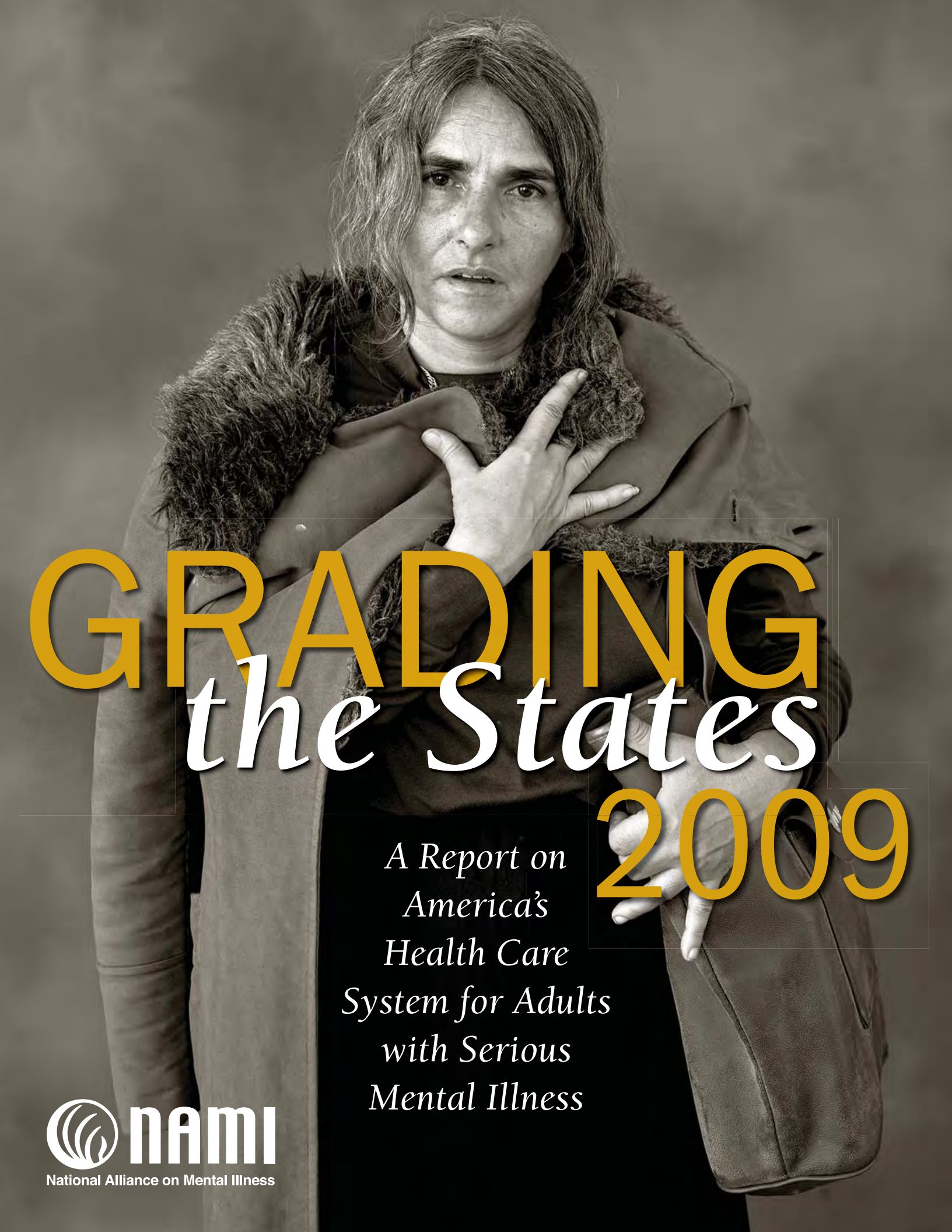

GRADING *the States* 2009

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

NAMI
National Alliance on Mental Illness

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NAMI is the National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1,100 affiliates in communities across the country who engage in advocacy, research, support, and education. Members of NAMI are families, friends and people living with mental illnesses such as major depression, schizophrenia, bipolar disorder, obsessive-compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD), and borderline personality disorder.

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LETTER FROM NAMI EXECUTIVE DIRECTOR

Mental illness causes more disability than any other class of illness in the nation. One in four Americans experience mental illness at some point in their lives; twice as many of us live with schizophrenia than live with HIV/AIDS. Yet in 2003, the presidential New Freedom Commission on Mental Health found that the service system responsible for helping those with mental illnesses was fragmented and "in shambles." In America today, the people who must rely on this system are actually being oppressed by it, and many years of bad policy decisions have left emergency rooms, the criminal justice system, and families to shoulder the burden of responding to people in crisis.

In 2006, NAMI published the first *Grading the States: A Report on America's Health Care System for Serious Mental Illness.* This is our second report, building on the baseline of the first. It measures each state's progress—or lack of progress in many cases—in providing evidence-based, cost-effective, recovery-oriented services for adults living with serious mental illnesses.

Grading the States promotes transparency and accountability in measuring our progress toward "transformation" of the nation's system of care, as envisioned by the New Freedom Commission. In our first report, the nation's grade was a D. Five states earned a B and eight states flunked outright. In this second report, three years later, NAMI documents marginal progress across the country, but not enough to move the nation from a D grade. Fourteen states increased their overall score over the past three years. For almost half the states (23), their grade remains unchanged since 2006, while 12 states have fallen behind. Although none of the states achieves a standard of excellence, NAMI might have been able to herald their progress as a small first step forward, except for a major dark shadow on the ground.

America today faces the greatest economic crisis since the Great Depression. Almost every state, county, and local government is facing large deficits and cutting public services across the board. State Medicaid programs are being squeezed. The budgets of state mental health agencies are being slashed. We know from experience that states often respond to fiscal crises by reducing mental health budgets. As a result, the status of each state system may *already* be falling below the levels documented in this report.

The challenge to our leaders across America today is to find the vision, the political will, and the funding to hold the line; to allow state mental health care systems to continue to move forward and build momentum for change. For NAMI, change means mental health care systems that are accessible, flexible, and promote continuity of care, while paying for only those services that work.

The challenge also is one of generating new ideas—creating innovative financing mechanisms or collaborations, including some described in this report. NAMI's natural allies in this will be the National Governors Association, the National Conference of State Legislatures, the Council of State Governments, the National Association of Counties, the National Association of State Mental Health Program Directors, and the National Council for Community Behavioral Healthcare, to name a few. We see this report as a tool for engaging all of these groups—a common rallying point and the foundation for a dialogue that will bring about real change.

Crisis creates opportunities. Publication of this report coincides with the inauguration of a new President who sees health care reform as part of the nation's broader economic challenge. Of course, mental health is part of health care. Indeed, this report highlights the need to better integrate mental health care with physical health care and wellness. Health care reform is therefore an important opportunity to strengthen the federal government's support of state and local mental health care systems, through improvements to the Medicaid program and key policy changes. Together, at every level, we must advance, not retreat.

As we move toward publication, a temporary infusion of greater federal funding for Medicaid seems likely as part of the nation's economic recovery plan. Federal support for building the mental health care workforce would address this system's staffing crisis while simultaneously responding to unemployment rates that threaten to reach 10 percent or more. Our hope is that this report will stimulate creative ideas like these that can have a direct impact on multiple fronts.

NAMI thanks all of the state mental health authorities that responded to the *Grading the States* survey. Their willingness to have an independent third party assess their work in close detail is particularly commendable. It is worth noting that many consumer and family comments included in the report praised the caring dedication of people who work within state systems—even as they condemned the lack of adequate resources and system failures.

NAMI thanks the Stanley Family Foundation for funding the report and Dr. E. Fuller Torrey, whose vision produced state ratings reports in 1986, 1988, and 1990. Without their support, this report would not have been possible.

Above all, NAMI thanks all those individuals and families who live with serious mental illnesses who lent their voices to this report and support our work. On their behalf, let us all seek together a new mental health care system, marked by hope, opportunity, and recovery.

Michael J. Fitzpatrick
Executive Director
National Alliance on Mental Illness

EXECUTIVE SUMMARY

Our national mental health care system is in crisis. Long fragile, fragmented, and inadequate, it is now in serious peril. In 2003, the presidential New Freedom Commission presented a vision for a life-saving, recovery-oriented, cost-effective, evidence-based system of care. States have been working to improve the system, but progress is minimal.

Today, even those states that have worked the hardest stand to see their gains wiped out. As the country faces the deepest economic crisis since the Great Depression, state budget shortfalls mean budget cuts to mental health services.

The budget cuts are coming at a time when mental health services are even more urgently needed. It is a vicious cycle that destroys lives and creates more significant financial troubles for states and the federal government in the long run.

One in four Americans experience mental illness at some point in their lives. The most serious conditions affect 10.6 million people. Mental illness is the greatest cause of disability in the nation, and twice as many Americans live with schizophrenia than with HIV/AIDS.

We know what works to save lives and help people recover. In the face of crisis, America needs to move forward, not retreat. We cannot leave our most vulnerable citizens behind.

The Grades

In 2006, NAMI published *Grading the States: A Report on America's Mental Health Care System for Serious Mental Illness*, to provide a baseline for measuring progress toward the transformation envisioned by the New Freedom Commission. In 2006, the national average was a D grade.

Three years later, this second report finds the national average to be stagnant—again a D. Fourteen states have improved their grades since 2006, but not enough to raise the national average. Twelve states have fallen back. Twenty-three states have stayed the same.

Oklahoma improved the most, rising from a D to a B; South Carolina fell the farthest, from a B to a D.

Overall, the grade distribution for 2009 is:

- Six Bs
- Eighteen Cs
- Twenty-one Ds
- Six Fs

A table comparing the 2006 and 2009 grades of each state immediately follows this summary.

Most of the information on which the 2009 grades are based was compiled and analyzed in 2008. As state legislatures work on budgets for 2009-2010, much of the work accomplished since 2006, no matter whether it occurred in states earning a B or an F, is now on the chopping block.

The grades are based on 65 specific criteria. Each state received grades in four categories, which then comprise the overall grade.

State mental health agencies were the primary source of information for the report, responding to a NAMI survey in August 2008. Other data were drawn from academic researchers, health care associations, and federal agencies.

NAMI conducted a nationwide Web-based survey, which drew over 13,000 responses from consumers and family members. The results were not used in the grading process, but helped inform the report. Some consumer and family comments from the survey accompany state narratives in Chapter 5. NAMI volunteers also conducted a "Consumer and Family Test Drive" of state mental health agency Web sites and telephone resources to measure the ease (or difficulty) of access to information—which is the first challenge in finding help when it is needed.

