurring disorder support groups. In 1999, Tennessee was one of the first states in the nation to implement a statewide suicide prevention network, responding to the Surgeon General's Call to Action to Prevent Suicide. Unfortunately, as funding becomes more limited, maintenance and expansion of these forward-thinking initiatives is at risk.

Access to inpatient psychiatric treatment until recently was not a major problem, because of a federal waiver allowing the state to use Medicaid for hospitalizations. The waiver expired in 2004, however, and because of a general policy shift, the federal government will not renew it. Concerns now exist that there no longer will be enough psychiatric beds in the state for those who need them.

One Tennessee advocate has likened the state mental healthcare system today to "a grocery store full of food, but the people who need the food are locked out." The state has the knowledge base and national models of evidence-based practices that under different circumstances would make it a leader in setting a pace for national transformation. Unfortunately, TennCare cuts have made treatment and services inaccessible to many who need them.

At best, the 2005 cuts were shortsighted—"penny wise and pound foolish." Experience has shown that limiting access to care for people with serious mental illnesses only increases costs in other sectors of the community—such as emergency rooms, police operations, homeless shelters, and correctional facilities, not to mention losses in economic productivity.

Unless misguided decisions are reversed and new financial strategies adopted, Tennessee will be considered a tragedy, rather than a state of national promise.

Score Card: TENNESSEE

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	2	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	1	2
Information Access	9	Consumer & Family Test Drive (CFTD)	10	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	1	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	0	2
	19	Feedback to doctors on prescribing patterns	1	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	1	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	1	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	4	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	1	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Texas

Grade: C

Category Grades

Infrastructure	**C**
Information Access	**D**
Services	**B-**
Recovery Supports	**C**

Spending, Income, & Rankings

PC Spending/Rank	$39.02	47
PC Income	$27,887	29
Total MH Spending/Rank	$858 *(in millions)*	6
Suicide Rank		37 *(tied with Georgia)*

Recent Innovations

- TMAP model
- Disease management strategy for serious mental illnesses
- State-mandated jail programs in all counties
- Leadership in reducing use of restraints and seclusion

Urgent Needs

- Funding
- Inpatient beds

In January 2006, the University of Texas Longhorns won the national championship for college football. The likelihood of the Texas mental health system achieving a similar result is remote, but a chance of success makes rooting for the underdog worthwhile.

The stakes also are higher when human lives are involved.

Texas has an immense, difficult service environment. Its geography includes sprawling urban areas, small towns, rural expanses, and sparse frontier areas. Population is growing steadily. Approximately 35 percent are Latinos, and the state is expected to become a minority-majority state in the not-so-distant future.

Unfortunately, the mental healthcare system has been chronically underfunded. State-directed mental health spending per capita has ranked only 46th nationally. Adjusted for inflation, state appropriations for mental health have declined by 6 percent since 1981. For a state that has one of the largest uninsured populations in the country and a large number of immigrants without access to healthcare, Texas hasn't invested enough in the system to meet minimum levels of need.

But it's not because the state doesn't have the capacity to do so. It is a wealthy state, with significant oil, agriculture, and tourism revenues. The primary reason that the state lags behind is because its policymakers simply do not make caring for society's most vulnerable populations a priority.

In 2003, the state enacted legislation to bring about a fundamental shift in mental healthcare. State resources are now prioritized primarily to treat people with the most serious mental illnesses. Adults living with schizophrenia, bipolar disorder, or major depression receive services under a disease management approach—based on the premise that mental illness is best managed through extensive interventions, monitoring, and holistic strategies.

But extensive problems exist:

- Because of the priority given to people with serious mental illnesses, other consumers are required to seek services through a fragmented, non-profit social services network.

- Prior to 2002, Texas was nationally known for open access to medications and a disease management model, known as the Texas Medication Algorithm Project, (TMAP), which outlines levels of care. However, implementation in its current form has resulted in restrictions on some medications. A recent recommendation by the state's pharmacy and therapeutics committee might reverse this barrier to services.
- There is not enough capacity. Approximately 2,300 state hospital beds currently serve a population base of 22 million. Consumers are cycled in and out without regard to the length of stay actually needed for recovery goals. The forensic population—for whom hospitalization is required—has grown from 20 percent to 30 percent, which further restricts access.

Overall, capacity hinges on community services. Every mental health system requires carefully balanced levels of care. That includes state hospitals, but also crisis centers and short-term acute inpatient and intermediate care facilities in communities, as well as outpatient services like Assertive Community Treatment (ACT), supported housing, and independent living options. When community services are not available, the entire system backs up. Long waiting lists result. Overcrowding and shortages become commonplace.

Lack of capacity merely shifts costs. Emergency room visits and hospitalizations increase. Greater burdens fall on police, who are often the first responders during psychiatric crises, and on the criminal justice system.

Not surprisingly, the 2002 legislation mandated jail diversion programs for each of the state's 254 counties. They were desperately needed. In 2002, approximately 150,000 persons with serious mental illness received services from the state. Sadly, an equal number who once received such care had moved on to jails and prisons. Such programs are most successful, however, when effective community services are readily available.

Texas also has received national attention for Northstar, a collaborative behavioral health model that draws on several funding streams—including Medicaid and state appropriations—and contracts with providers through managed care behavioral health organizations. Established in the Dallas-Fort Worth area, the program incorporates data-driven decision making and healthcare management. Although plagued initially by lack of competition among providers and overutilization of hospital beds, Northstar has endured and inspired innovations elsewhere, such as New Mexico's Behavioral Health Purchasing Collaborative. Challenges still remain, however, such as waiting lists and difficulties in getting newer-generation psychiatric medications. Providers in certain parts of the state are opposed to its expansion.

Texas deserves special commendation in one area: The state is providing national leadership in seeking to eliminate the use of restraints and seclusion—through internal agency mandates and a statewide review that includes all agencies within the Texas Department of Health and Human Services (DHHS).

Texas may be an underdog, but this state bears watching.

Score Card: TEXAS

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	2	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	5	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	2	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	0	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	1	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	3	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	2	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	1	3
	32	SMHA-Division of Vocational Rehab	1	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Utah

Grade: D

Category Grades

Infrastructure	**D-**
Information Access	**C-**
Services	**D**
Recovery Supports	**D+**

Spending, Income, & Rankings

PC Spending/Rank	$70.91	29
PC Income	$23,714	48
Total MH Spending/Rank	$166 *(in millions)*	34
Suicide Rank		11 *(tied with Oregon)*

Recent Innovations

- CIT and mental health courts
- Family and consumer education
- Peer-to-peer education and support in correctional settings

Urgent Needs

- Funding
- Service capacities
- Providers in rural communities

NAMI traditionally has seen Utah as having tremendous potential for good. Former Governor Mike Leavitt is now the U.S. Secretary of Health & Human Services and is responsible for the implementation of President Bush's New Freedom Commission recommendations for transforming the mental health system nationwide. Senator Orrin Hatch, chairman of the U.S. Senate Judiciary Committee, has played an important role in the expansion of mental health courts and jail diversion programs nationally, and is a co-sponsor of national legislation for mental health insurance parity.

At national conventions, NAMI also has honored the LDS Church for introducing mental health parity in its health insurance coverage for church employees, and *The Deseret News* for outstanding news coverage of issues related to mental illness.

All of which makes the fact that the state is largely unprepared to meet the needs of residents all the more puzzling. A few key facts illustrate its deficiencies:

- When the federal government reduced Medicaid funds for Utah, the state did not make up the loss. Instead, policymakers cut $14.5 million out of community mental health centers in 2004—a reduction of about 10 percent. Approximately 4,500 consumers were expected to lose services.
- Despite major increases in population, the state has not expanded inpatient capacity in 30 years. In 2004, budget cuts eliminated 56 beds from the state's only psychiatric hospital; they eventually were restored, but the erratic commitment reflects the state's approach to treatment. Every system requires carefully balanced levels of care. When community services also are not readily available, the entire system backs up. Waiting lists reduce access. People languish because they can't be placed elsewhere. The problem is one of overall capacity.
- The state does not provide funds to local community mental health centers to secure inpatient beds for general acute care settings. Without resources, mental health professionals frequently are forced to weigh reimbursement issues against quality of care.

Utah's challenges mirror those of other rural and frontier states. There is a chronic shortage of healthcare professionals who want to practice in rural communities —and the Division of Substance Abuse and Mental Health (DSAMH) has particularly identified psychiatric nursing shortages as being at a crisis level. For most rural mental healthcare, the state must rely on general practitioners.

Under Leavitt's governorship, Utah received a federal Medicaid waiver which allowed expansion of healthcare coverage to include some groups, but had the effect of reducing benefits for many poor and disabled persons. Coverage for the new beneficiaries also did not include mental healthcare. Old or new, Medicaid beneficiaries ended up shortchanged. Advocates report that people who need mental heath services are now waiting longer to see providers and often ending up in emergency rooms or jails, imposing greater costs on local governments and the state.

Cost-shifting to the criminal justice system has had two effects. On the one hand, because of a shortage of forensic hospital beds, there is a waiting list for inmates who need mental healthcare. On the other, the state has begun investing in Crisis Intervention Teams (CIT) and mental health courts—though their success ultimately depends on community services being available.

More positive notes include that the state legislative leaders have steered clear of Medicaid policies that would limit access to psychiatric medications. However, consumer and family advocates should not take legislators' understanding of the consequences of such policies for granted.

Restricting access to medication shifts costs elsewhere. The real question is whether policymakers can resist short-term expediency. When it comes to psychiatric medicines, one size does not fit all. With few exceptions, generics do not exist. Side effects vary among different individuals. Some medications require weeks or months to take effect; impeding optimal physician-patient choices at the outset can lead to greater suffering and costs over time. The cost of an emergency room visit and hospitalization from one relapse can greatly exceed any per-person savings from a restricted formulary. That also assumes a person in psychiatric crisis gets help in time. The costs of suicide, homelessness, or prison are even greater.

- Despite lack of state leadership, the community mental health network is promoting consumer and family education, and shifting toward a more recovery-oriented system.
- The state has one of the lowest rates nationally in the use of restraints and seclusion.

Handholds of hope exist for the state to climb upward. Priorities identified by the state in a 2005 White Paper, "Current and Emerging Issues in Public Substance Abuse and Mental Health," represent a promising path toward progress—one that would match the state's traditional values of family and community. What is needed is for state leaders to commit to providing resources to match those hopes.

Score Card: UTAH

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	0	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	7	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	0	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	0	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	0	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	1	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Vermont

Grade: C-

Category Grades

Infrastructure	**C-**
Information Access	**D**
Services	**D**
Recovery Supports	**A**

Spending, Income, & Rankings

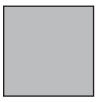
PC Spending/Rank	$152.35	4
PC Income	$29,186	23
Total MH Spending/Rank	$94 *(in millions)*	42
Suicide Rank		10

Recent Innovations

- Co-location and collaboration between Fletcher Allen and the state system
- Mental health insurance parity law
- Rehabilitation and recovery culture
- Consumer and family involvement

Urgent Needs

- Careful implementation of the Fletcher Allen-VSH transformation
- Long-term fiscal commitment to a system without a state hospital
- A written plan to ensure fidelity to ACT standards



Vermont stands at a critical juncture.

Traditionally, Vermont has excelled in clinical community care, integrating science into service, and adopting new models of care, as well as weaving consumer and family involvement into every level of the system. Its mental health insurance parity law is a national model that includes coverage of substance abuse. The state has a culture of rehabilitation and recovery.

It's an admirable record. The glaring exception has been the Vermont State Hospital (VSH) in Waterbury. The century-old hospital has lost federal certification twice, and a U.S. Department of Justice (DOJ) report in 2005 called the facility "dehumanizing" and "prison-like," in the course of cataloguing deficiencies in staff, psychiatric assessments, and risk- and quality-management systems, all of which translated into major safety concerns.

The DOJ report also exposed overuse of restraints and seclusion. Frequently, they were used for "staff convenience" or "punishment," as well as an intervention of "first resort," representing "gross departures" from good care.

To its credit, Vermont adopted an attitude of collaboration with DOJ to address the problems that were uncovered—in contrast to California, which has faced a similar challenge to one of its state hospitals. The state has contracted with Fletcher Allen Health Center at the University of Vermont to improve staff training, staffing levels, supervision, and quality of care.

Nonetheless, the VSH problems represented a failure of leadership at high levels, with consequences that are still unfolding.

The state is poised to develop a new facility on the campus of the Fletcher Allen Health Center in Burlington, which has potential to integrate medical services and reduce the stigmatizing isolation that marked VSH. Going from one state hospital to none, however, and working with a private hospital, brings potential risks as well as benefits. Co-location with an academic center offers opportunities for collaboration and workforce development, but many pieces will need to mesh to make it work—including common vision, community alternatives, and institutional cultures. It also requires the state legislature to make a long-term financial commitment.

An ominous sign recently arose when the City of Vergennes defeated a proposal by the Howard Center for Human Services and Addison County Counseling Service to run a former nursing home as a 10-bed sub-acute care facility under contract with the state. The proposal was part of the plan for satellite intermediate care facilities to supplement the new Fletcher Allen facility. The Vergennes city manager claimed no confidence in the state's commitment to the Fletcher Allen plan, although other major factors were involved, including the stigma that often attaches to mental illness.

Unfortunately, the Vergennes action was the second notable controversy involving stigma within a year to mar Vermont's reputation. In 2005, the Vermont Teddy Bear Company marketed a "Crazy for You" bear wrapped in a straitjacket, with "commitment papers" listing symptoms of mental illness, as a Valentine's Day gift. It sparked a national debate over stigma and trivialization of mental illness in popular culture. The company no longer manufactures or sells the bear, but its CEO was forced to resign from the Fletcher Allen board as a result of the controversy.

Reorganization of the state system comes at a time when Dr. Susan Wehry has left the Department of Health to become the Medical Director of the Department of Corrections. There is some irony in the move, if only as a warning.

If the Fletcher Allen reorganization doesn't work, many people with serious mental illnesses may end up in the corrections system—a tragic, cost-shifting phenomenon that occurs nationwide, but is nonetheless a sign of failure.

People expect better of Vermont.

Score Card: VERMONT

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	1	3
	6	Insurance parity for mental illness	2	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	1	2
Information Access	9	Consumer & Family Test Drive (CFTD)	5	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	0	2
	20	Integrated dual diagnosis treatment policies	1	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	2	3
	28	Reduction in use of restraints & seclusion	0	3
	29	Accreditation of state hospitals/facilities	0	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	3	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Virginia

Grade: D

Category Grades

Infrastructure	**D**
Information Access	**F**
Services	**D+**
Recovery Supports	**D+**

Spending, Income, & Rankings

PC Spending/Rank	$68.54	30
PC Income	$31,969	12
Total MH Spending/Rank	$496 *(in millions)*	18
Suicide Rank		32 *(tied with Michigan)*

Recent Innovations

- Governor Warner's $450 million investment initiative from state surplus
- Workforce development initiatives
- Jail diversion programs

Urgent Needs

- Full funding of the Warner proposal
- Increased implementation of EBPs across all CSBs
- Solution to private psychiatric bed crisis
- Culturally competent workforce
- Affordable, quality housing

In December 2005, Governor Mark Warner left office proposing a $460 million investment in the state's mental health system. That amount represented almost half of the state's $1 billion budget surplus.

Through the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS), $290 million would be used to replace four outdated state facilities, two psychiatric hospitals, and two training centers for individuals with developmental disabilities. The remaining $170 million would go toward upgrades in the community system. The investment is long overdue.

"If we miss this window, it might be another decade before we have a chance to do what we're going to be proposing today," Warner declared. The work, however, relies on the readiness of the Virginia General Assembly and Warner's successor, Governor Tim Kaine, to ensure appropriations.

Beneath the excitement and hope that Warner's announcement has inspired lies the reality that Virginia's public system has suffered from years of deep cuts that fell disproportionately on the community system. Traditionally, Virginia has bucked national trends by putting more emphasis on state inpatient psychiatric facilities than on community services—and the neglect is beginning to show.

DMHMRSAS requires the commonwealth's 40 Community Service Boards (CSBs) to deliver community services, but in FY 2003 alone, $12.5 million was cut from their budgets, resulting in elimination or consolidation of services and staff. The strain on CSBs shows in significant ways, including long waiting lists for services. In 2004, by the commonwealth's own conservative estimates, the CSBs have a combined waiting list of approximately 3,000 adults.

Housing for individuals with serious mental illnesses is in very short supply, with an average wait time of 42 weeks for supervised residential services. There is only one supported housing program. Advocates report that Virginia relies primarily on group homes, but many have checkered pasts of abuses and neglect. Additionally, Virginia has some of the lowest reimbursement rates in the country for group homes.

DMHMRSAS has worked to implement evidence-based practices (EBPs) such as Assertive Community

Treatment (ACT), supported employment, and integrated treatment for co-occurring disorders, but the budget crunch inevitably has affected progress. By DMHMRSAS's own admission, the use of EBPs is "very inconsistent statewide" and "the funding, licensing, and other infrastructure of the service system does not include incentives for providing EBPs."

Additionally, Virginia's ability to serve its growing population of ethnic and racial minorities has suffered because the state has shown no initiative on the issue of cultural competency. Virginia has not conducted a cultural competency assessment or developed a plan to meet the needs of minorities, who comprise nearly 30 percent of the state's total population.

Lack of short-term acute care beds for individuals in crisis is another major problem. In Northern Virginia, the commonwealth's most populous area, approximately 24 percent of the region's private bed capacity vanished in 2005 alone, due mostly to the closure of psychiatric wards at four different hospitals. Individuals in need of beds are transported downstate, resulting in trauma for the individual and diversion of local police officers, who must spend hours transporting people to areas as far away as Hampton Roads.

State hospitals have posed a different set of issues. In the 1990s, four out of 10 were under investigation by the U.S, Department of Justice (DOJ) for egregious violations of the rights of patients. Part of the remedy included creation of an Independent Office of Inspector General to conduct unannounced inspections and audits of public facilities and services for mental illness and developmental disabilities. Improvements have been sufficient for closure of the cases. Conditions will improve if the legislature approves Warner's proposal to transform Eastern and Western State Hospitals into state-of-the art facilities.

In addition to the Warner proposal, other sources of hope exist:

- Under Commissioner James Reinhardt, M.D., advocates believe DMHMRSAS has embraced a more recovery-oriented focus for its programs and policies. Continued, effective leadership in this regard and the necessary financial resources are critical to the system's improvement.
- DMHMRSAS has developed a comprehensive Workforce Development Plan and increased recruitment efforts for key occupations, along with establishing partnerships with educational institutions to offer additional training. It maintains a Workforce Development and Innovation Web site as a statewide resource.
- Some CSBs have partnered with local law enforcement to develop mental health courts and jail diversion programs. Fairfax County in Northern Virginia, the New River Valley in the state's rural southwest, and Virginia Beach in the southeast have developed especially strong programs.

Score Card: VIRGINIA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	3	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	1	2
Information Access	9	Consumer & Family Test Drive (CFTD)	3	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	1	3
	14	No restrictions for antipsychotic medications	3	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	2	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	0	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	1	4
	34	Efforts to reduce waiting lists for residential services	3	3
	35	Housing services coordinator	0	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Washington State

Grade: D

Category Grades

Infrastructure	**C-**
Information Access	**D**
Services	**D**
Recovery Supports	**D-**

Spending, Income, & Rankings

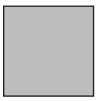
PC Spending/Rank	$91.01	19
PC Income	$31,647	14
Total MH Spending/Rank	$553 *(in millions)*	14
Suicide Rank		18

Recent Innovations

- Leadership commitment during 2005 budget crisis
- Mental health courts and jail diversion programs
- TSIG planning and coordination

Urgent Needs

- Funding
- Hospital beds
- Eliminate regional disparities in community services
- Increased RSN accountability
- Strong MHD leadership



In 2005, the Evergreen State averted disaster by significantly increasing state investment in its mental healthcare system.

Previously, Washington had relied to an unusual degree on federal Medicaid funds for mental health services. As federal Medicaid cuts kicked in, the system stared at an $82 million loss of funds over two years.

Governor Christine Gregoire, in partnership with key legislators such as House Speaker Frank Chopp, Representative Eileen Cody, and Senator James Hargrove, stepped into the breach and replaced the lost federal revenue with close to $80 million in state dollars.

Despite the 11th hour reprieve, mental health funding in the state "has not kept pace with healthcare inflation in recent years." The inevitable result has been an inadequate supply of services.

Management of the state system lies with the Washington Department of Social and Health Services, Mental Health Division (MHD), which contracts with 14 Regional Services Networks (RSNs) to provide inpatient and outpatient treatment and services under a managed care model. Despite its oversight responsibility, the MHD does not appear to have a complete handle on priorities and outcomes.

In its 2005 Mental Health Block Grant Plan submitted to the federal government, MHD acknowledged that it is "unable to clearly identify where funds are being spent, how much is spent on certain client groups, and whether funds provided are sufficient to accomplish the goals set forth in statute, rule and contract." The MHD was also unable to provide clear responses to the questions about evidence-based practices (EBPs) on our survey.

The problem, it appears, lies in lack of accountability to the state on the part of the 14 RSNs responsible for regional mental health services. The state thus has very limited oversight over regional services and does not even have a handle on what services are provided in specific regions. Although local control over mental health services may be appropriate, the state must play a critical role in setting standards, conducting oversight, and monitoring performance.

In an effort to address this problem, the Washington legislature in 2005 passed legislation establishing a more competitive process for selecting RSNs to manage regional mental health systems. Existing RSNs must demonstrate that they meet certain qualification

standards. If they cannot, the legislation requires a competitive bidding process. This process is underway, and six of 14 RSNs have not scored high enough to avoid competitive bidding.

There are also concerns in Washington State about a lack of hospital beds. Before 2005, Washington eliminated 150 beds from its two state psychiatric hospitals over several years, but less than half of the savings was reinvested in community-based mental health services. In 2005, the legislature imposed a moratorium on further reductions. Even so, a critical shortage exists. In 2003, 25 counties reported that they had no community inpatient or evaluation and treatment center beds for individuals in crisis or under civil commitment orders.

General hospital reductions or closures of psychiatric wards have exacerbated the problem. Lack of community-based services, including crisis prevention, also contributes to the shortage. Individuals often continue to occupy beds, because community services are not readily available, preventing them from being discharged.

Despite these significant problems, Washington is making progress in other areas.

Important initiatives are underway to improve the organization and coordination of services. Particularly interesting, but controversial, is the Washington Medicaid Integration Project, a pilot program in Snohomish County to integrate into one system medical care, mental health services, substance abuse treatment, and long-term care.

A federal Transformation State Incentive Grant (TSIG) will help facilitate comprehensive mental health services planning and coordination among key agencies, including medical assistance, housing, and vocational rehabilitation.

Washington also has moved commendably to decriminalize mental illness by developing alternatives to incarceration. Jail diversion programs are present in at least four counties. Five Mental Health Courts also exist. In addition, the legislature provided funds in 2005 for additional counselors to help facilitate timely restoration of Medicaid and Medicare benefits for individuals with mental illnesses leaving correctional facilities.

The state also is helping consumers find and maintain employment. It reports that supported employment services are available in 10 of the 14 RSNs, with Medicaid provided under a federal waiver. The state also is supporting consumer-run services, especially clubhouses.

If the leadership exhibited during the 2005 fiscal crisis extends into 2006, when the state has its first budget surplus in years, the Evergreen State will have an opportunity to make additional progress of a kind that could make it a national leader and heroic success story. It is an opportunity that should not be lost.

Score Card: WASHINGTON

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	4	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	1	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	0	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	1	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	2	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	0	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

West Virginia

Grade: D

Category Grades

Infrastructure	**D-**
Information Access	**B**
Services	**D+**
Recovery Supports	**D-**

Spending, Income, & Rankings

PC Spending/Rank	$48.74	45
PC Income	$23,146	49
Total MH Spending/Rank	$88 *(in millions)*	43
Suicide Rank		8

Recent Innovations

- Formation of the West Virginia Council for the Prevention of Suicide
- Strong involvement of families and consumers in planning process

Urgent Needs

- Funding for a historically undefended mental health system
- Implementation of EBPs
- Pre- and post-arrest diversion strategies for law enforcement

West Virginia, already plagued by a host of geographic and demographic impediments to effective treatment for mental illness, faces an uphill battle against emerging policies that may further threaten care in the state.

Dead last. That's the bottom line for the state of West Virginia when it comes to per capita expenditures of state-directed mental health services (SAMHSA, 2001). In the aggregate measurement, it is just as bad. The state ranked 50th in total state-funded expenditures the same year, despite the fact that the state is 37th in total population (US Census, 2000). The state of mental healthcare in West Virginia is so daunting that a mental health provider told NAMI that "this is the worst time for behavioral healthcare [in West Virginia] in the past 25 years."

It was in 2001 that the state emerged from the Hartley Consent Decree, a 1981 action brought by four residents of Huntington Hospital. The consent decree required federal supervision of West Virginia's Human Services Agency's part in providing consumers with constitutionally obligated behavioral healthcare.

In celebrating the exit from the decree, the West Virginia Behavioral Health Providers Association suggested that the pivotal issue of Hartley was "whether or not the state could support these people through alternative funding and support systems like Assertive Community Treatment (ACT) or Medicaid community-focused treatment teams." If this measure was the central point, then the state has failed miserably. As of 2005, the state lists only two operational teams for the entire state of West Virginia.

West Virginia still approaches behavioral health services without understanding the importance of holistic planning. The state has failed to learn from Hartley, and continues to develop services without adopting a coordinated approach based upon constituent needs and data evaluation. Advocates continue to push for coordinated planning and are advocating legislation to that effect in 2006.

For citizens of West Virginia, the challenges are daunting. The predominantly rural state ranks 48th in per capita income. Citizens with mental illnesses face a potential uphill battle in an environment with low provider availability, a significant community stigma

regarding mental illness, a high rate of substance abuse, and a suicide rate that ranks 8th nationally. The road to restoring the state's mental health system will be a difficult one. Based upon the priorities of current state leadership, the outlook is not good.

Among the serious challenges the state faces are:

Evidence-based practices—evidence-based practices other than ACT fare just as poorly. Measured against states with over 30 counties, practices such as supported housing, supported employment, and integrated dual-diagnosis treatment are scarce. While West Virginia has 55 counties, the most significant penetration achieved by any evidence-based service—supported employment—is six counties. This dispersion of programs suggests there is little access to proven supportive services for people living with mental illness in West Virginia.

Funding—While 90 percent of net patient revenue for community mental health centers in West Virginia is provided by Medicaid, the state legislature in 2005 underfunded Medicaid by $30 million. This resulted in a system loss of over $115 million—including federal contributions through Medicaid—through cuts to provider reimbursements. As a result, mental health consumers were affected by reduced provider availability and reduced services. And the impact of provider rate cuts piled on an estimated reduction of $31 million over three years when the state implemented Medicaid managed care and reduced outlays in support of clinic services, rehabilitation, and targeted case management.

Medications—The state legislature, executive leadership, and Medicaid advisory bodies have rebutted numerous attempts by advocates and provider organizations to overturn restrictive policies that minimize access to needed psychotropic medications. Two pieces of legislation have been introduced in 2006 to address this shortcoming in the state Medicaid program (HB 2046 and HB 2216).

Medicaid—West Virginia recently has stated its intent to make significant modifications to its Medicaid program. The basis of the proposal includes commitment to personal responsibility and greater cost-sharing. For consumers categorically eligible for Medicaid due to disability, early drafts of the plan suggest a broad benefit design with an emphasis on disease management. However, the proposal also seeks consumer-driven care authority which would reward "preferred behaviors" (West Virginia Comprehensive Medicaid Redesign Proposal, May 2005). This poses many risks for people living with mental illness. Consumers might choose to ignore psychiatric symptoms and avoid emergency treatment due to the higher co-pays assigned to emergency department care. Or, recipients might choose less effective medications due to co-pay structures that penalize recipients for using certain branded medications—even when the more expensive medicines are more effective for a given patient.

Housing—Housing currently is monitored on a regional level without the state having direct oversight or planning authority for identification of public housing opportunities. The availability of housing and levels of supported housing vary widely across the state (State response to NAMI survey).

Still, there are positive signs for the state as it goes forward:

Openness—The Bureau for Behavioral Health and Health Facilities does deserve credit for attempts to bring consumers and family members to the table for future decision making and planning. Support is evident for family and peer education from the Bureau. Additionally, the state employs external advocates at both state-operated hospitals to monitor conditions. These examples are promising and must be applied to the entire mental health system if the state is going to reverse its current course.