The Information Gap

This report presents 10 characteristics of a life-saving, cost-effective, evidence-based mental health care system, and discusses specific programs. A critical concern is the need for greater data to help drive decision-making.

An information gap exists in measuring the performance of the mental health care system. To some degree, states are groping blindly in the dark while seeking to move forward.

The fault begins at the federal level, where the U.S. Department of Health and Human Services' (HHS) Substance Abuse & Mental Health Services Administration (SAMHSA) has failed to provide adequate leadership in developing uniform standards for collecting state, county, and local data.

This report provides the nation's most comprehensive, comparative assessment of state mental health care systems to date. But more information on performance and outcomes is needed.

Key Findings

Many states are valiantly trying to improve systems and promote recovery, despite a stranglehold of rising demand and inadequate resources. Many states are adopting better policies and plans, promoting evidence-based practices, and encouraging more peer-run and peer-delivered services. But state improvements are neither deep nor widespread across the nation. This report's findings follow the four categories in which each state was graded:

Health Promotion and Management

- States are not focusing on wellness and survival for people with serious mental illnesses.
- States do not have adequate data on critical mental health services.
- Few states have public health insurance plans that adequately meet the needs of people with serious mental illnesses.
- Private insurance plans often lack sufficient coverage for mental health and substance use disorders.

- Most states have inadequate plans for developing and maintaining the mental health workforce.

Financing and Core Treatment/Recovery Services

- State mental health financing decisions are often penny-wise, pound-foolish.
- States are not adequately providing services that are the lynchpins of a comprehensive system of care, such as Assertive Community Treatment, integrated mental health and substance abuse treatment, and hospital based care when needed.
- States are not ensuring that their service delivery is culturally competent.

Consumer and Family Empowerment

- Information from state mental health agencies is not readily accessible.
- States are not creating a culture of respect.
- Consumers and family members do not have sufficient opportunities to help monitor the performance of mental health systems.

Community Integration and Social Inclusion

- Few states are developing plans or investing the resources to address long-term housing needs for people with serious mental illnesses.
- Effective diversion from the criminal justice system is more common, but remains scattershot without state-level leadership.
- Most states are beginning to provide public education on mental illness, but stigma remains a major concern.

Policy Recommendations

To transform our nation's mental health care system, the federal government, governors, and state legislators must take action in five key areas. This report offers specific recommendations in each area. Chapter 4 highlights states that are currently supporting some of these critical steps.

1. Increase Public Funding for Mental Health Care Services

- Institute modest tax increases
- Reallocate resources
- Establish dedicated trusts

2. Improve Data Collection, Outcomes Measurement, and Accountability

- Establish firm federal leadership
- Reestablish priority for mental health data collection at the federal level
- Standardize data collection within (and across) states

National and State Grades Comparison between 2006 and 2009

	2006	2009
USA	**D**	**D**
Alabama	D	D
Alaska	D	D
Arizona	D	C
Arkansas	D	F
California	C	C
Colorado	–	C
Connecticut	B	B
DC	C	C
Delaware	C	D
Florida	C	D
Georgia	D	D
Hawaii	C	C
Idaho	F	D
Illinois	F	D
Indiana	D	D
Iowa	F	D
Kansas	F	D
Kentucky	F	F
Louisiana	D	D
Maine	B	B
Maryland	C	B
Massachusetts	C	B
Michigan	C	D
Minnesota	C	C
Mississippi	D	F
Missouri	C	C
Montana	F	D
Nebraska	D	D
Nevada	D	D
New Hampshire	D	C
New Jersey	C	C
New Mexico	C	C
New York	–	B
North Carolina	D	D
North Dakota	F	D
Ohio	B	C
Oklahoma	D	B
Oregon	C	C
Pennsylvania	D	C
Rhode Island	C	C
South Carolina	B	D
South Dakota	F	F
Tennessee	C	D
Texas	C	D
Utah	D	D
Vermont	C	C
Virginia	D	C
Washington	D	C
West Virginia	D	F
Wisconsin	B	C
Wyoming	D	F

- Report on evidence-based practices
- Track wait times in emergency rooms

3. Integrate Mental and Physical Health Care

- Expand pilot programs that link physical and mental health
- Co-locate primary care physicians and psychiatrists in clinics
- Cover preventive care in private and public health insurance plans
- Increase use of health and wellness programs

4. Promote Recovery and Respect

- Employ peer specialists
- Fund peer-run services
- Fund peer-education programs
- Provide culturally and linguistically competent services
- Invest resources in reducing human rights violations
- Increase employment opportunities
- Increase housing opportunities

5. Increase Services for People with Serious Mental Illnesses Who are Most at Risk

- Eliminate the Institutions for Mental Diseases (IMD) exclusion
- Implement a coherent response on non-adherence to treatment, including peer counseling, psychiatric advance directives, treatment guardianships, and assisted outpatient treatment
- Adopt incentives to increase the qualified mental health workforce

In Conclusion

Today's economic crisis presents a daunting challenge for all Americans, including public officials who, NAMI recognizes, must make hard choices. But change is urgently needed.

We need leadership, political will, and investment from governors, legislatures, and other champions to preserve—and build on—the modest progress being made to improve public mental health care. We need to rise above existing inadequacy. We need to save lives and help people to recover.

Transformation of the mental health care system will take time. It will occur incrementally. We can measure its progress, but progress will only occur if we make it happen.

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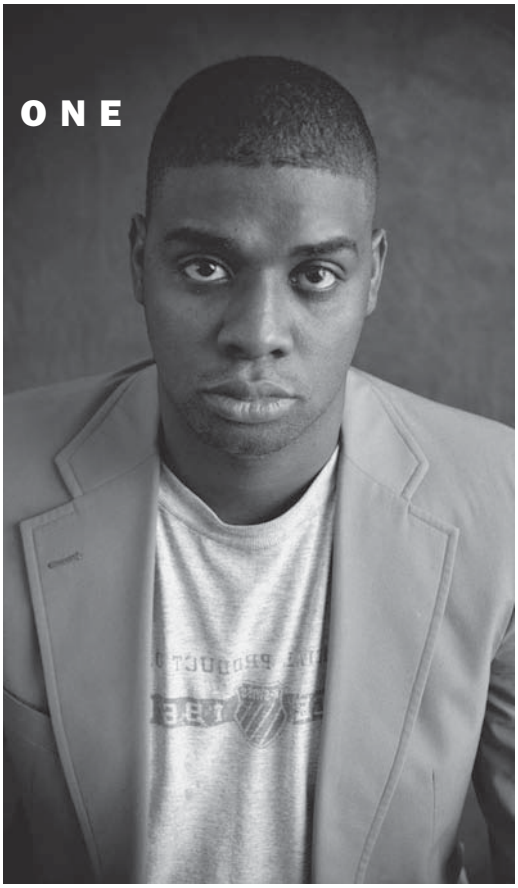
CHAPTER ONE



A Vision for Transforming State Public Mental Health Systems

In 2003, the presidential New Freedom Commission described mental health care in the United States as a "system in shambles," in need of fundamental transformation.[1] Three years later, in another major report, the National Academy of Sciences' Institute of Medicine (IOM) proposed a major overhaul of our behavioral health care system, calling it "untimely, inefficient, inequitable, and at times unsafe."[2] These findings built on the U.S. Surgeon General's landmark 1999 *Report on Mental Health*.[3] Yet despite these repeated calls for reform, the prospects for people with serious mental illnesses in this country remain bleak.[4]

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[1] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America: Final Report* (Rockville, MD: DHHS Publication No. SMA-03-3832, 2003). Available at http://www.mentalhealthcommission.gov/. These findings echo earlier assessments of the nation's public mental health system including the work of Dorothea Dix in the 1800s, Albert Deutsch in the 1940s, and E. Fuller Torrey in the 1980s and 1990s.

[2] National Academy of Sciences Institute of Medicine (IOM), *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series, Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders* (Washington, DC: The National Academies Press, 2006). Available at http://www.iom.edu/CMS/3809/19405/30836.aspx. "Behavioral health" is a term that encompasses the diagnosis and treatment of both mental illnesses and/or substance abuse disorders.

[3] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999). Available at http://mentalhealth.samhsa.gov/cmhs/surgeongeneral/surgeongeneralrpt.asp.

[4] NAMI identifies as a priority population those persons of all ages who have serious mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, borderline personality disorder, post-traumatic stress disorder (PTSD), autism and pervasive developmental disorders, and attention deficit/hyperactivity disorder. These disorders represent the major mental disorders that current scientific data and consensus conclude are identifiable, disabling medical illnesses, with significant biological underpinnings, and requiring treatment.

The nation can sit idly no longer. It is time to break down the barriers in government that have led to the abandonment of people with serious mental illness; and to undo years of bad policies that have increased the burdens on emergency rooms, the criminal justice system, families, and others who have been left to respond to people in crisis. We must invest adequate resources in mental health services *that work* and finally end the pervasive fragmentation in America's system of care.

A transformed mental health system would be comprehensive, built on solid scientific evidence, focused on wellness and recovery, and centered around people living with mental illnesses and their families. It would be inclusive, reaching underserved areas and neglected communities, and fully integrated into the nation's broader health care system.

A transformed system will require new attitudes and new investment. To reach this goal, we need vision and political will—on Capitol Hill, in state legislatures, and in communities across America. The good news: we know now what is necessary to create the mental health care system we want to see. Building on NAMI's *2006 Grading the States* report, this 2009 edition identifies the pillars of a high-quality system, provides an unvarnished assessment of where we are—state-by-state and as a nation—and identifies specific recommendations to guide the field towards the vision.

10 Pillars of a High-Quality State Mental Health System

As a nation, and as a mental health community, our knowledge base about mental illness is uneven. We know far less than we should about the causes and courses of mental illnesses. On the other hand, we know a lot about the staggering consequences—for the individual, for families, and for society—of untreated mental illness. We know that we provide treatments and services too late, and that too few people get the help they need to experience recovery. We also know that in order to deliver effective treatments to the many people who need them, public mental health service systems need to change dramatically.

Based on what we know, derived from 30 years of research and work in the field, NAMI understands what a successful mental health system must include. NAMI believes deeply that a transformed mental health system has the following very specific characteristics. It is:

1. Comprehensive;
2. Integrated;
3. Adequately funded;
4. Focused on wellness and recovery;
5. Safe and respectful;
6. Accessible;
7. Culturally competent;
8. Consumer-centered and consumer- and family-driven;
9. Well-staffed and trained; and
10. Transparent and accountable.