Diversion—The state's law enforcement community is directly aware of the consequences of untreated mental illness. In 2005, more than 40 law enforcement representatives attended a summit on developing pre- and post-arrest jail diversion strategies. The meeting is a potential starting point for the state to adopt proven diversion programs; however, there has been little progress made since the initial meeting. This meeting follows on the heels of the state's Healthy People 2010 report. The report suggests that the state is working to reduce the number of individuals jailed for minor offenses due to psychiatric conditions by 10 percent by 2010. In 2000, 543 people met those criteria. The 2010 report also calls for all West Virginia State Police Academy graduates to have 40 hours of training in

mental health issues, far more then the current four hours. A review of the curriculum posted on the Police Academy website suggests these changes have not been incorporated.

Staffing—West Virginia also deserves accolades for taking reasonable first steps to address the state's chronic shortage of mental health professionals. Using Rural Health Education Partnerships, the state has successfully implemented mental health-specific modules into medical student rotations. This effort is noteworthy in light of state research that shows a majority of West Virginians living with mental illness seek treatment through general practitioners.

There are several important steps West Virginia can take to improve the state's mental health system:

- West Virginia state leaders must challenge local and county officials to operationalize the lessons learned from a 2005 summit on pre-and post -arrest jail diversion.
- West Virginia must expand implementation of evidence-based practices far beyond its currently sparse distribution across the state.
- West Virginia must adopt a coordinated planning approach based upon constituent needs and data evaluation.
- West Virginia must ensure that any newly crafted Medicaid program does not include pay structures that cause those with mental illnesses to choose not to seek treatment or appropriate medications.

Score Card: WEST VIRGINIA

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	1	2
	5	Workforce development & strategic plan	0	3
	6	Insurance parity for mental illness	1	2
	7	Cultural competence assessment & plan	0	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	10	10
	10	Consumer & Family (CF) monitoring teams	1	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	2	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	1	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	1	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	0	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	0	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	2	3
	26	Restoration of benefits post-incarceration	1	2
	27	Psychiatric inpatient bed access	2	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	0	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	0	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Wisconsin

Grade: B-

Category Grades

Infrastructure	**C**
Information Access	**D**
Services	**B+**
Recovery Supports	**B+**

Spending, Income, & Rankings

PC Spending/Rank	$90.98	20
PC Income	$29,336	21
Total MH Spending/Rank	$498 *(in millions)*	17
Suicide Rank		28 *(tied with Alabama)*

Recent Innovations

- Statewide expansion of CSP
- CCS for clients between CSP and traditional outpatient care
- Broad community services reduce need for state hospitalization

Urgent Needs

- Outcome studies of CSPs and managed care
- Stronger CCS focus; commitment and monitoring over time
- State support and coordination for counties with underdeveloped service systems

Wisconsin is nationally distinguished as the birthplace of both NAMI and Assertive Community Treatment (ACT), and known locally for its strong network of consumer advocates, but its mental healthcare system still has weaknesses, as well as strengths.

The system is county-based. Some advocates believe it is too decentralized, with the state not providing enough financial support—particularly to counties with underdeveloped systems. At the same time, the state has limited ability to control care locally and quality of services varies across the state.

The Bureau of Mental Health and Substance Abuse Services (BMHSAS) is located inside the Division of Disability and Elder Services, which itself is a subdivision of the Department of Health and Family Services. Finances for mental healthcare are primarily controlled elsewhere—by the Division of Healthcare Financing and by the individual counties. This structure leaves BMHSAS facing barriers to controlling mental health expenditures, along with a bureaucratic view that counties are the state's primary customers—rather than people with serious mental illnesses.

Nonetheless, the county-based system is effective at reducing demand for state hospital admissions. Every system requires balanced options. Broad community services in Wisconsin get credit for the fact that no significant waiting lists exist for state inpatient hospital care.

The vision shown by the state leadership has been mixed with disappointments. To his credit, Governor Jim Doyle recently vetoed legislation that would have increased co-pays on Medicaid prescriptions and placed artificial limits on the total number of prescriptions. On the other hand, the governor vetoed a requirement that the state's new SSI managed care programs report on progress and outcomes to the legislature—effectively eliminating oversight of changes, and an opportunity to spot design errors in pilot programs.

In reporting on ACT use, BMHAS states that its community support programs (CSPs) are the equivalent of ACT. This is not true—a disappointing misconception for the state in which ACT began.

- ACT inspired CSPs, but they are not equivalent. CSPs do not meet ACT national standards. ACT teams have no more than 8-10 clients per staff member; 75 percent or more of services are

delivered outside program offices; and peer specialists are required. Wisconsin's CSP standards require only that 50 percent of services be delivered outside the office and the client ratio is 1:20. There are no requirements for peer specialists.

- Although CSPs are not the same as ACT, they do have some of the right ingredients and are well supported by the state. They deserve close study of their actual effectiveness. CSPs are present in all but 10 rural counties, and the state goal is to add programs in one county per year for the next three years. At last count there were approximately 80 certified CSPs, serving 5,500 persons with serious mental illness at a cost of about $10,000 per client.

- The state has created a new Medicaid benefit—Comprehensive Community Services (CCS)—designed to help consumers who don't require the intensity of CSP, but still need more assistance than general outpatient treatment provides. Unfortunately, the population served by CCS is poorly defined, with only vague definitions of the individuals to be served and no system-wide outcome measures. Advocates are concerned that these factors will cause the program to be simply eliminated, before it ever is adequately and uniformly implemented.

Overall, Wisconsin has a strong foundation built on community services. As the state continues to move forward, it is a model for the nation.

Score Card: WISCONSIN

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	1	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	2	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	1	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2
Information Access	9	Consumer & Family Test Drive (CFTD)	5	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	2	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	3	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	2	2
	17	Interagency cooperation between SMHA & Medicaid	2	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	3	3
	22	Written ACT fidelity standards	2	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	0	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	2	2
	27	Psychiatric inpatient bed access	3	3
	28	Reduction in use of restraints & seclusion	3	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	2	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	2	2
	36	Written plan for long-term housing needs	2	2
	37	Co-occurring disorders--No Wrong Door	2	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Wyoming

Grade: D

Category Grades

Infrastructure	**D**
Information Access	**C+**
Services	**D**
Recovery Supports	**D+**

Spending, Income, & Rankings

PC Spending/Rank	$103.27	16
PC Income	$31,149	16
Total MH Spending/Rank	$51 *(in millions)*	49
Suicide Rank		1

Recent Innovations

- Medicaid-funded disease management strategy

Urgent Needs

- Suicide prevention strategies
- Mental health insurance parity
- Implementation of EBPs while adhering to model standards
- Funding

Perhaps one indicator reveals more about the state of mental health treatment in the state of Wyoming than any other: Wyoming's rate of suicide is the country's highest, nearly twice the national average. The state legislature and Department of Health have responded to this community black-eye by creating a suicide prevention task force, mandating a prevention plan, and working collaboratively with Wyoming communities to develop local solutions. The plan includes all the appropriate strategies for addressing the crisis; however, the state has yet to demonstrate the political will to provide the needed resources to address the plan's recommendations.

Mental health advocates won an important victory in this state in early 2006 when a settlement was reached between the state and Wyoming Protection and Advocacy, Inc. (WPA). The ruling allows WPA "unaccompanied access to the State Hospital without advance notice when there is reason to believe that abuse or neglect has occurred or might occur."

This most recent ruling comes on the heels of a 2002 agreement to end the *Chris S. v. Jim Geringer* case of 1995. The case was initiated due to poor conditions at the Wyoming State Hospital. As part of the exit agreement, the state of Wyoming was required to develop a comprehensive community-based system of care and improve the standard of care for inpatient care at the state hospital.

Mental health services in the state are provided through a network of community mental health centers. Fifteen centers provide services for the state's 23 counties. Though not ideal, this network is a credible attempt at statewide care for this predominantly frontier state. Acknowledging the challenges of running a community-based system of care in a state with a population density of 4.6 persons per square mile, the state has prioritized engagement of general practitioners and allied healthcare workers as an important need for the state mental health system.

One area where Wyoming is a national model is in that of balancing fiscal constraints in Medicaid spending without compromising quality of care for participants. Using disease management techniques for all state Medicaid participants, the approach successfully curbed program spending without taking action to alter eligibility standards or available benefits.

The state's Medicaid program has carved out behavioral health services and contracted with APS Healthcare to provide mental health case management. APS has elected to provide disease management services for people living with depression who receive services through the state Medicaid program. The state's Medicaid program has also acknowledged the importance of access to a full selection of psychotropic medications by stopping short of implementing preferred drug lists and prior authorization for mental health medications.

Interaction between people with mental illness and law enforcement deserves special scrutiny in the state of Wyoming. One in four prisoners in the Wyoming correctional system receives mental health therapy, one of only four states to demonstrate such a high level of penetration. And, as recently as 2001, the state offered no special psychiatric facilities within the correctional system. Conditions in the state correctional system were so severe that the United States Department of Justice (DOJ) initiated an investigation under the Civil Rights of Institutionalized Persons Act (CRIPA) that led to specific mandatory improvements in the mental health services within the Department of Corrections.

The state has made progress across the community system of care in developing services that, at the surface, appear to be evidence-based practices (EBPs). With the exception of Assertive Community Treatment (ACT), the local community mental health centers have created numerous supported employment programs and illness self-management programs. ACT exists in two locations, but the state acknowledges that the programs are merely "ACT-like" and states that ACT programs are "too difficult to staff in a frontier state."

The state is appropriately skeptical of its own success in implementing these EBPs, stating in a recent block grant that "we rather glibly apply names to some services we purchase or supply, but really have little experience at monitoring fidelity or measuring well-defined and targeted outcomes."

In the broader policy context, the state can make an important step forward by passing a mental health parity bill. Wyoming is one of two states nationally that has not even added a non-binding mandate to the state legislative codes. Passing parity would not only be a significant anti-stigma statement, but for a state with a very modest unemployment rate of 3.2 percent, parity could free up state resources for providing care to the most vulnerable populations.

Improvement for this state is possible. A mental health administrator in the state reported that the legislature was contemplating a 50 percent increase to community service agencies as part of its 2006-07 legislative session. According to the administrator, a select committee is driving this effort and will continue to do so until the system is "transformed." This is welcome news and, if it becomes reality, the state could be a rising star in future report card efforts.

Score Card: WYOMING

Category		Criteria	Actual Score	Possible Score
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3
	2	Demonstrated innovation	2	2
	3	Health disparities program	0	2
	4	Studies regarding causes of death	2	2
	5	Workforce development & strategic plan	2	3
	6	Insurance parity for mental illness	0	2
	7	Cultural competence assessment & plan	2	2
	8	Unduplicated count & breakdown by race/ethnicity	0	2
Information Access	9	Consumer & Family Test Drive (CFTD)	9	10
	10	Consumer & Family (CF) monitoring teams	2	2
	11	Written mandate ensuring CF input	0	2
	12	CF involvement in EBP implementation	1	2
Services	13	No outpatient mental health co-pays	0	3
	14	No restrictions for antipsychotic medications	2	3
	15	No restrictions on prescriptions per month	3	3
	16	Benefit-service identification program	0	2
	17	Interagency cooperation between SMHA & Medicaid	1	2
	18	Wraparound coverage for benzodiazepines	2	2
	19	Feedback to doctors on prescribing patterns	2	2
	20	Integrated dual diagnosis treatment policies	2	3
	21	Assertive Community Treatment (ACT) teams	1	3
	22	Written ACT fidelity standards	0	2
	23	Family psychoeducation - SAMHSA model	2	2
	24	Illness management & recovery - SAMHSA model	1	2
	25	Jail diversion programs	1	3
	26	Restoration of benefits post-incarceration	0	2
	27	Psychiatric inpatient bed access	1	3
	28	Reduction in use of restraints & seclusion	2	3
	29	Accreditation of state hospitals/facilities	2	2
	30	Olmstead Plan	2	2
Recovery Supports	31	Supported employment	3	3
	32	SMHA-Division of Vocational Rehab	2	2
	33	Supported housing	3	4
	34	Efforts to reduce waiting lists for residential services	2	3
	35	Housing services coordinator	0	2
	36	Written plan for long-term housing needs	0	2
	37	Co-occurring disorders--No Wrong Door	0	2
	38	Financial-logistical support Family-to-Family education program	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	2

Explanation of State Narrative Tables Listing Spending and Rankings

For the table, entitled "Spending, Income, and Rankings," that accompanies each state narrative in this section of this report, the following is an explanation of the figures cited.

The first item, "PC MH spending / rank," indicates the per capita spending on mental health in that state and where that spending ranks the state nationally. The data given in this and the third item noted below are taken from the National Association of State Mental Health Program Directors Research Institute and include all 50 states plus the District of Columbia for 2003, the most recent year available.

The second item, "PC income / rank," indicates the state's per capita income and where that figure ranks the state nationally. This information is derived from U.S. Census Bureau data on Personal Income Per Capita for the year 2003, the most recent year available.

The third item, "Total MH spending / rank," indicates the total spending on mental health in the state.

The fourth item, "Suicide rank," indicates where the state ranks nationally according to the rate of reported suicides per 100,000 people in the year 2002, the most recent year available. The rank of 51, for example, indicates the lowest suicide rate. The data on which this ranking is based are derived from the National Vital Statistics Reports 2004 issued by the National Center for Health Statistics of the Centers for Disease Control.

List of Abbreviations

ACT	Assertive Community Treatment
CARF	Commission on Accreditation of Rehabilitation Facilities
CFTD	Consumer and Family Test Drive
CIT	Crisis Intervention Training
CMHC	Community Mental Health Centers
CMHS	Center for Mental Health Services
CRIPA	Civil Rights of Institutionalized Persons Act
EBP	Evidence Based Practice
IDDT	Integrated Dual Diagnosis Treatment
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
NASMHPD	National Association of State Mental Health Program Directors
NIMH	National Institute of Mental Health
PATH	Project to Assist the Transition from Homelessness
SAMHSA	Sustance Abuse and Mental Health Services Administration
SMHA	State Mental Health Authority
SMI	Serious Mental Illness
SSDI	Supplimental Security Disability Income

List of References

(*Addresses of state mental health authority Web sites and of state mental health block grant URLs are listed separately at the end of this reference list.*)

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Block Grant Section

Addresses of state mental health authority Web sites and of state block grant URLs are listed here.

Alabama Department of Mental Health and Mental Retardation, Division of Mental Illness
Web site: http://www.mh.state.al.us/services/mi/mi-main.html
Block Grant: http://www.mh.state.al.us/admin/downloads/MI/MI_AlabamaMentalHealthServicesBlock GrantApplication_50302.doc

Alaska Division of Behavioral Health
Web site: http://www.hss.state.ak.us/dbh/
Block Grant: http://www.hss.state.ak.us/dbh/PDF/block_grant_06.pdf

Arizona Department of Behavioral Health Services
Web site: http://www.azdhs.gov/bhs/
Block Grant: http://www.azdhs.gov/bhs/bg2006.pdf

Arkansas Division of Mental Health Services
Web site: http://www.arkansas.gov/dhhs/dmhs/

California Department of Mental Health
Web site: http://www.dmh.cahwnet.gov/

Colorado Division of Mental Health Services
Web site: http://www.cdhs.state.co.us/ohr/mhs/index.html
Block Grant: http://www.cdhs.state.co.us/ohr/mhs/BlockGrant/ColoradoCMHSBlockGrant_FY05-07_Final.pdf

Connecticut Department of Mental Health and Addiction Services
Web site: http://www.dmhas.state.ct.us/
Block Grant: http://www.dmhas.state.ct.us/OPPAS/blockgrants.htm

Delaware Division of Substance Abuse and Mental Health
Web site: http://www.dhss.delaware.gov/dhss/dsamh/index.html

District of Columbia Department of Mental Health
Web site: http://dmh.dc.gov/dmh/site/default.asp

Florida Division of Substance Abuse and Mental Health
Web site: http://www.dcf.state.fl.us/mentalhealth/
Block Grant: http://www.dcf.state.fl.us/mentalhealth/bg/index.shtml

Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases
Web site: http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/
Block Grant: http://mhddad.dhr.georgia.gov/DHR-MHDDAD/DHR-MHDDAD_CommonFiles/MHBG05March.pdf

Hawaii Mental Health Division
Web site: http://www.hawaii.gov/health/mental-health/
Block Grant: http://amh.health.state.hi.us/Public/REP/Planning/BlockGrant2005.htm

Idaho Bureau of Mental Health and Substance Abuse
Web site: http://www.healthandwelfare.idaho.gov/site/3458/default.aspx
Block Grant: http://www.healthandwelfare.idaho.gov/_Rainbow/Documents%5Chealth/adult_child_implementation_plan_fy2003.pdf

Illinois Office of Mental Health
Web site: http://www.dhs.state.il.us/mhdd/mh/
Block Grant: http://www.dhs.state.il.us/mhdd/mh/sri/docs/Final2006MentalHealthBlockGrantApplication.pdf

Indiana Mental Health Services
Web site: http://www.in.gov/fssa/servicemental/
Block Grant: http://www.in.gov/fssa/servicemental/pdf/2005BlockGrantAppl.pdf

Iowa Division of Mental Health and Developmental Disabilities
Web site: http://www.dhs.state.ia.us/mhdd/
Block Grant: http://www.medicine.uiowa.edu/ICMH/BlockGrantWork.htm

Kansas Mental Health and Substance Abuse Treatment and Recovery
Web site: http://www.srskansas.org/services/mhsatr_mental-health.htm
Block Grant: http://www.srskansas.org/hcp/MH/blockgrant2006.pdf

Kentucky Department for Mental Health and Mental Retardation Services
Web site: http://mhmr.ky.gov/kdmhmrs/default.asp
Block Grant: http://www.mhmr.ky.gov/mhsas/files/KMHS%20Block%20Grant%20Application%202006.pdf

Louisiana Office of Mental Health
Web site: http://www.dhh.state.la.us/offices/?ID=62
Block Grant: http://www.dhh.state.la.us/offices/publications.asp?ID=62&Detail=891

Maine Behavioral and Developmental Services
Web site: http://www.maine.gov/dhhs/bds/

Maryland Department of Health and Mental Hygiene
Web site: http://www.dhmh.state.md.us/

Massachusetts Department of Mental Health
Web site: http://www.mass.gov/dmh
Block Grant: http://www.mass.gov/Eeohhs2/docs/dmh/state_mental_health_plan_05_07.pdf

Michigan Department of Community Health
Web site: http://www.michigan.gov/mdch/0,1607,7-132-2941---,00.html
Block Grant: http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_4902-125922--,00.html

Minnesota Department of Human Services, Mental Health Division
Web site: http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/DHS_id_000085.hcsp
Block Grant: http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_003495.hcsp#FBG2005

Mississippi Department of Mental Health
Web site: http://www.dmh.state.ms.us/
Block Grant: http://www.dmh.state.ms.us/pdf/fy06stateplan_adult.pdf

Missouri Department of Mental Health
Web site: http://www.dmh.missouri.gov/
Block Grant: http://www.dmh.missouri.gov/cps/rpts/blockgrant/blockgrant.htm

Montana Addictive and Mental Disorders Division
Web site: http://www.dphhs.mt.gov/mentalhealth/index.shtml
Block Grant: http://www.dphhs.mt.gov/mentalhealth/adult/performancepartnership.shtml

Nebraska Mental Health Services
Web site: http://www.hhs.state.ne.us/beh/mh/mh.htm
Block Grant: http://www.hhs.state.ne.us/beh/mh/NE_MH_BLOC_2006.pdf

Nevada Division of Mental Health and Developmental Services
Web site: http://mhds.state.nv.us/mh/index.shtml
Block Grant: http://mhds.state.nv.us/pdfs/CMHSBlockGrantAppFY2006.pdf

New Hampshire Bureau of Behavioral Health
Web site: http://www.dhhs.state.nh.us/DHHS/BBH/default.htm

New Jersey Division of Mental Health Services
Web site: http://www.state.nj.us/humanservices/dmhs/index.html
Block Grant: http://www.state.nj.us/humanservices/dmhs/BLOCK-GRANT%20YRS%2005-07.pdf

New Mexico Behavioral Health Collaborative
Web site: http://www.state.nm.us/hsd/bhdwg/

New York State Office of Mental Health
Web site: http://www.omh.state.ny.us/

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Web site: http://www.dhhs.state.nc.us/mhddsas/

North Dakota Mental Health Services
Web site: http://www.nd.gov/humanservices/services/mentalhealth/

Ohio Department of Mental Health
Web site: http://www.mh.state.oh.us/
Block Grant: http://www.mh.state.oh.us/cmtypolicy/blockgrant/blockgrant.html

Oklahoma Department of Mental Health and Substance Abuse Services
Web site: http://www.odmhsas.org/
Block Grant: http://www.odmhsas.org/mhblockgrant.htm

Oregon Office of Mental Health and Addiction Services
Web site: http://www.oregon.gov/DHS/mentalhealth/index.shtml
Block Grant: http://www.oregon.gov/DHS/mentalhealth/publications/main.shtml#blokgrnts

Pennsylvania Department of Public Welfare, Mental Health Services
Web site: http://www.dpw.state.pa.us/Disable/MentalHealthServices/
Block Grant: http://www.dpw.state.pa.us/Resources/Documents/Pdf/AnnualReports/BlockGrantApp06-07.pdf

Rhode Island Department of Mental Health, Retardation and Hospitals
Web site: http://www.mhrh.state.ri.us/
Block Grant: http://www.mhrh.state.ri.us/governor_council_bh/blgrant_app2005.pdf

South Carolina Department of Mental Health
Web site: http://www.state.sc.us/dmh/
Block Grant: http://www.state.sc.us/dmh/spc2005_stateplan.pdf

South Dakota Division of Mental Health
Web site: http://www.state.sd.us/dhs/dmh/index.htm
Block Grant: http://www.state.sd.us/dhs/dmh/FY05-07%20State%20Plan.pdf
Block Grant: http://www.state.sd.us/dhs/dmh/StateplanmodFFY05-07.pdf

Tennessee Department of Mental Health and Developmental Disabilities
Web site: http://www.state.tn.us/mental/index.html
Block Grant: http://www.state.tn.us/mental/MHBGA.html

Texas Department of State Health Services
Web site: http://www.dshs.state.tx.us/mentalhealth.shtm
Block Grant: http://www.dshs.state.tx.us/mhprograms/MHBG06.pdf

Utah Division of Mental Health
Web site: http://www.hsmh.state.ut.us/

Vermont Department of Health, Mental Health Division
Web site: http://www.healthyvermonters.info/ddmhs/index.shtml
Block Grant: http://www.healthyvermonters.info/ddmhs/docs/adult/MHAdultFY05BlockGrantapplication.pdf

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
Web site: http://www.dmhmrsas.virginia.gov/
Block Grant: http://www.dmhmrsas.virginia.gov/OMH-BlockGrant.htm

Washington State Mental Health Division
Web site: http://www1.dshs.wa.gov/mentalhealth/
Block Grant: http://www1.dshs.wa.gov/pdf/hrsa/mh/2006_MHBG_Plan_FINAL_for_PUBLIC.pdf

Wisconsin Department of Health and Family Services, Community Mental Health Services
Web site: http://dhfs.wisconsin.gov/mh_bcmh/
Block Grant: http://www.mhc.state.wi.us/BlockGrant/BG06Intro.htm

West Virginia Office of Behavioral Health Services
Web site: http://www.wvdhhr.org/bhhf/
Block Grant: http://www.wvdhhr.org/bhhf/pdfs/block_grant/2006_block_grant.pdf

Wyoming Department of Health, Mental Health Division
Web site: http://mhd.state.wy.us/

Appendix

NAMI Grades the States National Score Card

Category		Criteria	AK	AL	AR
Infrastructure	1	Prioritizing services -- Severe & Persistent Mental Illnesses (SPMI)	3	3	2
	2	Demonstrated innovation	2	2	2
	3	Health disparities program	0	1	0
	4	Studies regarding causes of death	1	2	0
	5	Workforce development & strategic plan	1	1	0
	6	Insurance parity for mental illness	0	0	1
	7	Cultural competence assessment & plan	1	2	2
	8	Unduplicated count & breakdown by race/ethnicity	2	2	1
Information Access	9	Consumer & Family Test Drive (CFTD)	8	1	1
	10	Consumer & Family (CF) monitoring teams	2	2	0
	11	Written mandate ensuring CF input	0	1	0
	12	CF involvement in EBP implementation	2	2	2
Services	13	No outpatient mental health co-pays	2	3	3
	14	No restrictions for antipsychotic medications	3	1	3
	15	No restrictions on prescriptions per month	2	1	2
	16	Benefit-service identification program	1	2	1
	17	Interagency cooperation between SMHA & Medicaid	2	2	2
	18	Wraparound coverage for benzodiazepines	2	2	2
	19	Feedback to doctors on prescribing patterns	2	2	2
	20	Integrated dual diagnosis treatment policies	0	1	2
	21	Assertive Community Treatment (ACT) teams	0	2	1
	22	Written ACT fidelity standards	0	2	0
	23	Family psychoeducation - SAMHSA model	1	1	1
	24	Illness management & recovery - SAMHSA model	0	1	0
	25	Jail diversion programs	2	1	1
	26	Restoration of benefits post-incarceration	0	0	0
	27	Psychiatric inpatient bed access	1	1	1
	28	Reduction in use of restraints & seclusion	3	2	2
	29	Accreditation of state hospitals/facilities	2	1	2
	30	Olmstead Plan	1	2	2
Recovery Supports	31	Supported employment	2	0	1
	32	SMHA-Division of Vocational Rehab	0	0	2
	33	Supported housing	4	4	2
	34	Efforts to reduce waiting lists for residential services	1	2	0
	35	Housing services coordinator	2	2	2
	36	Written plan for long-term housing needs	2	1	0
	37	Co-occurring disorders--No Wrong Door	2	0	2
	38	Financial-logistical support Family-to-Family education program	1	2	2
	39	Financial-logistical support Peer-to-Peer education program	2	0	2

NAMI Grades the States National Score Card

Category	Criteria	AZ	CA	CO	CT	DC	DE	FL	GA	HI	IA	ID	IL
Infrastructure	1	3	3	U	3	3	3	3	3	3	0	3	3
	2	2	2	U	2	2	2	2	2	2	0	2	2
	3	0	1	U	2	0	2	0	0	0	0	0	0
	4	2	1	U	2	2	2	1	0	2	0	0	0
	5	2	3	U	3	3	1	0	2	0	0	0	1
	6	1	1	1	2	0	1	0	0	1	1	1	1
	7	2	2	2	2	2	2	0	1	2	1	1	1
	8	2	2	U	2	2	2	2	2	2	0	2	1
Information Access	9	6	6	4	9	7	4	8	6	6	4	3	2
	10	0	2	U	2	2	2	2	2	1	0	0	1
	11	0	1	U	0	0	1	2	0	0	1	0	0
	12	2	2	U	1	2	1	2	2	2	2	2	2
Services	13	2	3	U	3	3	3	0	3	3	3	3	1
	14	2	3	U	3	3	2	3	1	3	1	3	1
	15	3	2	U	3	3	2	3	1	3	3	3	1
	16	0	2	U	1	2	0	1	2	1	1	2	1
	17	2	2	U	2	2	2	2	2	2	2	1	2
	18	1	2	U	2	2	2	2	2	2	2	2	0
	19	1	2	U	1	2	2	2	1	0	2	2	2
	20	2	1	U	2	1	3	2	2	3	2	0	2
	21	2	2	U	3	3	1	2	2	2	1	1	2
	22	0	1	U	1	2	2	2	2	2	2	2	2
	23	0	2	U	2	0	0	2	0	1	0	0	0
	24	0	1	U	2	0	0	1	1	2	1	0	0
	25	1	1	U	3	1	1	2	1	2	1	2	1
	26	2	0	U	2	1	0	1	0	0	0	0	0
	27	1	1	1	1	2	2	0	1	1	1	1	0
	28	2	0	U	0	2	3	2	3	2	2	3	3
	29	2	0	2	0	0	2	0	2	2	1	1	1
	30	2	2	U	2	1	2	1	2	2	2	0	2
Recovery Supports	31	2	2	U	3	2	0	2	2	2	0	0	2
	32	2	2	U	2	1	2	2	0	2	0	1	0
	33	2	3	U	4	3	4	3	2	4	2	2	3
	34	3	3	U	2	3	3	1	2	2	0	0	0
	35	2	2	U	2	2	2	2	2	2	0	2	2
	36	2	2	U	2	2	2	2	2	2	0	0	2
	37	2	2	U	0	2	0	1	1	2	0	0	1
	38	2	2	U	2	2	2	2	0	2	0	1	2
	39	2	2	U	2	2	2	2	2	2	0	1	0