These are the 10 pillars of a high-quality mental health system. Following is a brief discussion of each one—why it is critical and where things stand (a more detailed, state-by-state analysis can be found in Chapter 5). The sections below also provide some strategies states can pursue to begin addressing the challenges in each area.

1. Providing Comprehensive Services and Supports

Today, having a serious mental illness need no longer mean a lifetime of suffering or dependency. Indeed, many people living with mental illnesses, and their families, often describe themselves as being in "recovery," meaning they are, or are working toward, living independently in a community of their choice, while striving to achieve their full potential.[5] For many, this goal is realistic if the right services and supports are in place. Throughout this report, we include direct quotes about recovery from people living with serious mental illnesses and their family members.

[5] This definition was developed at a National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. As part of this conference, a series of technical papers and reports were commissioned examining topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center: Center for Mental Health Services, *National Consensus Statement on Mental Health Recovery* (Washington, DC: U.S. Department of Health and Human Services, 2004). Available at http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129/.

Every mental health system must have carefully balanced and adequate levels of care. The service continuum includes state hospitals, short-term acute inpatient and intermediate care facilities, crisis services, outpatient and community-based services, and independent living options. The exact mix and intensity of necessary services will vary from one person to another, and even for the same person, over time. A truly comprehensive mental health system must offer, regardless of ability to pay, services such as:

- Access to prescribers and medications;
- Acute and long-term care treatment;
- Affordable and supportive housing;
- Assertive Community Treatment (ACT);
- Consumer education and illness self-management;
- Crisis intervention and stabilization services;
- Family education;
- Integrated treatment of co-occurring disorders;
- Jail diversion;
- Peer services and supports; and
- Supported employment.

This list is not exhaustive. A comprehensive system would also include screening, assessment, and diagnosis; a wide range of diagnostic-specific therapies (e.g., Dialectical Behavior Therapy for borderline personality disorder); case management; psychosocial rehabilitation; certified clubhouses; drop-in centers; supported education, and many other critical services and supports. The list will grow and change as new scientific evidence identifies emerging, promising, and best practices. Brief descriptions of the service components listed above are found in a textbox towards the end of this chapter.

Services Should Be Evidence-Based

State mental health systems and other state agencies must ensure that the services and supports they deliver are *effective*. Treatments and approaches with proven effectiveness are growing and must be made available in every community that needs them, replacing outdated and less effective alternatives (see textbox on "Bridging Research and Practice").

"Recovery means that my mental illness is a part of my life instead of the focus."

— Consumer from Montana

More research must be conducted so that "promising practices" and treatments can be developed for sub-groups of people that lack well-established, effective approaches. As the lead federal agency for transformation initiatives that have flowed from the New Freedom Commission, the Substance Abuse and Mental Health Services Administration (SAMHSA) has played an important role in disseminating national guidelines and "implementation resource kits" for proven evidence-based practices (EBPs) such as ACT, supported employment, and inte-

Bridging Research and Practice

Many non-profit organizations and government agencies are helping disseminate up-to-date information about evidence-based practices (i.e., those that have been proven to consistently produce specific, intended results). These include:

- The federal Agency for Healthcare Research and Quality (AHRQ): http://www.ahrq.gov/clinic/epcindex.htm#psychiatry
- The American Psychiatric Association (APA). Practice Guidelines can be found at: http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm
- The American Psychological Association's Committee for the Advancement of Professional Practice's (CAPP) Task Force on Serious Mental Illness and Severe Emotional Disturbance (TFSMI/SED): http://www.apa.org/practice/grid.html
- The Centre for Evidence-Based Mental Health (CEBMH): http://www.cebmh.com/
- The Cochrane Collaboration: http://www.cochrane.org
- The National Guideline Clearinghouse. Diagnostic, assessment, and treatment guidelines can be found at: http://guideline.gov
- The Substance Abuse and Mental Health Services Administration (SAMHSA). Evidence-Based Practices Implementation Web site: http://ebp.networkofcare.org; Evidence-Based Practice (EBP) Implementation Resource Kits: http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/; and National Registry of Evidence-Based Programs and Practices (NREPP): www.nrepp.samhsa.gov
- The Technical Assistance Collaborative (TAC) and the American College of Mental Health Administration (ACMHA). A step-by-step manual, *Turning Knowledge into Practice: A Manual for Behavioral Health Administrators and Practitioners About Understanding and Implementing Evidence-Based Practices* (Fall 2003), can be found at: http://www.tacinc.org/Pubs/TKIP.htm

grated dual diagnosis treatment (IDDT). SAMHSA has also awarded Transformation State Incentive Grants (TSIGs) to nine states to accelerate improvements in their mental health infrastructure (e.g., inter-agency collaboration, technology use, and workforce development).[6] Together, these are meaningful first steps, but much more is needed.

[6] In October 2005, grants were awarded to Connecticut, Maryland, New Mexico, Ohio, Oklahoma, Texas, and Washington. In October 2006, two additional awards were made to Hawaii and Missouri. See http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/mentalhealth/ default.asp.

Finding the Right Balance

Establishing the right balance of high-quality services means avoiding shortages on either end of the continuum of care. When a full spectrum of community-based services is not available, people languish in emergency rooms, hospital beds, jails, and nursing homes, and those facilities become overcrowded. As one commentator succinctly noted:

> The key to all this is a balance between adequate inpatient slots and a robust set of community services—a balance many states have had trouble striking, especially as they cut or fail to fund

Non-Adherence to Treatment

It is not uncommon for people with serious mental illnesses to discontinue their own treatment, in particular, their use of prescribed medications. There are a number of reasons for this:

- They have a neurological syndrome called Anosognosia that leaves them unaware that they are ill. As many as 50 percent of people with schizophrenia are affected by this condition,[7] and it is the most significant reason why people with illnesses characterized by psychosis refuse treatment;
- Their medications have uncomfortable or even debilitating side effects;
- They experience little or inadequate symptom relief;
- They perceive stigma about having a mental illness; and/or
- They have had negative experiences in the mental health system, ranging from indifference and disrespect to abusive and inhumane treatment.

What Are The Consequences?

The consequences of discontinuing treatment can be devastating, including unnecessary hospitalizations, homelessness, criminal justice involvement, victimization, and suicide.[8]

What Can Be Done?

Because of the very real potential for harmful or tragic consequences, mental health systems should have a range of strategies in place to help people with serious mental illnesses adhere to their prescribed treatment.

Assertive Community Treatment (ACT) — An evidence-based, outreach-oriented, service delivery model using a 24/7 multi-disciplinary clinical team approach, ACT provides comprehensive, individualized community treatment (including substance abuse treatment, housing, and employment support) and is particularly effective in helping people who are most at risk of falling through the cracks of the mental health system.

Peer Support — People who live with mental illness are often very effective in assisting or encouraging their peers to stick with treatment. Programs emphasizing self-help and mutual support have gained prominence in public mental health systems,[9] and anecdotal evidence suggests they should be studied further.

Motivational Approaches — Borrowing from the success of motivational approaches used to treat addictions, mental health-oriented techniques are emerging. For example, the LEAP (Listen-Emphasize-Agree-Partner) method has been shown to build trust, reduce conflict, and lead to positive outcomes over time.[10]

Respectful Treatment Environments — Environments in which people are treated with respect and dignity are important to forging trust,

(continued)

[7] Mark Olfson et al., "Awareness of Illness and Non-Adherence to Antipsychotic Medications Among Persons with Schizophrenia," *Psychiatric Services* 57 (2006): 205; and Stefano Pini et al., "Insight into Illness in Schizophrenia, Schizoaffective Disorder, and Mood Disorders with Psychotic Features," *American Journal of Psychiatry* 158 (2001): 122.

[8] A study of individuals with severe mental illnesses in the Los Angeles county jail revealed that 92 percent had a history of non-adherence to psychiatric medications prior to arrest. H. Richard Lamb et al., "Treatment Prospects for Persons with Severe Mental Illness in an Urban County Jail," *Psychiatric Services* 58, no. 6 (2007): 782. The Olfson et al (2006) study, cited above, also revealed that individuals with schizophrenia who discontinued psychiatric medications were more likely to be hospitalized.

[9] Ingrid D. Goldstrom et al., "National Estimates for Mental Health Mutual Support Groups, Self-Help Organizations, and Consumer-Operated Services," *Administration and Policy in Mental Health* 33, no. 1 (2006): 92.

[10] Christina Bruni, "An Interview with Xavier Amador, Ph.D.," *Schizophrenia Connection.com*, http://www.healthcentral.com/schizophrenia/c/120/27693/interview-part/pf/ (accessed on January 12, 2008).

Non-Adherence to Treatment *(continued)*

which then promotes adherence to treatment. When positive, respectful attitudes are conveyed by everyone from receptionists to treatment professionals, an individual's experience of treatment is greatly improved.

Psychiatric Advance Directives (PADs) — PADs are legal agreements through which people with mental illnesses can state treatment preferences and/or authorize others to act on their behalf if they cannot make informed decisions concerning treatment of their mental illness. Twenty-five states have laws authorizing PADs; in others, PADs may be part of living wills or general healthcare advance directives.

Conservatorships and Guardianships — All states have laws authorizing courts to appoint an individual to make treatment decisions for another individual who has been determined to lack capacity (i.e., competence) to make those decisions. These legal tools for substitute decision-making are time limited and last only as long as the person remains incompetent.

Assisted Outpatient Treatment (AOT), or Involuntary Outpatient Commitment — Assisted outpatient treatment laws authorize courts to order certain individuals to participate in community treatment. There are strong differences of opinion among mental health advocates and others about AOT. Proponents assert that it is humane and life-saving, while opponents argue that it is an egregious violation of individual rights. NAMI's position is that mental health systems should strongly emphasize strategies that promote voluntary participation, and use involuntary treatment as a last resort.

Forty-two states have laws authorizing AOT. Though many rarely use it, a few use it with regularity including Iowa, New York, North Carolina, and Wisconsin. Legal criteria for using AOT are very narrowly defined in virtually all states, court orders are time limited, and individuals have the right to free legal representation, to present testimony and witnesses on their own behalf, and to have their cases periodically reviewed, among other rights.

Studies suggest that AOT can produce positive outcomes when implemented properly. For example, it must be done in conjunction with sufficient and proven community-based treatment services.

AOT is not a solution for the inadequacies of the public mental health system. If effective and humane community mental health services were more widely available, involuntary interventions would be less necessary. However, experiences in states that use AOT suggest it is one tool that, when used judiciously, can make a positive difference.

> the community services that might keep people out of inpatient beds—all the while cutting the number of those beds.[11]

Another important consideration and challenge is that many people with serious mental illnesses do not seek treatment or follow through with treatment plans. The consequences of this can be devastating, from unnecessary hospitalizations or homelessness, to criminal justice involvement, victimization, and even suicide. A number of strategies designed to respond to these challenges are used in many states, including: ACT, targeted peer supports, specific motivational techniques, psychiatric advance directives (PADs), and Assisted Outpatient Treatment (AOT), also known as involuntary outpatient commitment. State mental health systems must stand ready to bring a range of supports and interventions to treatment non-adherence. For a more detailed discussion of this issue, see textbox on "Non-Adherence to Treatment."

Finally, identifying which combinations of interventions work best in different locations is critical to providing comprehensive services and supports. From state to state, service structures, and administrative and financing arrangements will be different. The age composition, race/ethnicity, and poverty level of the population also will have a major impact on how services are selected and implemented. In the end, each state must find its own recipe for success.

2. Integrating Multiple Systems

Mental health services and supports typically are delivered by a wide range of providers working with different funding streams and a variety of rules and regulations. The result, in the words of the New Freedom Commission, "looks more like a maze than a coordinated system of care."[12] By contrast, a well-integrated system of care would have:

[11] Rob Gurwitt, "Breakdown," *Governing* 22, no. 1 (2008). Available at http://www.governing.com/articles/0810mental.htm.

[12] New Freedom Commission on Mental Health, *Interim Report of the President's New Freedom Commission on Mental Health* (Rockville, MD: U.S. Department of Health and Human Services, 2002). Available at http://www.mentalhealthcommission.gov/reports/Interim_Report.htm.

- Funding streams that are blended (or braided) and can be easily accessed by a range of programs;[13]
- Close collaboration among the full range of involved agencies (e.g., housing, Medicaid, addictions, criminal justice, vocational rehabilitation, education);
- Seamless transitions, especially along frequently-traveled paths such as from inpatient to outpatient care, or from homeless shelters or prisons back into the community;
- Accessibility (i.e., services that are "user-friendly"—especially for those who may have limited physical capacities); and
- Administrative and programmatic requirements that are well-aligned and designed with cross-agency coordination and integration in mind.

No single state agency has complete control over all mental health services. However, because state mental health agencies have fundamental responsibility for organizing and delivering mental health care, they must assume primary responsibility for coordinating with other agencies, even those over which they have limited control (e.g., criminal justice, housing, employment, education, and workforce development). It is especially vital that state mental health agencies coordinate with Medicaid, given its large and growing importance in financing mental health services.[14]

3. Providing Adequate Funding

Finances—both available dollars and the sources of funding—drive service delivery and program design. Effective mental health services, like other types of health services, require resources and a high-quality system of care, and therefore cannot be achieved without adequate funding.

Analyses of public funding have shown that the failure to fund mental health services adequately results in significantly greater funding being required in other systems, such as child welfare, jails and prisons, and emergency rooms, to address the consequences of untreated mental illness.

Since few states put enough money into their public mental health systems to ensure services for all—or even most—of the people who need them, these systems must routinely make decisions to preserve intensity of services for fewer people or serve greater numbers by providing fewer or less intensive services. Public mental health systems are also challenged because mental health care is "countercyclical"—the need for state-provided services rises during economic downturns and other crises.

Funding for public mental health systems comes from Medicaid and other sources such as state and local general funds. Each plays an important role in the design and delivery of services

The Role of Medicaid

Medicaid, which provides federal matching funds for every state dollar spent, pays for more mental health services than any other public or private source. Medicaid covers mental health services for (among others) low-income individuals who meet strict federal disability criteria. As a result, Medicaid is an important source of coverage for many who live with serious mental illnesses. In states that have expanded Medicaid eligibility, more people with mental illnesses are likely covered.

As a significant payer of services, Medicaid has played a substantial role in shaping public mental health systems.[15] For example, Medicaid dollars may not be used to pay for inpatient psychiatric treatment for people aged 22 to 64 in facilities that primarily serve individuals with mental illnesses. This Medicaid exclusion has helped drive the trend to downsize or close state psychiatric hospitals.

The Medicaid program allows states a great deal of latitude in determining plan design. While state Medicaid plans can include a range of im-

[13] Funding streams are "blended" when money from multiple sources is pooled together to pay for a given provider or service. A newer development is "braided" funding, in which each stream is kept separate for accounting and reporting purposes, but they are combined to pay for a package of services for a given individual.

[14] Medicaid now accounts for over half of all state mental health spending (and is projected to grow to as much as two-thirds by 2017), and yet there has been little systematic state-by-state analysis of the effect of Medicaid's growing influence on mental health service systems in terms of policy, funding, and data sharing. A preliminary examination of these issues was sponsored by SAMHSA: see James Verdier et al., *Administration of Mental Health Services by Medicaid Agencies* (Rockville, MD: Department of Health and Human Services Publication No. SMA 07-4301, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2007). Available at http://mentalhealth.samhsa.gov/publications/allpubs/sma07-4301/.

[15] For an overview of Medicaid coverage of mental health services and some of the key challenges in the program, see Cynthia Shirk, *Medicaid and Mental Health Services* (Washington, DC: National Health Policy Forum, Background Paper No. 66, 2008). Available at www.nhpf.org/pdfs_bp/BP66_Medicaid_&_Mental_Health_10-23-08.pdf.

portant community-based mental health services (such as case management, ACT, psychiatric rehabilitation, peer supports, etc.), Medicaid-reimbursable services vary greatly from state to state depending on what services states choose to have covered by their plans. Because of differences in available services and other program elements, people who rely on Medicaid for service coverage can have very different experiences depending on the state in which they live.

Unfortunately, current Medicaid requirements and burdensome processes can make it difficult for states to bill and get adequately reimbursed for effective services, such as ACT and peer supports. The U.S. Department of Health and Human Services could help promote recovery for people with mental illness by expediting the Medicaid reimbursement process for all direct and ancillary costs of evidence-based and emerging best practices in state Medicaid plans. Given Medicaid's prominent role in funding services, mental health leaders should advocate for a well-designed Medicaid plan with policies and services that benefit persons living with serious mental illnesses.

The Role of Non-Medicaid Mental Health Funding

Non-Medicaid mental health funding, such as state and local general funds, plays a vital role in public mental health systems, as it pays for most state hospital care and provides a critical community safety net for persons in crisis or in need of other care. These funds are used to serve persons with serious mental illnesses who are not insured, who have exhausted private coverage, or who are not eligible or are awaiting eligibility for Medicaid.

Because the Medicaid program is limited in scope, non-Medicaid dollars provide important services and supports that are either reimbursed inadequately by Medicaid or not reimbursed at all. Non-Medicaid dollars, when adequate, offer the flexibility needed for comprehensive supports and, importantly, enable the development of new and innovative programs that will become the best practices of tomorrow.

Given the scarcity of resources for public mental health services, it is particularly important that state reimbursement policies and incentive structures support those services proven or that show promise to promote the health and well-being of individuals living with mental illnesses. As a recent review of financing in the behavioral health industry noted:

> A statement of values, a strategic plan, research on evidence-based practices, and even regulatory efforts are critical, but they cannot overcome the reality that what is paid for is what will be provided. Frequently, what is paid for well or easily, or with a high reimbursement rate, will have more influence on which services are provided and in what manner they are provided than the professional standards or the non-financial actions of system leaders and stakeholders.[16]

Much of the cost of care for persons living with serious mental illnesses is shifted onto public systems when private coverage is exhausted and when the private sector fails to provide equitable, timely, and effective mental health treatment.

To minimize such cost shifts and promote earlier intervention, state laws should ensure equal coverage (parity) of mental health and substance use disorders in all public and private health plans.[17] States should also ensure important patient protections such as requiring adequate numbers of specialty providers, assuring timely and appropriate access to care, and covering evidence-based interventions for serious mental illnesses.

4. Focusing on Wellness and Recovery

Mental and physical wellness are strongly linked. Studies have documented that individuals with serious mental illnesses have a higher risk of medical problems such as diabetes, hypertension, and heart disease, and die decades younger (on average) than their counterparts in the general population.[18]

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[16] American College of Mental Health Administration (ACHMA) Workgroup, "Financing Results and Value in Behavioral Health Services," *Administration and Policy in Mental Health* 31, no. 2 (2003): 85. Available at www.acmha.org/publications/FinancingPaperFinal5-16-03.pdf.

[17] Mental health insurance "parity" means that insurance plans must treat mental illnesses and medical and surgical services equally in terms of annual and lifetime limits, co-payments, coinsurance requirements, deductibles, out-of-pocket expenses, frequency of treatment, number of visits, days of coverage, or other limits on the scope and duration of treatment.

[18] Joseph Parks et al. (eds.), *Morbidity and Mortality in People with Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, 2006). Available at http://www.nasmhpd.org/general_files/ publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf.

Many factors contribute to this phenomenon, including the side effects of many antipsychotic medications (e.g., obesity, insulin resistance, and hypertension), the use of medications without adequate monitoring, high rates of smoking, and reduced physical activity and fitness levels among people with serious mental illnesses. Having a mental illness can also undermine self-care and the ability to follow treatments, including substance abuse treatment.

There are also system-based reasons why people living with serious mental illnesses suffer from poorer health. For example, in mental health settings, general medical problems are often under-treated because:

- Many of the clinicians and organizations involved specialize in mental health care, and coordination with general health care is inadequate;
- The ability to measure and improve the quality of care (e.g., by using electronic health records) is less developed in mental health systems; and
- The mental health workforce often includes staff without professional certification and/or who have had minimal training.

At the same time, in primary care settings, mental health problems often go undiagnosed, untreated, or under-treated because a lack of training and ongoing stigma around mental illness mean medical providers may not deliver proper care. Moreover, despite the fact that many people have both mental illnesses and substance use disorders, major administrative, financial, and operational barriers still separate these two care systems.

"Recovery for me means having the ability to function at the best possible level with my mental illness in all areas of my life—specifically in all physical, social, mental, and professional capacities."

— Consumer from Alabama

Given the proven links between physical and mental health concerns and outcomes, these two parts of an individual's health must be addressed together. For people with serious mental illnesses, access to effective substance abuse treatment and health-promoting activities like exercise, smoking-cessation programs, and dietary education are critically important.

High-quality health systems recognize these institutional challenges and work to bridge the many gaps between mental health care, substance abuse treatment, and primary medical care.

5. Creating Safe and Respectful Treatment Environments

Tragically, many people with serious mental illnesses have had painful experiences with the treatment system: they have been put into restraints or seclusion, coerced into certain forms of treatment, suffered abuse or assault, or generally had their concerns ignored. In some parts of the country, inpatient psychiatric treatment facilities, community treatment centers, and residential programs are unsafe and even dangerous. All of this undermines trust and one's willingness to participate in future treatment.