NAMI Grades the States National Score Card

Category	Criteria	IN	KS	KY	LA	MA	MD	ME	MI	MN	MO	MS	MT
Infrastructure	1	0	2	3	3	3	3	3	3	2	3	2	2
	2	0	1	2	2	2	2	2	2	2	2	2	1
	3	0	0	0	0	1	2	2	0	0	2	0	0
	4	0	0	0	1	2	2	1	2	2	2	1	0
	5	0	0	0	2	0	0	0	2	2	1	0	0
	6	1	0	1	1	1	2	1	0	2	1	0	1
	7	1	0	1	0	2	0	0	1	1	2	2	1
	8	2	1	2	2	1	2	2	2	2	2	2	2
Information Access	9	10	3	2	2	5	8	7	10	9	1	7	4
	10	0	0	0	0	1	1	1	0	1	1	2	2
	11	0	0	0	1	0	2	2	1	1	2	2	1
	12	2	1	2	2	1	2	1	2	2	2	2	1
Services	13	3	0	3	2	3	3	3	2	3	3	3	0
	14	1	3	0	1	1	3	3	1	3	3	2	1
	15	3	3	1	2	3	3	3	3	3	3	1	3
	16	1	1	1	0	1	2	1	2	1	2	1	1
	17	2	1	1	2	2	2	2	2	2	2	2	2
	18	2	2	0	2	2	2	2	2	2	2	2	2
	19	1	1	0	2	2	2	2	2	1	2	2	2
	20	1	2	1	1	0	1	3	3	1	1	3	1
	21	2	0	0	1	2	1	1	3	2	1	0	1
	22	2	1	0	1	2	2	2	2	2	0	0	2
	23	0	0	1	1	1	2	1	1	0	1	1	0
	24	2	0	0	1	0	1	1	0	1	1	0	0
	25	1	0	1	1	1	1	3	2	1	2	1	1
	26	0	0	0	0	2	2	1	1	2	0	0	0
	27	1	1	1	0	1	0	1	1	1	1	0	1
	28	1	3	3	2	2	3	2	2	2	2	2	2
	29	2	2	2	2	2	2	2	2	2	1	1	0
	30	2	2	2	2	2	2	2	2	1	2	2	2
Recovery Supports	31	2	2	2	1	2	2	3	2	2	3	0	1
	32	2	2	0	0	0	2	2	1	2	2	1	0
	33	1	4	3	2	4	3	3	3	4	3	3	1
	34	0	2	2	0	3	2	3	3	2	2	2	0
	35	0	2	2	2	2	2	2	2	2	2	2	2
	36	0	2	0	1	2	2	2	2	2	0	1	1
	37	0	0	2	1	2	0	2	2	2	2	2	0
	38	2	2	2	2	2	1	2	0	2	2	2	2
	39	2	2	2	2	2	1	2	2	2	2	2	2

NAMI Grades the States National Score Card

Category	Criteria	NC	ND	NE	NH	NJ	NM	NV	NY	OH	OK	OR	PA
Infrastructure	1	3	0	3	2	3	3	3	U	3	3	3	3
	2	2	2	2	1	2	2	2	U	2	2	2	2
	3	0	0	0	1	2	1	0	U	2	0	1	2
	4	2	0	0	1	1	0	2	U	2	0	2	1
	5	0	0	1	0	1	3	0	U	3	1	2	1
	6	1	0	1	1	1	1	1	0	0	1	2	0
	7	2	0	0	0	2	2	0	2	1	0	2	1
	8	2	0	2	2	2	2	0	U	2	2	2	2
Information Access	9	7	2	3	6	8	1	3	7	10	5	8	2
	10	0	1	0	2	2	2	2	U	2	0	1	2
	11	0	0	2	1	0	0	0	U	1	0	0	2
	12	2	0	2	2	2	2	2	U	2	2	2	2
Services	13	3	3	3	3	3	3	0	U	3	3	1	1
	14	3	3	2	2	2	3	3	U	3	3	3	1
	15	1	3	3	3	3	3	3	U	3	1	3	2
	16	2	2	1	2	1	1	2	U	1	2	2	2
	17	2	2	2	2	2	2	2	U	2	2	2	2
	18	2	2	2	2	2	2	2	U	2	2	2	2
	19	1	2	0	2	1	1	2	U	2	1	2	2
	20	1	1	1	0	1	1	2	U	1	2	1	2
	21	2	0	1	1	2	1	1	U	2	2	2	2
	22	1	0	2	0	1	2	0	U	2	2	2	2
	23	1	0	0	1	2	2	0	U	1	1	2	1
	24	1	1	0	2	2	2	0	U	2	1	2	1
	25	2	0	1	1	1	2	1	U	3	1	1	1
	26	0	0	0	0	0	1	0	U	1	1	2	1
	27	1	3	3	1	1	2	1	1	1	1	1	1
	28	0	2	3	2	3	0	2	U	3	2	3	3
	29	0	2	2	2	2	2	2	2	2	2	1	2
	30	2	2	0	2	2	2	1	U	2	2	0	2
Recovery Supports	31	2	0	1	2	2	3	2	U	2	0	2	0
	32	2	2	1	0	2	2	2	U	0	2	1	1
	33	3	1	3	3	3	2	3	U	4	4	4	2
	34	3	2	2	1	0	2	2	U	2	0	2	3
	35	2	2	2	2	2	2	2	U	2	2	2	2
	36	1	2	2	0	1	2	0	U	2	2	2	1
	37	2	0	2	0	2	0	0	U	2	2	1	2
	38	2	0	1	0	2	2	0	U	2	2	2	2
	39	2	1	1	0	2	2	2	U	2	2	2	2

NAMI Grades the States National Score Card

Category	Criteria	RI	SC	SD	TN	TX	UT	VA	VT	WA	WI	WV	WY
Infrastructure	1	3	3	3	2	3	3	3	3	3	3	3	3
	2	2	2	0	2	2	2	2	2	2	2	2	2
	3	2	2	0	1	2	0	0	1	1	1	0	0
	4	1	2	0	1	1	0	1	2	1	2	1	2
	5	0	1	1	1	0	1	3	1	0	2	0	2
	6	1	1	1	1	1	1	1	2	1	0	1	0
	7	1	2	0	1	2	0	0	0	2	1	0	2
	8	2	2	0	1	2	2	1	1	2	2	2	0
Information Access	9	9	10	1	10	5	7	3	5	4	5	10	9
	10	0	2	0	1	1	2	1	2	2	2	1	2
	11	2	2	2	2	1	2	0	0	1	2	0	0
	12	0	2	1	2	2	0	2	2	2	1	2	1
Services	13	3	3	2	3	2	3	1	3	3	3	3	0
	14	3	3	3	2	3	3	3	3	1	2	1	2
	15	3	0	3	1	0	3	3	3	3	3	3	3
	16	1	2	1	1	2	1	2	1	2	2	1	0
	17	1	2	2	2	2	2	2	2	2	2	2	1
	18	2	2	2	0	1	0	2	2	2	2	2	2
	19	2	2	2	1	2	2	2	0	2	2	0	2
	20	2	1	1	1	3	0	2	1	0	2	2	2
	21	3	2	1	1	2	1	2	1	1	3	1	1
	22	2	2	2	2	2	0	2	0	0	2	2	0
	23	1	0	0	1	2	0	0	2	0	2	0	2
	24	0	2	0	1	2	0	0	1	1	0	0	1
	25	1	1	0	2	2	1	1	2	1	1	2	1
	26	2	0	0	0	2	1	0	2	1	2	1	0
	27	1	1	1	1	1	1	0	2	1	3	2	1
	28	3	2	3	2	3	3	3	0	2	3	2	2
	29	2	2	0	2	2	2	2	0	2	2	2	2
	30	2	2	1	1	2	2	2	2	2	2	2	2
Recovery Supports	31	2	2	1	2	1	2	2	3	1	2	2	3
	32	2	2	0	2	1	0	2	2	2	2	0	2
	33	4	3	1	4	2	3	1	3	2	3	3	3
	34	2	2	0	3	2	1	3	3	2	2	2	2
	35	0	2	0	2	2	2	0	2	0	2	0	0
	36	2	2	1	0	2	2	2	2	0	2	0	0
	37	2	2	1	1	2	0	0	2	0	2	0	0
	38	2	1	2	2	2	2	2	2	2	2	2	2
	39	1	2	1	2	2	2	2	2	2	2	2	2

Compendium of State Category Grades

Infrastructure		Information Access		Services		Recovery Supports	
Grade		**Grade**		**Grade**		**Grade**	
A	Connecticut Oregon	**A**	Ohio South Carolina Tennessee	**B+**	Wisconsin	**A**	California Hawaii Maine Minnesota Vermont
B	California Delaware Missouri Ohio South Carolina	**B+**	Florida	**B**	Maine Ohio	**B+**	Arizona Connecticut District of Columbia Massachusetts North Carolina Wisconsin
B-	Arizona District of Columbia New Jersey New Mexico	**B**	Maryland Michigan Minnesota Mississippi West Virginia	**B-**	Texas	**B**	Kansas Missouri Ohio Oregon South Carolina Tennessee
C	Alabama Maryland Minnesota Texas Wisconsin	**C+**	Alaska Connecticut Indiana New Jersey Wyoming	**C+**	Connecticut Hawaii Maryland Michigan Rhode Island	**C+**	Delaware Florida Michigan New Mexico Rhode Island
C-	Hawaii Massachusetts Michigan North Carolina Pennsylvania Rhode Island Vermont Washington	**C-**	California District of Columbia Maine New Hampshire Oregon Rhode Island Utah	**C**	New Jersey New Mexico Oklahoma Oregon	**C**	Alaska New Jersey Oklahoma Texas
D	Alaska Georgia Louisiana Maine Tennessee Virginia Wyoming	**D**	Georgia Hawaii North Carolina Texas Vermont Washington Wisconsin	**C-**	District of Columbia Minnesota Pennsylvania	**C-**	Kentucky Maryland Mississippi Nebraska Pennsylvania
D-	Idaho Illinois Kentucky Mississippi Nebraska Oklahoma Utah West Virginia	**D-**	Arizona Delaware Montana Pennsylvania	**D+**	Delaware Florida Georgia Massachusetts Missouri New Hampshire North Dakota South Carolina Virginia West Virginia	**D+**	Utah Virginia Wyoming
F	Arkansas Florida Indiana Iowa Kansas Montana New Hampshire Nevada North Dakota South Dakota	**F**	Alabama Arkansas Idaho Iowa Illinois Kansas Kentucky Louisiana Massachusetts Missouri Nebraska Nevada New Mexico North Dakota Oklahoma South Dakota Virginia	**D**	Alaska Alabama Arizona Arkansas California Idaho Indiana Iowa Nebraska Nevada North Carolina South Dakota Tennessee Utah Vermont Washington Wyoming	**D**	Arkansas Georgia Illinois Nevada
U	Colorado New York	**U**	Colorado New York	**D-**	Kansas Louisiana Mississippi	**D-**	Alabama Louisiana Washington West Virginia
				F	Illinois Kentucky Montana	**F**	Idaho Indiana Iowa Montana New Hampshire North Dakota South Dakota
				U	Colorado New York	**U**	Colorado New York

Compendium of State Narrative Tables Listing Spending and Rankings

	PC MH Spending	Rank	PC Income	Rank	Total MH Spending (in millions)	Rank	Suicide Rank
Alabama	$60.95	38	$25,006	41	$274	25	28
Alaska	$85.06	23	$31,871	13	$54	46	2
Arizona	$126.33	8	$25,481	39	$702	10	6
Arkansas	$29.57	50	$23,061	50	$80	44	16
California	$109.34	14	$32,043	10	$3,862	1	42
Colorado	$66.30	33	$32,550	9	$300	23	7
Connecticut	$151.03	5	$40,990	2	$525	15	47
Delaware	$81.40	24	$31,151	15	$66	45	42
District of Columbia	$414.08	1	$45,898	1	$232	27	51
Florida	$37.99	48	$28,907	24	$644	12	15
Georgia	$49.88	44	$27,953	28	$430	20	37
Hawaii	$125.38	10	$29,350	20	$152	35	41
Idaho	$33.69	49	$24,601	46	$46	51	9
Illinois	$66.12	34	$31,987	11	$835	7	44
Indiana	$72.37	28	$27,328	36	$448	19	24
Iowa	$73.70	27	$27,575	34	$217	29	35
Kansas	$75.22	26	$28,422	27	$204	31	21
Kentucky	$51.27	42	$24,925	42	$210	30	19
Louisiana	$51.34	41	$24,780	44	$230	28	31
Maine	$127.92	7	$27,373	35	$167	33	20
Maryland	$147.08	6	$35,444	5	$805	8	45
Massachusetts	$106.21	15	$37,802	4	$683	11	48
Michigan	$97.79	17	$28,900	25	$986	5	32
Minnesota	$119.07	12	$32,702	8	$602	13	40
Mississippi	$93.49	18	$22,263	51	$268	26	25
Missouri	$67.30	31	$27,773	31	$383	22	23
Montana	$123.41	11	$24,610	45	$113	39	3
Nebraska	$58.29	39	$29,203	22	$101	40	27
Nevada	$62.78	36	$29,685	19	$140	37	4
New Hampshire	$117.14	13	$32,948	7	$151	36	39
New Jersey	$125.60	9	$38,383	3	$1,084	4	49
New Mexico	$28.80	51	$24,250	47	$54	47	5
New York	$192.07	3	$34,725	6	$3,681	2	49
North Carolina	$50.26	43	$26,808	38	$417	21	25
North Dakota	$81.06	25	$27,728	33	$51	48	13
Ohio	$62.03	37	$28,430	26	$709	9	30
Oklahoma	$39.43	46	$25,308	40	$138	38	14
Oregon	$56.49	40	$27,857	30	$201	32	11
Pennsylvania	$195.01	2	$30,380	17	$2,410	3	34
Rhode Island	$88.75	21	$30,302	18	$95	41	46
South Carolina	$67.18	32	$24,811	43	$276	24	35
South Dakota	$65.89	35	$27,756	32	$50	50	22
Tennessee	$87.22	22	$27,016	37	$508	16	17
Texas	$39.02	47	$27,887	29	$858	6	37
Utah	$70.91	29	$23,714	48	$166	34	11
Vermont	$152.35	4	$29,186	23	$94	42	10
Virginia	$68.54	30	$31,969	12	$496	18	32
Washington	$91.01	19	$31,647	14	$553	14	18
West Virginia	$48.74	45	$23,146	49	$88	43	8
Wisconsin	$90.98	20	$29,336	21	$498	17	28
Wyoming	$103.27	16	$31,149	16	$51	49	1

Explanation of Compendium of State Narrative Tables Listing Spending and Rankings

For the preceeding chart of four categories of data, entitled "Compendium of State Narrative Tables Listing Spending and Rankings," the following is an explanation of the figures cited.

The first category, "PC MH spending / rank," indicates the per capita spending on mental health in each state and where that spending ranks the state nationally. The data given in this and the third item noted below are taken from the National Association of State Mental Health Program Directors Research Institute and include all 50 states plus the District of Columbia for 2003, the most recent year available.

The second category, "PC income / rank," indicates the state's per capita income and where that figure ranks each state nationally. This information is derived from U.S. Census Bureau data on Personal Income Per Capita for the year 2003, the most recent year available.

The third category, "Total MH spending / rank," indicates the total spending on mental health in the state.

The fourth item, "Suicide rank," indicates where each state ranks nationally according to the rate of reported suicides per 100,000 people in the year 2002, the most recent year available. The rank of 51, for example, indicates the lowest suicide rate. The data on which this ranking is based are derived from the National Vital Statistics Reports 2004 issued by the National Center for Health Statistics of the Centers for Disease Control.

Methodology of Values and Scoring

Listed below are the individual scoring criteria organized by category. In each case the value standard is indicated, along with the source of information used in the assessment, and whether the determination of the scoring was masked or unmasked.

Following this methodology is a reproduction of the survey sent to each State Mental Health Authority (SMHA), self-reported responses to which were scored for each state.

Infrastructure – 18 possible points

Criterion 1. Prioritizing services to people with severe and persistent mental illness (3 points)

Value Standard: In addition to knowing whom they serve, the SMHA should clearly prioritize scarce resources to the most severely ill.

0 – If "no," the SMHA does not prioritize services to people with severe and persistent mental illness.
1 – If "no," but some minimal efforts are evidenced.
2 – If "no," but substantial efforts are evidenced.
3 – If "yes."

SMHA self-reported questionnaire ~ masked scoring

Criterion 2. Demonstrated Innovation (2 points)

Value Standard: Many states have demonstrated innovative efforts in solving complex problems. Mental health systems as well as consumers benefit from a spirit of innovation and creative problem solving.

0 – If "no," the state has not demonstrated any innovations in solving problems in our mental health system.
1 – If yes but specific innovations are not referenced or the state is working on plans to embrace an innovation.
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring

Criterion 3. Health Disparities Program (2 points)

Value Standard: The Surgeon General has documented health disparities among both minorities and the serious mental illness (SMI) population.

0 – If "no," the SMHA does not have a program to address health disparities among people living with mental illness.
1 – If "some programs exist" or "no," but considerable efforts taking place.
2 – If "yes," and programs are listed.

SMHA self-reported questionnaire ~ masked scoring

Criterion 4. Studies Regarding Causes of Death (2 points)

Value Standard: People with SMI often lose a least a decade of life. As states reconfigure their systems, this is among the most important outcome to study: who is dying and why.

0 – If "no," the state does not study the causes of death of individuals with mental illness and does not gather other information about race and ethnicity of those individuals.
1 – If "some reporting takes place," but no study is in effect or a study exists in hospital settings only.
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring

Criterion 5. Workforce Development Assessment and Strategic Plan (3 points)

Value Standard: There is an acknowledged shortage of caregivers in the field. Advocates and professionals cite an aging workforce and/or inadequate supply.

0 – If "no," the state has not completed in writing a comprehensive mental health workforce needs assessment and strategic plan.
1 – If "some parts of a plan exist" or a plan is in development, but no specifics are listed.
2 – If "yes," but no comprehensive plan is listed and no considerable efforts are taking. place in that direction.
3 – If "yes," and a comprehensive plan is listed or detailed in its development.

SMHA self-reported questionnaire ~ masked scoring

Criterion 6. Insurance Parity for Mental Illness (2 pts)

Value Standard: Mental illnesses are equivalent to "physical" illnesses, yet health insurance discrimination has long existed. Access to reasonable care of the middle class also reduces some of the burden on the public system.

0 – If no state parity law exists or language includes "shall offer mandates."
1 – If a parity law exists but is not inclusive of substance abuse or has significant restrictions.
2 – If a parity law exists without exemptions and contains benefits for both mental health and substance abuse.

Research and evaluation of state mental health parity laws via the NMHA Web site at http://www.nmha.org ~ unmasked scoring

Criterion 7. Cultural Competence Assessment and Plan (2 points)

Value Standard: Mental health systems should be accessible and reflective of the cultures of those served by the system. Evidence of attention to cultural competence is an indicator of a responsive system. There is a well-documented shortfall in the mental health outcomes of minority groups.

0 – If the SMHA has neither conducted a cultural competence assessment nor has a cultural competence plan.
1 – If the SMHA has conducted a cultural competence assessment or has a cultural competence plan.
2 – If the SMHA has conducted a cultural competence assessment and has a cultural competence plan.

NASMHPD Research Institute, Inc. SMHA Profiling System 2004 and SMHA interviews. ~ unmasked scoring

Criterion 8. Unduplicated Count of Persons Served with Breakdown by Race and Ethnicity (2 points)

Value Standard: To do a good job of planning state systems should know who they serve. For good multicultural services to be developed, the SMHA should know the mix of their population's cultural needs.

0 – If neither a breakdown nor an unduplicated count of individuals being served by the state system is given (or a reasonable doubt regarding unduplicated count exists).
1 – If either a breakdown or an unduplicated count is given.
2 – If both a breakdown is given and a (probable) unduplicated count are given.

SMHA self-reported questionnaire ~ masked scoring

Information Access – 16 possible points

Criterion 9. Consumer and Family Test Drive (10 points)

Value Standard: Basic information on accessing services at the state level should be reasonably available via the phone and the Web to the average person who has a major mental illness or to their family.

See elsewhere in this Appendix for Consumer and Family Test Drive Methodology.

A trained group of consumers and family members made structured phone calls and internet searches for basic information and compared the states to each other ~ unmasked scoring

Criterion 10. Use of Consumer and Family Monitoring Teams (2 points)

Value Standard: Individuals who receive care in the state hospitals and their families should be an integral part of reviewing the conditions at these facilities for appropriateness of care and safety.

0 – If "no," the state does not utilize consumer and family monitoring teams to review conditions in state hospitals and other state facilities.
1 – If "not yet," but substantial efforts are being taken or small scale efforts are evidenced.
2 – If " yes".

SMHA self-reported questionnaire ~ masked scoring

Criterion 11. Formulary Decisions—A WrittenConsumer and Family Mandate (2 points)

Value Standard: Medications are a foundation of recovery for many. Written policies ensuring consumer and family member participation in medication decision making process ensures a responsive mental health system.
0 – If "no," the state does not have a written mandate for consumer and family input on all state medication formulary decisions.
1 – If "no," but substantial involvement from consumers or family exists.
2 – If "yes," a written mandate for involvement from consumers and family exists, or an open formulary exists.

SMHA self-reported questionnaire ~ masked scoring

Criterion 12. Consumers and Families Involved in EBP Implementation (2 points)

Value Standard: Evidence Based Practices (EBPs) are recognized as cost and outcome effective. Consumer and family member participation in the implementation of EBPs is an indicator of an inclusive and responsive mental health system.

0 – If "no," consumers and families are not involved in the implementation of EBPs in the state.
1 – If "considerable efforts are taking place" and/or either consumers or family members involvement is noted.
2 – If "yes," both consumer and family member involvement is noted.

SMHA self-reported questionnaire ~ masked scoring

Services – 44 possible points

Criterion 13. No Outpatient Co-pays for Mental Health Services (3 points)

Value Standard: Though there are myriad mental health care choices available in the United States, nearly half of all Americans who have a severe mental illness do not receive treatment. Those with low socio-economic circumstances often find financial barriers when attempting to receive health care. The high cost of care and disparity of coverage by health insurance providers are, "among the foremost reasons why people do not seek needed mental health care."

0 – If "yes," the state charges co-pays for outpatient mental health services to Medicaid beneficiaries.
1 – If "yes," but exceptions exist for certain population groups or co-pay are $1 or less.
2 – If "yes," but exceptions exist for certain population groups and co-pay are $1 or less.
3 – If no co-pays exist.

SMHA self-reported questionnaire ~ masked scoring

Criterion 14. Antipsychotic Medications – No Restrictions (3 points)

Value Standard: Decisions about the best medications for a person with SMI are the sole purview of the individual and the doctor. One size does not fit all. In particular, access to an array of antipsychotic medications is essential to positive treatment and recovery outcomes.

0 - If "no," the state Medicaid agency does not allow doctors and patients to select the antipsychotic compound they feel is best, and a restricted formulary exists without any exceptions.
1 – If significant restrictions/limitations exist, but exceptions are possible in some cases, or prior authorization is a kind of exception.
2 – If reasonable restrictions/limitations exist for which an easy 'appeals process' is in place/described.
3 – If "yes" and no restrictions/limitations exist.

SMHA self-reported questionnaire ~ masked scoring

Criterion 15. Medications—who decides how many? (3 points)

Value Standard: Many people with SMI often have multiple medical problems and may need multiple medications to manage their comprehensive treatment needs. Strategies to address rising medication costs are available and far outweigh the negative consequences of limiting the number of prescriptions allowed a consumer.

0 – If 1–3 prescriptions allowed per month.
1 – If 4–5 allowed per month.
2 – If more than 5 allowed per month.
3 – If no restrictions to medications exist.

SMHA self-reported questionnaire ~ masked scoring

Criterion 16. Benefit Service Identification Program (2 points)

Value Standard: Medicaid is the primary provider of benefits to many people living with SMI. SMHAs have an affirmative duty to help people access benefits.

0 – If "no," the state does not have a program to help Medicaid beneficiaries with SMIs identify appropriate benefits and effective treatment services.
1 – If "yes," but no clear information/indication about existing programs is provided or if "no," but some programs exist for a substantial part of the population.
2 – If "yes," and clear information/indication is provided about existing programs.

SMHA self-reported questionnaire ~ masked scoring

Criterion 17. Interagency Cooperation Between SMHA and Medicaid (2 points)

Value Standard: To ensure the access of treatment for people with SMI, SMHA's must demonstrate active collaboration with their state's Medicaid agency.

0 – If no substantial cooperation between the SMHA and the state's Medicaid agency seems to exist.
1 – If some cooperation is listed, but either there is no mention of adult systems collaboration or the state only mentioned that they are working on it.
2 – If a clear and solid example of cooperation was given.

SMHA self-reported questionnaire ~ masked scoring

Criterion 18. Wraparound Coverage for Benzodiazepines (2 points)

Value Standard: Beginning on January 1, 2006, federal benefit coverage excluded benzodiazepines. Access to this class of medications, however, is critical for the treatment of anxiety disorders and substance abuse withdrawal, among others, and states should provide access to this class of medications.

0 – If no plan to offer wraparound coverage of benzodiazepines for people dually eligible for Medicaid and Medicare enrolled in Medicare Part D exists.
1 – If some.
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring

Criterion 19. Medications—Prescriber Feedback (2 points)

Value Standard: Studies have shown that a small percentage of doctors engage in extensive polypharmacy prescribing practices. Feedback to doctors has been shown to improve prescribing patterns and clinical outcomes.

0 – If "no," the state does not provide doctors with feedback on their prescribing patterns, or only to very small extent.
1 – If "no," not systematically, but some efforts are being made to address this issue.
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring

Criterion 20. Policies to Encourage Integrated Treatment of Dual-Disorder Mental Illness and Substance Abuse (3 points)

Value Standard: As many as half of people with SMI develop alcohol or drug abuse problems at some point in their lives. States should have programs that support integrated treatment.

0 – If no programs to encourage integrated treatment exist.
1 – If 1–3 teams per 1 million people exist or if other models are used or substantial efforts are demonstrated.
2 – If 4–20 teams per 1 million people exist.
3 – If more than 20 teams per 1 million people exist.

SMHA self-reported questionnaire ~ masked scoring

Criterion 21. ACT (3 points)

Value Standard: Assertive Community Treatment (ACT) is a service-delivery model for providing comprehensive community-based treatment to persons with SMI. ACT offers continuous and integrated community-based care to people with SMI who have complex needs. The use of the SAMHSA model of ACT is an indicator of a state's commitment to recovery.

0 – If no SAMHSA model programs of ACT are available.
1 – If 1–7 SAMHSA model ACT teams are available.
2 – If 8–99 SAMHSA model ACT teams are available.
3 – If 100 SAMHSA model ACT teams are available or there are more than 8 teams per 1 million people.

SMHA self-reported questionnaire ~ unmasked scoring

Criterion 22. ACT Fidelity Standards (2 points)

Value Standard: SAMHSA promotes guidelines that articulate standards for fidelity to ACT. Fidelity to standards in this EBP supports successful treatment and recovery outcomes.

0 – If no ACT fidelity standards exist.
1 – If "some, but not necessarily to evidence based standards" or "no, but substantial efforts are taking place".
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring

Criterion 23. Family Psychoeducation (2 points)

Value Standard: Family psychoeducation programs that educate and inform families about mental illness demonstrate a reduction in relapse and re-hospitalization rate.

0 – If no SAMHSA model programs of family psychoeducation are available.
1 – If "no substantial efforts towards EBPs is evidenced and/or they are spotty across the state.
2 – If "yes," the SMAHSA model is available AND it is state wide.

SMHA self-reported questionnaire ~ masked scoring

Criterion 24. Illness Self Management (2 points)

Value Standard: Illness self-management programs for people with SMI provide consumers strategies for minimizing symptoms and preventing relapse. State support of these programs is an indicator of a system that is responsive to recovery.

0 – If no SAMHSA model programs of illness self-management exist.
1 – If no SAMHSA programs exist but other wellness programs are mentioned OR substantial efforts are taken to include them.
2 – If "yes," the SAMHSA model for illness management and recovery is in effect.