Just like consumers of any health care service, people with serious mental illnesses should be treated with respect and dignity; they should be informed about their medical conditions, consulted about treatment options, and play an important role in planning for their recovery. People with serious mental illnesses should also experience safe and respectful treatment environments which, at a minimum:

- Have well-trained staff and adequate staffing levels;
- Recognize that most clients have histories of trauma, and that forced interventions (which cause trauma as well as re-traumatization) are to be avoided;[19]
- Promptly investigate complaints of abuse and neglect;
- Follow a policy of sharing the findings of any investigation with the individual and family involved;
- Take immediate action to remedy problems; and
- Investigate fully and report publicly on all deaths, serious injuries, and incidents of abuse or neglect.

[19] Trauma, in this context, refers to the personal experience of interpersonal violence including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence, terrorism and/or disasters. See the National Association of State Mental Health Program Directors (NASMHPD), *Position Statement on Services and Supports to Trauma Survivors* (Alexandria, VA: NASMHPD, 2004). Available at www.nasmhpd.org/general_files/position_statement/posstmb.htm; see also Kevin Ann Huckshorn, *Trauma Informed Care: Training Curriculum for Preventing Violence and Coercion, Reducing the Use of Seclusion and Restraint: A Workforce Training Curriculum for State Mental Health Agencies* (Alexandria, VA: NASMHPD Office of Technical Assistance, 2004).

6. Providing Accessible Services

The onset and diagnosis of a mental illness is, at a minimum, unsettling; more often, it is very traumatic. It is extremely important that consumers and their family members have quick and easy access to current and accurate information about mental illnesses, options for further evaluation and diagnosis, treatment alternatives, and local resources and supports.

State mental health agencies play a critical role in ensuring this information is available, both electronically and through other sources. Through the Internet, information should be searchable on all state mental health agency websites, and must quickly and easily connect individuals and families to mental health services in their communities. Since not all Americans have access to online information, mental health information must also be made available in primary health care settings, over the telephone, in schools, libraries, and through faith-based and other community-based organizations. Multiple forms of access are especially important for traditionally underserved groups and for people living in rural and frontier communities.

7. Establishing Cultural Competence

As the Surgeon General said in the 2001 supplemental report *Mental Health: Culture, Race, and Ethnicity*, culture—beliefs, norms, values, and language—play a key role in how people think about and experience mental illness, whether they seek help, the quality of the services they receive, and the kinds of treatments that may work best for them. This report, as well as the New Freedom Commission and IOM reports referenced earlier, all have documented that people from minority racial and ethnic communities have less access to mental health services, are less likely to receive these services, and often receive a poorer quality of care once in treatment.[20]

While each of these reports calls for better access to high-quality mental health services for the underserved, the New Freedom Commission specifically concludes that providing culturally competent care is an effective way to reduce disparities in treatment and outcomes. Thus, mental health systems must provide care that is sensitive and responsive to cultural differences. This means being aware of the impact of culture and having the skills to respond to a person's unique cultural circumstances, including his/her race and ethnicity, national origin, ancestry, religion, age, gender, sexual orientation, physical disabilities, or specific family or community values and customs.

"In the world of mental health, recovery doesn't mean getting healed of the illness but being able to cope in the world—holding a job, having opportunities…"

— Family member from Arizona

A number of state mental health systems have made great strides in increasing their cultural competence, using evidence-based practices to bring cultural awareness to their workforce training, service delivery, written materials, and other resources.

8. Building Consumer-Centered and Consumer- and Family-Driven Systems

Historically, people with serious mental illnesses have had little input into the services they receive. Moreover, their families' views often have been discounted, even though family members are often the primary caregivers. Negative experiences with the treatment system ultimately undermine trust and participation in treatment. A mental health system that is truly consumer-centered and consumer- and family-driven requires the meaningful involvement of individuals and families in the design, implementation, and evaluation of all services. Individual needs and preferences should also drive the type and mix of services selected in individualized plans of care.

Many states and communities have tried to accomplish this by putting people with mental illnesses and their families in advisory roles. Advisory activities can help individuals and families achieve a certain level of empowerment. However, sometimes as "advisors," their feedback can be easily ignored. Individuals and family members must be included on state Pharmacy and Therapeutics (P&T) committees, monitoring teams authorized to make unannounced visits in hospitals and

[20] U.S. Department of Health and Human Services, *Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001). Available at www.surgeongeneral.gov/library/mentalhealth/cre/.

other treatment settings, and policy committees with real decision-making authority. A more equal partnership between people with mental illnesses and their family members, mental health administrators, and service providers is the goal.

Additional steps states should take to build consumer-centered mental health systems include: adopting high standards for certifying peer support specialists; promoting opportunities for individuals to get certified; and ensuring that peer support specialists are paid well and can be reimbursed through state Medicaid plans. Increasing the number and variety of high-quality consumer-*run* services also will help empower consumers and their families.

9. Fielding an Adequate and Qualified Mental Health Workforce

Across the country there is a critical shortage of qualified mental health personnel—from psychiatrists and nurses, to social workers and other direct service providers. Recruitment, diversity, retention, training, education, and performance are all falling short of what is needed. As the Annapolis Coalition reported in its 2007 *Action Plan for Behavioral Health Workforce Development*:

> It is difficult to overstate the magnitude of the workforce crisis in behavioral health. The vast majority of resources dedicated to helping individuals with mental health and substance use problems are human resources, estimated at over 80 percent of all expenditures. […] there is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services. There is equally compelling evidence of an anemic pipeline of new recruits to meet the complex behavioral health needs of the growing and increasingly diverse population in this country.[21]

Without a well-trained and appropriately-sized workforce, all efforts at mental health system transformation are likely to fail. To ensure there is an adequate supply of qualified mental health personnel, state mental health agencies must work with other organizations (e.g., universities and colleges, state and local workforce investment boards, state labor agencies) on initiatives such as:

- Establishing education subsidy and loan forgiveness programs for students pursuing careers in mental health;
- Promoting and providing training on the key skills necessary for working with people who have serious mental illnesses;
- Providing on-going education for mental health service professionals and paraprofessionals; and
- Developing competitive salary and benefit structures for employees working in mental health services.

Finally, people living with mental illnesses and their families are *de facto* members of the mental health workforce, providing an enormous amount of self-care, peer support, and care for loved ones. In addition, they have a unique capacity to educate the formal members of the mental health workforce about the experience of illness, treatment, and recovery. Strengthening the ability of consumers and families to assume care-giving and advocacy roles is therefore critical, and can be accomplished by providing them with education about illnesses; training in self-management techniques; and strategies for navigating systems of care, among other things.

10. Ensuring Transparency and Public Accountability

A transformed mental health system must be both transparent and accountable to the people it serves and to the public at large. It therefore must be able to measure, analyze, publicly report on, and improve the quality of care it delivers.

It is also critical that these measures and reports be standardized across states, a process that requires federal direction and leadership. The IOM recommended in 2006 that the U.S. Department of Health and Human Services[22] convene multiple stakeholders as part of a National Quality Forum "for the purpose of reaching con-

[21] Michael A. Hoge et al., *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion* (Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2007). Available at www.annapoliscoalition.org.

[22] This federal department oversees the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute of Mental Health (NIMH), the Centers for Medicare & Medicaid Services (CMS), and the Agency for Healthcare Research and Quality (AHRQ).

sensus on and implementing a common, continuously improving set of mental health and substance-use health care quality measures for providers, organizations, and systems of care" (IOM, 2006, p. 14).

The IOM goes on to recommend that these measures be analyzed and displayed "in formats understandable by multiple audiences, including consumers, those reporting the measures, purchasers, and quality oversight organizations" (IOM, 2006, pp.14-15). The IOM also recommends that measures:

> […] include a set of mental health/substance use "vital signs": a brief set of indicators—measurable at the patient level and suitable for screening and early identification of problems and illnesses and for repeated administration during and following treatment—to monitor symptoms and functional status. The indicators should be accompanied by a specified standardized approach for routine collection and reporting as part of regular health care. Instruments should be age- and culture-appropriate. (p.15)

The development of standardized, valid, and reliable person-level outcome measures to assess treatment results is critical to tracking performance and quality improvement in state public mental health systems. Ideally, measures such as these will become available and serve as the foundation of future editions of *Grading the States*.

New Challenges Ahead

In NAMI's view, these 10 elements are the pillars of a transformed state public mental health system. The broad values they represent work in different settings and will remain relevant over time. As we look ahead, we also see new challenges on the horizon:

Scientific Advances

We are witnessing a near revolution in basic neuroscience that is challenging our understanding of mental wellness and illness; redefining the boundaries between the fields of neurology, psychiatry, and psychology; and pointing the way to completely new interventions that promise to prevent, treat, and even cure some mental disorders. These new discoveries will shift the landscape of state- and community-based mental health services in ways we can only begin to predict.[23]

Emerging Populations in Need

As wars in Iraq and Afghanistan continue, increasing numbers of veterans, including members of the National Guard, are returning with serious mental illnesses that require substantial assistance for them and their families as they transition back home. This emerging population of mental health consumers will challenge state mental health systems in new and unpredictable ways.

"Recovery means being able to manage my illness to the point that you don't know I'm schizophrenic unless I tell you."

— Consumer from Texas

Also, as states and communities make real efforts to increase their cultural competence, new populations will continue to enter the mental health system (racial/ethnic minorities, non-English speaking individuals, people with hearing impairments, people living in rural and frontier areas, etc.). States must be prepared to meet the needs of all these groups.

Technological Developments

Innovative technologies such as telemedicine, electronic health records, computer-based clinical decision-support systems, and computerized provider order entry (electronic prescribing systems) have the potential to greatly improve access to high-quality mental health services.

The mental health care system must be fully included as a National Health Information Infrastructure (NHII) begins to take form. From the earliest stages of this new initiative, the interests of mental health consumers must be recognized. For example, consumers' specific needs around data and privacy standards and electronic health records must be taken into account; and community and regional mental health networks must be also integrated within the larger NHII.

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[23] For a discussion of these issues, see Laudan Aron and Carl Zimmer, *The New Frontier: Neuroscience Advancements and Their Impact on Nonprofit Behavioral Health Care Providers* (Milwaukee, WI: Alliance for Children and Families, 2005). Available at www.alliance1.org/home/neuroscience_full06.pdf.

Comprehensive Services and Supports

Access to Prescribers and Medications

Medications—and someone to prescribe them—are an essential part of successful treatment. According to the National Institute of Mental Health, individual patients need more, not fewer, choices. Unfortunately, in an attempt to control prescription drug costs, many state Medicaid programs have adopted policies that limit access to psychiatric medications, especially newer "second-generation" or "atypical" antipsychotics. These policies include requiring prior authorization, requiring or encouraging the use of generic medications, imposing higher co-pays, limiting the monthly number of prescriptions covered, requiring that enrollees fail on one medication before another is prescribed ("fail-first" policies), and developing a preferred drug list (PDL) to promote the use of less expensive drugs. All of these can lead to poorer health outcomes (including death), increased emergency room visits, hospital care, and institutionalization. In a high-quality mental health system, decisions about medications are based on an individual's needs and preferences and the best available clinical judgment.

Acute and Long-Term Care Treatment

While advances in mental health treatments (and the provision of comprehensive community-based supports) may reduce the number and length of inpatient hospitalizations for many people with serious mental illnesses, it is clear that there will always be a need for these inpatient services. Acute care beds, group homes, and other 24-hour residential programs for people who require continuous care on a long-term basis must be available at sufficient levels.

Yet, across the country, there are significant shortages. States seeking to reduce costs by closing, consolidating, or reducing state hospital services are simply shifting the burden to other systems. Neither nursing homes nor unlicensed and unregulated board and care homes are effective or appropriate treatment options. Instead, states must provide innovative, high-quality and accessible inpatient options, including quality state hospital settings.

Affordable and Supportive Housing

Many people with serious mental illness have limited incomes and need access to decent and affordable housing. Some also need "supportive housing," which combines affordable housing with support services such as job training, life skills training, alcohol and drug abuse programs, and case management. The combination of housing and support works well for people with serious mental illnesses whose housing is at risk and who have very low incomes. Without supportive housing, many will end up in (and often overwhelm) much higher-cost and less appropriate settings like jails, hospitals, mental health facilities, and homeless shelters.

Assertive Community Treatment (ACT)

The most studied and widely used intervention for people with serious mental illnesses who require multiple services and highly intensive supports is known as Assertive Community Treatment (ACT). An evidence-based, outreach-oriented, service delivery model using a 24-hours-a-day/seven-days-a-week multi-disciplinary clinical team approach, ACT provides comprehensive, individualized community treatment (including substance abuse treatment, housing and employment support) to individuals in their homes, at work, and in the community. ACT teams consist of a psychiatrist, mental health professionals, psychiatric nurses, peer specialists, vocational specialists, substance abuse specialists, and administrative support.

Consumer Education and Illness Self-Management

Illness management and recovery programs educate people about their diagnoses and treatment options so they can make informed decisions and manage their illnesses more effectively. These programs teach strategies for minimizing symptoms, preventing relapse, and using medication effectively. They also cover topics such as building social supports, setting and achieving personal goals, and getting needs met in the mental health system.

Crisis Intervention and Stabilization Services

The mental health care system must be able to respond to people in crisis in a timely and compassionate way. In many places, law enforcement personnel take on this role, often with little or no training. By contrast, in high-quality mental health systems, crisis intervention and stabilization services are available around the clock. These include telephone crisis hotlines, suicide hotlines, consumer-run warm-lines, crisis counseling, crisis outreach teams, crisis respite care, crisis residential treatment services, and first responders spe-

The Importance of Data

A key component of the transformation agenda NAMI envisions is that decision-making be consistently driven by reliable data. We believe this will not only increase accountability but will improve results. However, little systematic reporting—especially reporting that allows state-by-state comparisons—has been available.

NAMI stepped into this vacuum in 2006 with the first *Grading the States* report, and remains committed to tracking progress towards our vision of a treatment system that is accessible, flexible, and promotes continuity of care, while paying for only those services that work.

This 2009 report takes an important step in that direction: it begins to track outcomes in addition to simply recording the availability of various services. For exam-

cially trained to deal with mental health emergencies in safe and appropriate ways, such as through the CIT (Crisis Intervention Team) program.

Family Education

Family education programs are designed to educate family members about the mental illness of a loved one, and help them work effectively with that family member, as well as with any professionals who are involved, to prevent relapse and promote recovery. Through relationship building, education, collaboration, problem solving, and an atmosphere of hope and cooperation, family education helps families and supporters learn new ways of managing mental illness, reduce tension and stress within the family, and support and encourage each other.

Integrated Treatment of Co-occurring Disorders

Research shows that integrated approaches to treating people with co-occurring mental illness and substance abuse disorders produce better outcomes. The best known approach is integrated dual diagnosis treatment (IDDT), an evidence-based program that provides treatment for both illnesses at the same time and in one setting. Many states and communities understand that co-occurring disorders should be the expectation, not the exception.

Jail Diversion

One of the most visible and tragic indicators of how poorly our mental health care system is performing is the number of people with serious mental illnesses in our nation's jails and prisons. Many are there for misdemeanors or minor non-violent felonies, yet their mental illness may end up prolonging their stay. Jail diversion programs (as well as mental health courts and reentry programs) bring together the criminal justice and mental health systems to decrease the incarceration of people with mental illnesses. By linking people with mental illnesses with appropriate services both prior to, and following, an arrest, these programs short-circuit the usual law enforcement and criminal court processes. They have multiple benefits, including improving public safety, reducing burdens on law enforcement and corrections, and facilitating positive treatment outcomes for individuals.

Peer Services and Peer-Run Services

People living with serious mental illnesses are a growing and important part of the mental health workforce. They partner with mental health professionals on teams that provide day-to-day services (e.g., in ACT or certified clubhouses) and work on the design and administration of many programs. They may also serve in executive leadership positions. Peer-*run* programs, which are independent, autonomous programs controlled by, and accountable to, mental health consumers themselves, are gaining in prominence. These programs can serve many purposes in a community including leading advocacy or community education efforts; making drop-in centers, employment assistance programs, or recreation/arts programs available; providing crisis prevention or respite services; conducting homeless outreach or housing work; and offering peer-to-peer case management, companionship, counseling, and support.

Supported Employment

"Supported employment" is an evidence-based approach to helping people living with serious mental illnesses find and keep competitive employment. It encourages people to work within their communities and promotes successful work, social interaction, and inclusion. In contrast to traditional vocational rehabilitation, which generally begins with job training and moves to job placement when the person is "job ready," supported employment follows a "place and train" model that gives working participants job coaching, transportation, specialized job training, and continuous follow-along supports.

[24] A clubhouse is a structured rehabilitation program focusing on developing vocational skills. Clubhouse participants or "members" are involved in making decisions and in the day-to-day operations of the clubhouse. Many clubhouses have paid staff members who are people with serious mental illnesses. The International Center for Clubhouse Development (ICCD) oversees certification of clubhouses that follow the "Clubhouse Model" pioneered by Fountain House in New York City. See www.iccd.org for more information.

ple, whereas in the 2006 report we asked whether a state had a program to reduce seclusion and restraints, this time we asked for data on reductions in seclusion and restraints, and whether these data are shared regularly with the public.

With this kind of information, NAMI can begin to assess the actual quality of state mental health systems, and determine their potential for improvement. We are also able to make a number of specific, strategic recommendations. For example, while no one system, agency, or individual is authorized to make *all* decisions about mental health care, we find that ultimate ownership of—and accountability for—results must be firmly lodged in a single organization. NAMI believes the state mental health agency and its commissioner should play that role. The full set of NAMI's recommendations can be found in Chapter 4.

Perhaps most important, the data in this report can help build the political will that is desperately needed to move the nation's mental health care system forward. NAMI hopes it will drive governors, legislators, agency directors, and other leaders to finally do what needs to be done.

Chapter 2 describes NAMI's approach to assessing state mental health systems: why this is so important, what data are needed to accurately measure a state's performance, and what data are currently available instead. Chapter 2 also describes how NAMI used available data to grade state public mental health service systems.

CHAPTER TWO

Measuring the Performance of State Systems

Anyone living with a serious mental illness knows that recovery can take many years. The milestones are familiar: the onset of symptoms, an initial diagnosis, an *accurate* diagnosis, beginning treatment, and, hopefully, effective evidence-based treatments. Tragically, too many people are never diagnosed or accurately diagnosed, and many never receive effective treatments.

The data are staggering: one study showed 60 percent of people with a mental disorder received no services in the preceding year;[1] another revealed that the time between symptom onset and receiving any type of care ranged from six to 23 years.[2] The situation is even worse for traditionally underserved groups, such as people living in rural/frontier areas, the elderly, racial/ethnic minorities, and those with low incomes or without insurance.

There are many reasons public mental health systems are failing to reach and care for their target population, but a single problem is at the root: an alarming lack of reliable data that can accurately reflect states activities and help guide improvements.

To design and implement high-quality mental health systems, states and localities must be able to accurately identify the needs in their communities, and track the use of services currently in place. Put simply, if you can't see the problems, how can you fix them? Further, in an environment of limited (and increasingly shrink-

[1] Ronald C. Kessler et al., "Prevalence and Treatment of Mental Disorders, 1990 to 2003," *New England Journal of Medicine* 352 (2005): 2515.

[2] Philip S. Wang et al., "Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication," *Archives of General Psychiatry* 62 (2005): 603.

ing) resources, funding anything but the most effective services is simply not sustainable. Yet how can states appropriately target their funding if they don't know what works and what doesn't? With *Grading the States*, NAMI is unequivocally asserting that funding for mental health treatment services must be tied to performance and outcomes.

Understanding the Information Gap

The gaps in states' collection, compilation, and monitoring of data regarding mental illness and mental health services are both wide and deep.

Service Availability and System Capacity are Often Unknown

Many states are unable to report even basic information about their mental health services. Many do not know, for example, the total number of inpatient psychiatric beds in their systems, how long it takes to get such a bed following an emergency room stay, or how many people receive evidence-based treatments, such as ACT.

Data like these should be collected in every state (as well as at the county level where services are often managed and delivered). But often there are no systems in place for accomplishing this.

"Recovery, not stability, is more than an acceptance of the illness—it is an embracing of the situation, making the best of it, and living the fullest life possible with the limitations given. It is like learning to dance with a broken leg."

—Consumer from Illinois

Service Effectiveness is Truly a Mystery

Compiling trustworthy data about the level of available services is just the first step. States must also be able to measure how well those services meet the needs for quality mental health care: are a person's physical and mental wellbeing improving with the services and supports received? Are they reaching their educational and vocational goals? Do they have adequate income and affordable housing? Are unnecessary hospitalizations and arrests decreasing? Too often, states do not know the answers to these types of questions.