SMHA self-reported questionnaire ~ masked scoring

Criterion 25. Jail Diversion (3 points)

Value Standard: Jail diversion programs have been important catalysts for diverting people from unnecessary incarceration and linking them with needed services and supports. State support for jail diversion programs, including pre- and post-booking diversions, ensure that people with SMI are more likely to have access to appropriate services and avoid more costly and traumatic encounters with the criminal justice system.

0 – If there are no jail diversion programs.
1 – If there are 1 or 2 jail diversion programs per 1 million people.
2 – If there are 2 to 5 jail diversion programs per 1 million people.
3 – If there are more than 5 programs per 1 million people.

Research and evaluation of state jail diversion programs via the mental health courts survey Web site at http://www.mentalhealthcourtsurvey.com ~ unmasked scoring

Criterion 26. Restoration of Benefits Post-Correctional Stay (2 points)

Value Standard: A gap in access to SSI/SSDI and Medicaid/Medicare benefits is a major problem for individuals re-entering the community from correctional settings, promoting systems, and treatment failures.

0 – If "no," the state does not have a written plan to ensure the timely restoration of SSI/SSDI and Medicaid/Medicare benefits for individuals with SMI discharged from jail.
1 – If "considerable efforts are taking place."
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring

Criterion 27. Psychiatric Inpatient Bed Access (3 points)

Value Standard: Inpatient psychiatric beds are often critical for crisis stabilization and are disappearing across the nation. This places supporting an undue burden on Emergency Rooms and placing consumers at risk.

0 – If serious problems exist in accessing inpatient psychiatric beds, such as the state is having problems with access to both acute care beds and long-term care beds, and there are no publicly disclosed plans for improvement.
1 – If moderate problems exist, such as the state has problems with access to both acute care beds and long-term care beds, but there are plans for improvement.
2 – If mild problems exist, such as the state has a problem with access to either acute care beds or long-term care beds.
3 – If the state has no major problem with either acute care beds or long-term care beds.

Research of external sources such as NASMHPD Research Insitute's SMHA Profiling System and survey of state advocates ~ unmasked scoring

Criterion 28. Reduction in the Use of Restraint and Seclusion (3 points)

Value Standard: Restraint and Seclusion has been shown to be traumatizing, has no therapeutic benefits, and should be viewed as a failure. Efforts to reduce the use of R&S should be documented.

0 – If "no," the state can not document actual reductions in the use of restraint and seclusion in adult treatment facilities.
1 – If "yes," but the state only tracks information; no documentation is available.
2 – If "yes," the state tracks information and evidence of proven improvements exists.
3 – If "yes," the state tracks information and extraordinary improvement exists; documentation is given.

SMHA self reported questionnaire ~ unmasked scoring

Criterion 29. State Hospital Safety and Quality Processes (2 points)

Value Standard: State hospitals should be safe and therapeutic environments and should be accredited by a reputable organization such as Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF).

0 – If no state hospitals/facilities are accredited or there have been findings of civil rights violations by the Department of Justice for Civil Rights of Institutionalized Persons Act (CRIPA).
1 – If some of the state hospitals are accredited, but not all.
2 – If all of the state hospitals/facilities are accredited by JCAHO or CARF.

Website review of the JCAHO, the CARF and CRIPA to assess state hospital accreditation and Department of Justice action ~ unmasked scoring

Criterion 30. Olmstead Plan (2 points)

Value Standard: *Olmstead v. LC* requires states to develop an orderly system for helping institutionalized individuals obtain services in the most integrated settings appropriate to their needs.

0 – If "no," the state does not have an Olmstead Plan.
1 – If "not yet," but considerable efforts are taking place.
2 – If "yes."

SMHA self reported questionnaire ~ masked scoring

Recovery Supports – 22 possible points

Criterion 31. Supported Employment (3 points)

Value Standard: Employment is a cornerstone to recovery for people with SMI. Fewer than one in five people with a severe mental disorder is employed.

0 – If no substantial efforts towards evidence based programs is evidenced.
1 – If substantial efforts towards evidence based programs are in progress.
2 – If SAMHSA model teams exist but there are less than 10 per 1 million people.
3 – If SAMHSA model teams exist and there are more than 10 per 1 million people.

SMHA self-reported questionnaire ~ masked scoring

Criterion 32. SMHA/Vocational Rehabilitation Cooperation (2 points)

Value Standard: A successful work experience for people with SMI requires close cooperation between the SMHA and the State Vocational Rehabilitation Agency (SVRA). Work is essential to recovery for people with SMI.

0 – If "no," or if there is a small effort at collaboration between the SMHA and the SVRA evidenced, but no plan exists.
1 – If no written agreement on collaboration exists, but substantial collaboration takes place.
2 – If "yes," a written cooperative agreement between the SMHA and the state's Department of Vocational Rehabilitation to collaboratively finance supported employment services exists.

SMHA self-reported questionnaire ~ masked scoring

Criterion 33. Supported Housing (4 points)

Value Standard: Although SMHA's do not generally control affordable housing resources, they do have important responsibilities to ensure that extremely low income individuals with SMI do have access to decent, safe, and affordable housing in the community.

0 – If there is a general lack of awareness of supportive housing resources, no progress being made at the state level to expand access to supportive housing, and no effective plan to expand access to supportive housing exists.
1 – If there is a general lack of awareness of supportive housing resources despite progress being made (independent of the SMHA) by the affordable housing system in expanding access to supportive housing that serves individuals with SMI.
2 – If there is an awareness of supportive housing resources, but no formal engagement with the affordable housing system, and no plan to expand access to supportive housing.
3 – If there is an awareness of available supportive housing resources and some engagement with affordable housing system, existence of a plan to expand access to supportive housing.
4 – If there is a strong awareness of available supportive housing resources, effective engagement with the affordable housing system and a demonstrated commitment on the part of the state and the mental health system to expanding supportive housing.

SMHA self-reported questionnaire and research of source information including the Technical Assistance Collaborative's Housing Center (N-TAC) and other reputable sources ~ unmasked scoring
Note: Information about state mental health resources being invested in housing was not measured. The focus on the general awareness of available supportive housing resources and relative engagement of the SMHA in the affordable housing system, however, was evaluated and scored.

Criterion 34. Reduce Waiting Lists for Residential Services (3 points)

Value Standard: An array of housing options for people with SMI is important to ensure recovery. A state plan to reduce the wait list for housing is important, and a state's engagement in this effort is an indicator of commitment to consumer recovery.

0 – If "no," the state does not have a plan to reduce waiting lists for residential services for people with SMI.
1 – If "no identification as of now," but the problem is acknowledged and some efforts are being taken.
2 – If "yes," and a waiting list exists
3 – If "yes," and information about substantial efforts and existing programs-plans are validated.

SMHA self-reported questionnaire ~ masked scoring

Criterion 35. Housing Service Coordinator (2 points)

Value Standard: Generating housing is a cross agency function that requires dedicated individuals who know the different programs and rules. The designation and promotion of a state housing services coordinator indicates a commitment to this important function.

0 – If "no," the state does not have a housing coordinator.
1 – If "yes," but the contact information of the coordinator is not listed.
2 – If "yes," and the contact information of the coordinator is listed.

SMHA self-reported questionnaire ~ masked scoring

Criterion 36. Written Plan for Long Term Housing Needs (2 points)

Value Standard: To meet future housing needs, a written plan for addressing the long-term housing needs of people with SMI is an important first step and is an indicator of a state's commitment to this important aspect of recovery.

0 – If "no," the state does not have a written plan to address long term housing needs for people with SMI.
1 – If considerable efforts to develop a plan are taking place.
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring

Criterion 37. Co-Occurring Disorders/No Wrong Door for Treatment (3 points)

Value Standard: As many as half of people with SMIs develop alcohol or drug abuse problems at some point in their lives. Policies should be in place to ensure that individuals with co-occurring disorders are not discharged from mental health care due to substance abuse.

0 – If "no," formal policies do not exist to ensure that individuals with substance abuse disorders retain access to mental health care.
1 – If considerable efforts to implement a policy are taking place.
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring

Criterion 38. Family-to-Family/Logistical or Financial Support (2 points)

Value Standard: The National Association of State Mental Health Program Directors (NASMHPD) recognizes that consumers have a unique contribution to make to the improvement of the quality of mental health services in many areas of the service delivery system. Evidence of financial support for Family-to-Family and other family peer education programs is an indicator of an inclusive and responsive mental health system.

0 – If "no," the state does not provide logistical or financial support for Family-to-Family or other family peer education programs.
1 – If some efforts at supporting these programs exists.
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring
Family-to-Family is a NAMI program.

Criterion 39. Peer to Peer/WRAP/BRIDGES/Logistical or Financial Support (2 points)

Value Standard: Consumer-driven recovery is well represented by consumer driven programs and is an increasingly important component of recovery. Evidence of financial support for Peer-to-Peer, BRIDGES, WRAP, and other illness-self management programs is an indicator of an inclusive and responsive mental health system.

0 – If "no," the state does not provide logistical or financial support for Peer-to-Peer, BRIDGES, WRAP, or other illness-self management program.
1 – If some efforts at supporting these programs exist.
2 – If "yes."

SMHA self-reported questionnaire ~ masked scoring
Peer-to-Peer is a NAMI program.

Questionnaire Sent to State Mental Health Authorities

NAMI Questionnaire Sent to State Mental Health Authorities

October 17, 2005

Dear [COMMISSIONER'S or DIRECTOR'S NAME]:

NAMI National has undertaken a project to profile every state's public mental health system for adults with serious mental illnesses. As part of this effort, NAMI has been in touch with your office over the past year to collect information on the implementation of evidence-based practices in your state. We greatly appreciate the data you have provided in the past, and we are now coming back to your office for additional information to ensure that we have an accurate picture of the shape of services and trends in your state.

To help us finalize our profile of your state, please complete the attached brief questionnaire by Monday, November 14th. Unless otherwise noted, these questions pertain to individuals with serious mental illnesses in your state. For the sake of simplicity, most of the questions can be answered with a "Yes" or "No." However, we invite you to provide more information when you feel it would be useful for our understanding of your state. If you have any questions on this project, please contact Abigail Graf at 703-600-1107 or abigail@nami.org.

Thank you again for helping NAMI to compile as accurate information as possible about services provided to people with serious mental illnesses in your state.

Sincerely,

Michael Fitzpatrick, MSW
Executive Director
NAMI National

Directions: Please complete the following questionnaire about your state's mental health services for adults with serious mental illnesses. Unless otherwise noted, the questions can be answered with a "Yes" or "No." However, we invite you to provide more information when you feel it would be useful for our understanding of your state. If you have any questions on this project, please contact Abigail Graf at 703-600-1107 or abigail@nami.org. Thank you in advance for providing NAMI with this information. **Please submit the completed questionnaire via e-mail by November 14th to abigail@nami.org.**

1. Does your state have an unduplicated count of persons served by the state mental health authority, and does this count include data on the race and ethnicity of clients? Please provide your state's unduplicated count, including the breakdown by race and ethnicity.

2. Can your state document examples of cooperation between the state mental health authority (SMHA) and Medicaid agency in priority-setting or planning? Please provide a brief example in five sentences or less.

3. Does your state charge co-pays for outpatient mental health services for mandatory Medicaid beneficiaries with serious mental illnesses? If so, how much are the co-pays?

4. Does your state have Medicaid waivers to increase coverage beyond federal requirements for mental illness services (e.g., ACT, integrated mental health and substance abuse services, Peer Specialists)? Please provide a brief example in five sentences or less.

5. Does your state have a program to help Medicaid beneficiaries with serious mental illnesses identify appropriate benefits and effective treatment services?

6. Does your state's Medicaid agency allow doctors and patients to select the antipsychotic compound they feel is best with no intermediary steps or restrictions, such as prior authorization?

7. Does your state plan to offer wraparound coverage of benzodiazepines for people dually eligible for Medicaid and Medicare enrolled in Medicare Part D?

8. Does your state restrict the total number of prescriptions that can be filled per month for Medicaid beneficiaries? If so, what are the specific limits?

9. Does your state have a written mandate for consumer and family input on all state medication formulary decisions?

10. Does your state provide doctors with feedback on their prescribing patterns?

11. Does your state offer a structured medication management strategy to help inform clinical decision making around prescribing?

12. Can your state document actual reductions in the use of restraint and seclusion in adult state treatment facilities, or efforts to reduce the use of these practices?

13. Does your state utilize consumer and family monitoring teams to review conditions in hospitals and other state facilities?

14. Does your state have an Olmstead Plan?

15. Does your state engage in efforts to reduce waiting lists for residential services? Please provide details in five sentences or less.

16. Could you please list the counties, and if applicable the number of teams in each county, where the SAMHSA model of Assertive Community Treatment (ACT) is available? NAMI has data from fiscal year XXXX indicating that the state has XX ACT teams. If that information is no longer accurate, please update as necessary.

17. Does your state have written standards to monitor the fidelity of ACT teams?

18. Could you please list the counties, and if applicable the number of programs in each county, where the SAMHSA model of Supported Employment is available? NAMI has data from fiscal year XXXX indicating that the state has XX Supported Employment programs. If that information is no longer accurate, please update as necessary.

19. Is there a written co-operative agreement between the SMHA and Department of Vocational Rehabilitation to collaboratively finance Supported Employment services?

20. Could you please list the counties, and if applicable the number of programs in each county, where the SAMHSA model of Family Psychoeducation is available? NAMI has data from fiscal year XXXX indicating that the state has XX Family Psychoeducation programs. If that information is no longer accurate, please update as necessary.

21. Does your state provide financial and/or logistical support for NAMI's Family-to-Family Education program, Journey of Hope, or another nationally recognized family education program?

22. Could you please list the counties, and if applicable the number of programs in each county, where the SAMHSA model of Illness Management and Recovery is available? NAMI has data from fiscal year XXXX indicating that the state has XX Illness Management and Recovery programs. If that information is no longer accurate, please update as necessary.

23. Does your state provide financial and/or logistical support for NAMI's Peer-to-Peer Education program, WRAP, Bridges, or another nationally recognized illness-self management program?

24. Could you please list the counties, and if applicable the number of programs in each county, where the SAMHSA model of Integrated Dual Diagnosis Treatment for mental illness and substance abuse is utilized? NAMI has data from fiscal year XXXX indicating that the state has XX programs utilizing Integrated Dual Diagnosis Treatment. If that information is no longer accurate, please update as necessary.