Available Data are Not Standardized Within or Across States

In order for data to truly drive system improvements, individual service providers and provider groups must consistently collect information that can be aggregated to the community and county levels and then to the state level. Unfortunately, even among those states that *do* collect some data in this manner, the variety of definitions and measures they use makes accurate—and therefore useful—comparisons across states extremely difficult.[3] At the state level, part of the problem is outdated information technology (IT) systems in use by many state mental health agencies. In addition, the persistence of paper health records decreases the likelihood that data can and will be standardized. Updating technology and adopting electronic record-keeping should ultimately facilitate the collection of outcome data that can be used for rigorous program evaluations and system performance assessments.

Unfortunately, once data are compiled at the federal level they are of limited use for cross-state analysis. Despite its name, SAMHSA's Uniform Reporting System (URS) gathers administrative data that are far from uniform because of significant differences in how states define variables, variable categories, and collect the data. SAMHSA itself warns analysts not to use the data to compare states, presumably because of these inconsistencies. The quality of the URS data appears to be improving, and SAMHSA's adoption of a subset of the URS to be used as National Outcome Measures (NOMS) is a step in the right direction. However, none of these data are currently reliable or robust enough to support the ongoing performance measurement NAMI and others in the mental health community need and expect, nor is it clear if they will be in the future.

Federal Agencies Give Mental Health Data Collection Low Priority

Data collection efforts, like direct service provision, reflect values and priorities. Across key federal agencies, mental health- and mental illness-related data collection is often given short shrift.

[3] While we have no way of assessing overall state performance in this area, states receiving federal Transformation State Incentive Grants (TSIG)—Connecticut, Hawaii, Maryland, Missouri, New Mexico, Ohio, Oklahoma, Texas, and Washington—are clearly making additional investments in their mental health data infrastructures.

What are Electronic Health Records?

Electronic Health Records (EHRs) compile comprehensive information about an individual's health in a format based on nationally recognized standards. An EHR is typically created and managed by authorized health care professionals in a variety of settings, such as a provider's office, pharmacy, emergency room, or laboratory. An EHR provides "real time" patient health information and an immediate health history for providers. As a result, EHRs can help reduce adverse drug reactions, decrease duplicate testing, increase medication compliance, and improve benefit and claim management. For people with mental illnesses and/or substance use problems, who often interact with large numbers of providers, EHRs facilitate information exchange that increases the efficiency of care.

A Personal Health Record (PHR) is also a comprehensive electronic record of an individual's health information based on nationally recognized standards. While similar to an EHR, a PHR is typically managed and controlled by the individual, who can download health information. PHRs can empower consumers by increasing their understanding of, and sense of control over, their health, and facilitate communication with providers. As the technology and standards for EHRs and PHRs develop, it is essential that security measures to protect the privacy of individuals as well as the confidentiality of their information be in place. Without such safeguards, people with serious mental illnesses are at risk of further exclusion and discrimination.

For more information, see the National Alliance for Health Information Technology's *Report to the Office of the National Coordinator for Health Information Technology on Defining Key Health Information Technology Terms,* April 28, 2008. Available at http://www.nahit.org/images/pdfs/HITTermsFinalReport_051508.pdf.

Within SAMHSA, resources devoted to the collection and analysis of mental health and mental illnesses pale in comparison to investments on the substance abuse side. For example, unlike SAMHSA's National Survey on Drug Use and Health (NSDUH), the size and budget of its Client/Patient Sample Survey (which covers mental health) is too small to support state-level estimates. The major national psychiatric epidemiological surveys also preclude the development of state- and small-area estimates of mental illness.[4]

SAMHSA's support to states to collect data through the Behavioral Risk Factor Surveillance System (BRFSS) has also declined in recent years. The BRFSS is a unique population health surveillance tool designed to gather information on behavioral risk factors and conditions for chronic diseases, injuries, preventable infectious diseases, and health care access at the state and local levels.[5] It includes multiple optional modules (with standard sets of questions developed by the CDC and/or its partners) that each state decides to include based on priorities and funding. A major strength of BRFSS is that it has individual- and state-level data on both mental and physical health. Unfortunately, not all states opt to include modules that include mental health information. The number of states collecting mental illness-related information through BRFSS declined from 39 states (including Washington, D.C.) in FY 2006, to 35 states in FY 2007, to only seven states (Arizona, Colorado, New York, Idaho, Illinois, Massachusetts, and Ohio) in FY 2008.[6]

Medicaid administrative data are another potentially rich source of information on state mental health systems, but they are rarely systematically analyzed on a state-by-state basis for mental health-related purposes. This is likely because the data are highly complex (the unit of analysis is usually a claim, not a person or a provider) and analyses would need to be tailored to each state's program since Medicaid itself varies considerably from one state to another.[7]

[4] These surveys are sponsored by NIMH and include the National Comorbidity Survey (NCS) and the Collaborative Psychiatric Epidemiology Surveys (CPES), which includes the National Comorbidity Survey Replication (NCS-R), the National Survey of American Life (NSAL), and the National Latino and Asian American Study (NLAAS). More information about these surveys is available at www.hcp.med.harvard.edu/ncs and www.icpsr.umich.edu/CPES/.

[5] BRFSS is a telephone survey conducted by state health departments with technical and methodological assistance provided by the federal Centers for Disease Control and Prevention (CDC).

[6] This decline is in spite of improved measures that were built into the BRFSS beginning in 2006. These measures are the Physician Health Questionnaire-8 (PHQ-8), a validated screening instrument for current symptoms of depression, and the K-6, a measure of whether a person has serious mental illness. The BRFSS alternates between these two measures each year. SAMHSA reports that in FY 2009, the number of participating states will increase to 15.

[7] For a preliminary examination of these issues see James Verdier et al., *Administration of Mental Health Services by Medicaid Agencies* (Rockville, MD: Department of Health and Human Services Publication No. SMA 07-4301, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2007). Available at http://mentalhealth.samhsa.gov/publications/allpubs/sma07-4301/.

Finally, the Bureau of Justice Statistics (BJS) has dropped all mental health questions from its periodic census of state and federal adult correctional facilities.[8] The agency's inmate survey, which alternates between jails and prisons every two years and *does* include questions on mental illness, only supports national estimates.[9]

Missed Opportunities

States, inpatient and outpatient provider groups, and individual practitioners have a great deal to learn from one another. Policies and practices that are successful in one state or community can be replicated or adapted in other places. Knowing what works around the country, and how different jurisdictions compare to one another, can also push state and local governments to increase and improve resource allocation, and tackle issues in their own systems. Without reliable data these important opportunities will continue to be missed.

"Recovery for me means having the ability to function in society without having to take a yearly 'vacation' in the mental ward."

—Consumer from Kentucky

NAMI's *Grading the States* Report

Americans have come to expect regular scorecards on a variety of key public issues: child well-being (*Kids Count*), education (*Leaders and Laggards*), and mainstream healthcare (*America's Health Rankings*), among others. The popularity of these scorecards reflects a growing demand for transparency and accountability in public sector systems. By making factual information widely available, the scorecards have improved the quality of public debate, increased government oversight, and in many cases have led to better decision making.

In 2006, NAMI launched an effort to bring this kind of information-gathering and reporting to the mental health field to help fill the information gap that is putting people who live with serious mental illnesses at risk. The 2006 *Grading the States* report was NAMI's first comprehensive effort to assess state mental health systems in more than 15 years. Overall, the national grade was a dismal D.

In August 2008, NAMI surveyed state mental health agencies in preparation for this 2009 report (the survey questions are reproduced in the appendix). While covering similar topic areas, this latest edition of the survey has evolved in several ways:

- *More Detail-Oriented Questions:* Questions have been structured to draw out clearer and more detailed information. States were also encouraged to offer clarifications and additional comments to their responses.
- *Supplemental Information Requested:* For this report, NAMI asked states to provide a variety of supporting materials and planning documents, including those covering cultural competence, housing, and workforce development. NAMI was able to review many of these to assess if the plans were comprehensive and well crafted.
- *Direct Consumer and Family Input:* NAMI conducted (in English and Spanish) a Web-based survey of consumers and family members, seeking input on their experiences with state mental health systems. Using a "snowball sample," in which mental health system users participated and were then asked to forward the survey to other eligible people, more than 13,000 responses were received from across the country. These findings are not statistically representative and were not scored, but they allowed NAMI to confirm that many of the issues and measures that *are* scored are indeed of great importance to consumers and family members. This direct consumer and family input will also help NAMI refine questions and measures for future editions of *Grading the States*. Finally, these real-world experiences and personal stories serve as powerful reminders of why it is so important to assess how well states are providing critical mental health services. First-person accounts from this survey can be found throughout this report and in each state narrative in Chapter 5.

[8] Until 2000, this survey identified, for each state, the number of facilities that provided mental health screening and treatment, and the number of prisoners receiving these screenings and treatment services.

[9] This survey has also been widely criticized for overestimating the prevalence of mental illness in incarcerated settings; BJS is currently working with NIMH, SAMHSA, and others to correct this.

- *Some New Sources of Information:* As in 2006, most of the data for assessing states in this report came from NAMI's survey of state mental health agencies. However, three secondary sources of information were used for state estimates on these measures: (1) the number of adults living with serious mental illnesses (based on work by Charles E. Holzer, III, Ph.D., of the University of Texas Medical Branch in Galveston, Texas, and Hoang T. Nguyen, Ph.D., of LifeStat LLC[10]); (2) the extent of shortages in the mental health workforce (based on work by Joseph P. Morrissey, Ph.D., Thomas R. Konrad, Ph.D., Kathleen C. Thomas, Ph.D., and Alan R. Ellis, M.S.W., of the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill); and (3) hospital-based inpatient psychiatric bed capacity (based on annual survey data from the American Hospital Association). Other information sources were used to identify states with ongoing federal investigations and lawsuits involving public sector programs' treatment of adults living with serious mental illnesses. *For more information about NAMI's questionnaire, scoring methodology, and these secondary data sources, see the appendix.*

State Scorecards and Survey Methodology

All states except South Dakota responded to NAMI's survey for this 2009 *Grading the States* report.[11] The information was scored and weighted in four broad categories:

I. Health Promotion and Measurement
II. Financing and Core Treatment/Recovery Services
III. Consumer and Family Empowerment
IV. Community Integration and Social Inclusion

Individual questionnaire items in each category were first given a "raw" or unweighted score (zero to 10 points depending on the number of levels needed to distinguish between state responses) and then these scores were weighted to reflect NAMI's judgment of the relative importance of the measure.[12] State grades—both overall and for each of the four categories listed above—are based on these weighted scores. The nation's grade was calculated by averaging the weighted state scores. The measures and weights used in each category, and information sources used, are described below.