25. Does your state have formal policies to ensure that individuals with serious mental illnesses and active co-occurring substance disorders are not discharged from mental health care due to substance abuse?

26. Could you please list the counties, and if applicable the number of programs in each county, where supported housing is available? NAMI has data from fiscal year XXXX indicating that the state has XX supported housing programs. If that information is no longer accurate, please update as necessary.

27. Does your state have a person who is responsible for coordinating housing services for people with serious mental illnesses? If yes, please provide that person's name and telephone number.

28. Does your state have a written plan for addressing the long-term housing needs of people with serious mental illnesses?

29. Could you please list the counties, and if applicable the number of programs in each county, where pre- and post-booking jail diversion services are available? NAMI has data from fiscal year XXXX indicating that the state has XX jail diversion programs. If that information is no longer accurate, please update as necessary.

30. Does your state have a written plan to ensure the timely restoration of SSI/SSDI and Medicaid/Medicare benefits for individuals with serious mental illnesses discharged from jails?

31. Are consumers and families in your state involved in the implementation of evidence-based practices? Please provide a brief example in five sentences or less.

32. Did your state apply for a Transformation State Incentive Grant (TSIG), and is the state able to document meaningful consumer and family participation in the grant application process?

33. Has your state completed in writing a comprehensive mental health workforce needs assessment and a strategic plan to address those workforce needs?

34. Does your state study the causes of death for individuals with serious mental illnesses, and does it gather information about race and ethnicity of those individuals?

35. Does your state have a program to address the health disparities among individuals with serious mental illnesses? Please provide a brief example in five sentences or less.

36. Does your state's mental health authority prioritize services to individuals with serious and persistent mental illnesses through service eligibility criteria and benefit design?

37. In the past 3 years, has your state demonstrated innovation in solving a pressing mental health problem? Please provide a brief example in five sentences or less.

Thank you for completing this questionnaire. Please submit your response to Abigail Graf at abigail@nami.org by Monday, November 14th.

Consumer and Family Test Drive Methodology and Results

Purpose

An effective mental health system has to be both inclusive and responsive. The Consumer and Family Test Drive (CFTD) was designed to measure actual experiences of consumers and families as they attempted to navigate the system. Specifically, the CFTD sought to determine the level of ease a consumer and/or family member would experience when seeking information about mental health through a state mental health authority's website and/or phone service.

To conduct this study, NAMI National contracted with NAMI New Hampshire to develop and conduct a brief survey to be included in the National State Report Card project. CFTD results represent 10 percent of each state's overall grade in NAMI's *Grading the States* report.

Survey

The survey included 10 common questions and concerns pertaining to mental health issues, rated on a Likert scale of 0-4:

- 0 represented "no information found"
- 1 represented information that was found "with great difficulty"
- 2 represented information that was found "with some difficulty"
- 3 represented information that was found "easily"
- 4 represented information that was found "very easily"

The maximum total score per survey was 40 points. A copy of the survey instrument. A copy of the survey is attached.

The goal was to have two family members and two consumers survey each state. For a state, each rater would conduct both a phone and web survey, for a total of eight surveys per state.

Raters

Consumers and family members were recruited from NAMI New Hampshire's network of volunteers and leadership. All those recruited were currently receiving services, or have received services from the New Hampshire community mental health system. In the end, six consumers and five family members were recruited to be raters. All family members were asked to survey 20 states each. Four consumers were asked to survey 20 states each, and 2 were asked to survey 10 each. Raters received a stipend when their completed surveys were received, and they were also reimbursed for postage and phone bills.

Inter-rater Training

In order to ensure inter-rater reliability, two one-hour orientation sessions were held and raters were asked to attend one of these two sessions. Raters were all trained under the same set of directions. They were to treat their information-gathering role as if they were new to a state and/or were participating in a NAMI survey, and wanted information about where to go for treatment and what services were available.

Training also attended to issues like: How to search for a state mental health authority's website, when to consult the provided "cheat sheet" (NAMI National provided phone and website information if the consumer and/or family member could not find it on their own); how long to spend on each item before checking the "No info found" box; inclusion of anecdotal information; how to score the fact that multiple voice messages were left (score of 0); when to "give up" searching for information and provide a score.

Data Collection

The data collection period ran 6 weeks, from the beginning of November to mid-December, 2005. Before raters began their surveys, project staff piloted the survey on a few states to determine possible problems that raters might encounter during the process. Throughout the data collection period, project staff provided extensive and consistent phone technical assistance to raters.

In all, 322 surveys were collected out of a possible 400. Reasons for not obtaining the full 400 surveys included: a family member dropped out of the project for personal reasons; raters were sidetracked by the holidays and work responsibilities; in one phone case, the rater had a negative experience with a state mental health authority staff member and, as a result, did not wish to make any more phone calls.

All state surveys had consumer and family member representation. Although the goal was to have eight surveys completed for each state, final completed state survey data points ranged from 4-8. In the case where states only had four completed surveys, these represented data from at least one family member and one consumer, and included at least two phone surveys and two website surveys.

Scoring

A state's CFTD score represented 10% or 10 points of its overall grade. The CFTD rating system was established as such: For each state, a Mean Score was obtained by calculating the average total survey score (out of a possible 40 points) for that state. The Mean Score was calculated using all completed phone and website surveys for that state. States were then rank ordered according to their Mean Score, and distributed into 10 groups of 5 states each. Final scores were curved as follows: the top 5 states received 10 points for their CFTD score, the next 5 received 9 points for their CFTD score, and so on. In one case, a sixth state was placed in a group because of a tied score.

Results and Discussion

Overall, the results point to major lags in the communication of important service and treatment information. Given the overall fragmentation of mental health systems, this is not surprising, but is not acceptable.

Clear trends emerged across states and across communication medium:

- **Inadequate phone and website accessibility**

Over 80 percent of states did not acquire even *half* of the total possible points on the survey, indicating that the vast majority of state mental health authorities do not adequately communicate basic information to their customers. Both consumers and family members felt frustrated and discouraged at the difficulty in accessing information, feelings that are potential roadblocks to empowering consumers and families to play an active role in their treatment. Greater emphasis should be placed on enhancing state information service systems. Making contact with public health service systems easy and informative for consumers and family members will add to the likelihood of better treatment outcomes.

- **Information systems lack cultural competency**

As indicated above, accessibility to information on mental health is inadequate for the majority population, but it is even worse for diverse, underserved populations. In the CFTD, raters assessed the ease of access to information on mental illnesses and their treatment *in a non-English language*, using a broad definition of "non-English speaker" that included those who are deaf and hard of hearing, as well as those who are blind.

The mean for this item, including both phone and website surveys, was the lowest of any item (1.19 points out of 4 possible points). Such a low score indicates that information in a non-English language was found *only with great difficulty*. Some states did better than others on this item, specifically New York, California, Arizona and Maryland, although no state earned a perfect score. Disappointingly, some states with large multicultural populations scored well below the mean, including Virginia, New Mexico and Florida.

It is well documented that individuals of multicultural backgrounds already face a myriad of barriers in accessing services, and the experience of this survey just confirms that sad reality.

• Phone services are superior to websites
The mean scores for phone service were significantly greater than the scores for web service. On average, states scored 17.02 points on their phone surveys, and 12.99 points on their website surveys. Some states (Massachusetts and Texas) had much higher mean scores for web service than phone service, indicating that those states better utilize their websites to communication information. In contrast, some states (New Jersey and Washington) still rely heavily on the phone to communicate information, as indicated by a much higher mean score for phone service than web service.

In a rapidly changing world of information technology, more and more consumers and family members will rely on the web, but our survey results confirm that states have been slow to adapt. State mental health authorities need to take advantage of the new technology and put more resources into their web-based systems. And, in this time of limited staff resources, enhanced information on websites can help to relieve the burden on phone personnel within state mental health authorities in answering frequently asked questions.

Additionally, states should be mindful of using technologies that the general public have available to them, rather than esoteric or sophisticated technologies. As an example, some raters were frustrated by the large quantity of website documents that could only be accessed as PDF files. Their computers did not have the required technology to open these documents.

• Intra-state inconsistency with respect to phone service personnel responses
Inconsistency within state phone services was an issue in general for consumers and family members. For example, in over half the states, phone personnel within the state mental health authority requested a zip code, mailing address, and /or county before providing information and referral services. However, within those same states, other raters had a different experience when requesting information and were not asked to provide a zip code, mailing address, and/or county, indicating that phone personnel within states may not be dealing with calls in a consistent way. Another example of intra-state inconsistency is captured by this common situation: Two raters left voicemails for the same staff person, and only one of those raters received a call back.

• Communication between phone carriers and state mental health authorities needs improvement
Raters complained numerous times that phone carriers (e.g. Information, 411) gave them the wrong numbers for state mental health authorities, even when raters gave these phone carriers the name of the city in which the state mental health authority was based. Oftentimes, raters called these phone carriers a few times, yet multiple phone calls did not always yield the correct phone number. State mental health authorities should ensure that phone carriers have updated contact information

Following in this Appendix is a listing of each state's performance on the Consumer and Family Test Drive, including a breakdown of the phone and Web scores. For a more detailed analysis of the CFTD, visit www.nami.org.

Test Drive Score Results

State	Test Drive Score (out of 10 pts)	Mean Score Phone + Web (out of 40 points)	Mean Score Phone (out of 40 points)	Mean Score Web (out of 40 points)	Total # of surveys collected
1. Tennessee	10	24.75	28.00	21.50	8
2. Ohio	10	23.88	28.75	19.00	8
3. Indiana	10	23.57	32.00	17.25	7
4. South Carolina	10	22.33	21.33	23.33	6
5. Michigan	10	21.50	22.67	20.33	6
6. West Virginia	10	21.50	23.50	19.50	4
7. Rhode Island	9	20.25	30.00	10.50	4
8. Connecticut	9	20.17	24.00	16.33	6
9. Wyoming	9	20.00	22.75	16.33	7
10. Minnesota	9	19.75	17.75	21.75	8
11. Alaska	8	19.57	15.00	23.00	7
12. Florida	8	18.75	22.50	15.00	4
13. New Jersey	8	18.67	30.67	6.67	6
14. Oregon	8	18.00	16.00	20.00	4
15. Maryland	8	18.00	27.50	8.50	4
16. New York	7	17.83	14.00	21.67	6
17. Mississippi	7	17.75	18.50	17.00	8
18. North Carolina	7	17.63	23.75	11.50	8
19. Maine	7	17.33	19.00	15.67	6
20. Washington DC	7	17.25	20.00	14.50	4
21. Utah	7	17.00	21.50	12.50	8
22. New Hampshire	6	16.63	14.50	18.75	8
23. Arizona	6	16.50	23.00	10.00	6
24. California	6	16.00	12.00	20.00	6

State	Test Drive Score (out of 5 pts)	Mean Score Phone + Web (out of 40 points)	Mean Score Phone (out of 40 points)	Mean Score Web (out of 40 points)	Total # of surveys collected
25. Georgia	6	16.00	16.75	15.25	8
26. Hawaii	6	15.33	22.00	8.67	6
27. Texas	5	14.75	8.00	21.50	4
28. Wisconsin	5	14.60	14.00	15.00	5
29. Oklahoma	5	14.25	16.75	11.75	8
30. Massachusetts	5	14.17	7.33	21.00	6
31. Vermont	5	14.00	10.67	16.50	7
32. Delaware	4	13.88	20.50	7.25	8
33. Colorado	4	13.50	23.50	3.50	4
34. Iowa	4	13.38	20.75	6.00	8
35. Washington	4	12.80	25.00	4.67	5
36. Montana	4	12.63	18.00	7.2	8
37. Nebraska	3	12.14	12.00	12.25	7
38. Virginia	3	11.38	16.75	6.00	8
39. Idaho	3	11.33	13.00	9.67	6
40. Nevada	3	11.17	11.33	11.00	6
41. Kansas	3	11.0	5.00	17.00	6
42. Pennsylvania	2	10.50	19.33	1.67	6
43. Louisiana	2	10.33	6.67	14.00	6
44. North Dakota	2	10.17	10.33	10.0	6
45. Kentucky	2	8.50	6.00	11.00	6
46. Illinois	2	7.50	10.00	5.00	6
47. Arkansas	1	7.13	8.50	5.75	8
48. New Mexico	1	6.67	10.00	3.33	6
49. South Dakota	1	6.00	2.00	8.67	5
50. Missouri	1	5.50	6.00	5.00	8
51. Alabama	1	3.38	2.00	4.75	8

NAMI Instrument Used for Consumer and Family Test Drive

NAMI's Consumer and Family Test Drive of Accessible Information from the State Mental Health Authority

Name of person completing this form: _____ Date: _____

US State surveyed: _____

Conducted *(please mark one)*: Phone Website

How would you describe yourself? *(Please check box that best describes your work for this survey)*:

❑ Consumer ❑ Family member

Did you have to ask NAMI NH for the website address or phone number of the State Mental Health Authority?

❑ Yes ❑ No

If phone survey, did you leave a voice message, and not hear back within 24-48 hours?

❑ Yes ❑ No

If phone survey, did you leave a second voice message, and not hear back within 24-48 hours again?

❑ Yes ❑ No

Start Time: _____ Finish Time: _____

Names/Positions of people with whom you spoke on the phone *(if available)*:

1. _____

2. _____

3. _____

4. _____

Survey

Please indicate how easy it was to find or obtain information from the State Mental Health Authority on the following topics. If you were unable to find or obtain any information on a particular topic in 2-3 minutes, check the box that reads, "No information found" and go on to the next question.

	0	1	2	3	4	Comments
I can find information from the State Mental Health Authority on…	No info found	With great difficulty	With some difficulty	Easily	Very easily	Indicate additional information here (described in Directions)
1.Where to go for help for mental illness						
2.The treatment of severe mental illness (schizophrenia, bipolar disorder, major depressive disorder)						
3. Treatment for co-occurring disorder (having both a mental illness and a substance abuse disorder)						
4. Supported housing						
5. How to apply for Medicaid						
6. The process of involuntary commitment to inpatient care (state psychiatric hospital)						
7. Mental illnesses and their treatment in a non-English language						
8. How to communicate feedback or complaints to the State or County Mental Health Authority						
9. Medications for the treatment of mental illness						
10. Recovery and wellness promotion (quitting smoking, exercise, managing medications, etc.)						

The National Alliance on Mental Illness

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