Category I: Health Promotion and Measurement

In NAMI's survey of state mental health agencies, states were asked to report a variety of basic information, such as the number of programs delivering evidence-based practices, emergency room wait-times, and the quantity of psychiatric beds by setting. The number of states unable to provide this type of data was troubling. Unfortunately, inconsistencies in the way states reported these data (among those that did) prohibited cross-state comparisons. As a result, in this category NAMI scored states only on their *ability* to provide seemingly accurate data on a variety of services, *not* on whether they provide enough evidence-based practices, have an *adequate* number of inpatient psychiatric beds, or provide *timely* access to those beds, etc. (two of these measures were further analyzed in Category II using estimates and external sources).

"Recovery means I have many 'identities' not only my mental illness. I am a wife, mother, sister, daughter, friend, nana. My illness is not the first thing I think about when I wake up in the morning."

—Consumer from Pennsylvania

Other components of Category I include state performance on seclusion and restraint, state insurance parity laws, programs for the uninsured, and plans and activities in the areas of mortality reduction, health promotion, and workforce development (see Table 2.1).

[10] The estimates used in this study are available online at psy.utmb.edu. For a description of the general methodology used to derive these estimates, see Charles E. Holzer, III et al., "Horizontal Synthetic Estimation: A Strategy for Estimating Small Area Health Related Characteristics," *Evaluation and Program Planning* 4 (1981): 29.

[11] The survey was sent by U.S. mail and electronically on August 4, 2008. States were given six weeks to complete it.

[12] For three measures, NAMI divided states into four equal groups (or quartiles) and scored them on a scale of 1 to 4: (1) the share of adults with serious mental illnesses (SMI) served by state mental health agencies, (2) the number of non-federal psychiatric hospital beds per 1,000 people with SMI, and (3) the extent of shortage in the mental health workforce (with lower shortage states receiving higher scores). These raw quartile scores were then weighted in the same way as the other measures.

Table 2.1 Health Promotion & Measurement, Category I (25 percent)

	Domain Weight	Overall Weight
Workforce Development Plan (Questionnaire Item 47)	15.0%	3.8%
State Mental Health Insurance Parity Law (Item 9)	8.1%	2.0%
Mental Health Coverage in Programs for Uninsured (Item 18)	8.1%	2.0%
Quality of Evidence-Based Practices Data (Item 23)	8.1%	2.0%
Quality of Race/Ethnicity Data (Item 4)	8.1%	2.0%
Have Data on Psychiatric Beds by Setting (Item 27)	8.1%	2.0%
Integrate Mental and Primary Health Care (Item 41)	8.1%	2.0%
Joint Commission Hospital Accreditation (AHA)	4.0%	1.0%
Have Data on ER Wait-times for Admission (Item 26)	4.0%	1.0%
Reductions in Use of Seclusion & Restraint (Item 33)	4.0%	1.0%
Public Reporting of Seclusion & Restraint Data (Item 34)	4.0%	1.0%
Wellness Promotion/Mortality Reduction Plan (Item 39)	4.0%	1.0%
State Studies Cause of Death (Item 38)	4.0%	1.0%
Performance Measure for Suicide Prevention (Item 40)	4.0%	1.0%
Smoking Cessation Programs (Item 42)	4.0%	1.0%
Workforce Development PlanDiversity Components (Item 47)	4.0%	1.0%
	100.0%	**25.0%**

This category accounts for 25 percent of a state's overall score.

Category II: Financing and Core Treatment/Recovery Services

Category II includes a variety of financing measures, such as whether Medicaid reimburses providers for all, or part, of important evidence-based practices; if the state charges outpatient co-pays; and if access to antipsychotic medications is restricted in any way.

Category II also includes some measures that capture the extent of service delivery in each state: the share of adults with serious mental illnesses served by the state mental health system and availability of ACT per capita. For this measure, NAMI used state reports on the number of people served with ACT (estimated for states reporting numbers of ACT *teams* only) and calculated what share of people with serious mental illnesses in the state would have access to ACT. For two other measures NAMI turned to external sources of data and analyses: the number of inpatient psychiatric beds per 1,000 adults with serious mental illnesses based on annual survey data from the American Hospital

Table 2.2 Financing & Core Treatment/Recovery Services, Category II (45 percent)

	Domain Weight	Overall Weight
Workforce Development Plan (Questionnaire Item 47)	15.0%	3.8%
Workforce Availability (Sheps Center)	8.0%	3.6%
Inpatient Psychiatric Bed Capacity (AHA)	8.0%	3.6%
Cultural Competence–Overall Score (Questionnaire Items 35–37)	8.0%	3.6%
Share of Adults with Serious Mental Illness Served (Item 2)	5.0%	2.3%
Assertive Community Treatment (ACT) —per capita(Item 23)	5.0%	2.3%
ACT (Medicaid pays part/all) (Item 10)	4.0%	1.8%
Targeted Case Management (Medicaid pays) (Item 10)	4.0%	1.8%
Medicaid Outpatient Co-pays (Item 11)	4.0%	1.8%
Mobile Crisis Services (Medicaid pays) (Item 10)	3.0%	1.4%
Transportation (Medicaid pays) (Item 10)	3.0%	1.4%
Peer Specialist (Medicaid pays) (Item 10)	3.0%	1.4%
State Pays for Benzodiazepines (Item 12)	3.0%	1.4%
No Cap on Monthly Medicaid Prescriptions (Item 14)	3.0%	1.4%
ACT (availability) (Item 22)	3.0%	1.4%
Certified Clubhouse (availability) (Item 22)	3.0%	1.4%
State Supports Co-occurring Disorders Treatment (Items 6–8)	2.0%	0.9%
Illness Self Management & Recovery (Medicaid pays) (Item 10)	2.0%	0.9%
Family Psychoeducation (Medicaid pays) (Item 10)	2.0%	0.9%
Supported Housing (Medicaid pays part) (Item 10)	2.0%	0.9%
Supported Employment (Medicaid pays part) (Item 10)	2.0%	0.9%
Supported Education (Medicaid pays part) (Item 10)	2.0%	0.9%
Language Interpretation/Translation (Medicaid pays) (Item 10)	2.0%	0.9%
Telemedicine (Medicaid pays) (Item 10)	2.0%	0.9%
Access to Antipsychotic Medications (Item 13)	2.0%	0.9%
Clinically-Informed Prescriber Feedback System (Item 16)	2.0%	0.9%
Same-Day Billing for Mental Health & Primary Care (Item 17)	2.0%	0.9%
Supported Employment (availability) (Item 22)	2.0%	0.9%
Integrated Dual Diagnosis Treatment (availability) (Item 22)	2.0%	0.9%
Permanent Supported Housing (availability) (Item 22)	2.0%	0.9%
Housing First (availability) (Item 22)	2.0%	0.9%
Illness Self Management & Recovery (availability) (Item 22)	1.0%	0.5%
Family Psychoeducation (availability) (Item 22)	1.0%	0.5%
Services for National Guard Members/ Families (Item 25)	1.0%	0.5%
	100.0%	**45.0%**

Association, and the severity of shortages in the mental health workforce based on recent pioneering analysis by researchers at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill.[13]

This category also includes measures of: the availability of specific evidence-based practices in parts of the state or statewide; state policies and practices that deal with co-occurring mental health and substance abuse treatment needs; and state mental health agency programs for individuals and families involved in the National Guard. It also includes a multi-faceted measure of state planning and activities to develop cultural competence (see Table 2.2). This category, Financing and Core Treatment/Recovery Services, is the most heavily weighted of the four, accounting for 45 percent of each state's overall score.

Category III: Consumer and Family Empowerment

Category III consists of a variety of measures that NAMI views as top priorities. It includes results from the Consumer and Family Test Drive (CFTD), an original research instrument developed by NAMI in 2006 that measures how well people with serious mental illnesses and their family members are able to access essential information about conditions and treatment resources from state mental health agencies.

This category also measures whether there is a written mandate that consumers or family members sit on the state Pharmacy and Therapeutics (P&T) Committee, and if the state promotes consumer-run programs, peer services, and other important educational and support resources such as family and peer education programs and provider education programs with significant consumer involvement. Finally, Category III measures the extent to which consumers and family members monitor conditions in inpatient and community-based mental health treatment programs (see Table 2.3). This category accounts for 15 percent of a state's overall score.

Table 2.3 Consumer/Family Empowerment, Category III (15 percent)

	Domain Weight	Overall Weight
Consumer & Family Test Drive (CFTD)	25.0%	3.8%
Consumer & Family Monitoring Teams (Questionnaire Item 32)	15.0%	2.3%
Consumer/Family on State Pharmacy (P&T) Committee (Item 15)	10.0%	1.5%
Consumer-Run Programs (availability) (Item 22)	10.0%	1.5%
Promote PeerRun Services (Item 24)	10.0%	1.5%
State Supports Family Education Programs (Item 28)	10.0%	1.5%
State Supports Peer Education Programs (Item 29)	10.0%	1.5%
State Supports Provider Education Programs (Item 30)	10.0%	1.5%
	100.0%	**15.0%**

Category IV: Community Integration and Social Inclusion

Category IV includes activities that require collaboration among state mental health agencies and other state agencies and systems. It covers topics such as the suspension and restoration of Medicaid benefits during and after incarceration; the availability of jail diversion, reentry programs, and mental health courts; state public education campaigns and activities; and efforts to plan for, and secure, the resources needed to address long-term housing for people with mental illnesses (see Table 2.4). This category accounts for 15 percent of a state's overall score.

Table 2.4 Community Integration & Social Inclusion, Category IV (15 percent)

	Domain Weight	Overall Weight
Housing—Overall Score (Questionnaire Items 43–44)	25.0%	3.8%
Suspend/Restore Medicaid Post-Incarceration (Items 19–20)	10.7%	1.6%
Jail Diversion Programs (availability) (Item 22)	10.7%	1.6%
Reentry Programs (availability) (Item 22)	10.7%	1.6%
Mental Illness Public Education Efforts (Item 31)	10.7%	1.6%
State Supports Police Crisis Intervention Teams (CIT) (Item 45)	10.7%	1.6%
Mental Health Courts—Overall Score (Item 46)	10.7%	1.6%
Mental Health Courts—per capita (Item 46)	10.7%	1.6%
	100.0%	**15.0%**

[13] Joseph P. Morrissey et al., "Development of a New Method for Designation of Mental Health Professional Shortage Areas," unpublished report prepared under contract HHSH-230200532038C with the Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services, December 2007.

Challenges in Assessing a Complex System

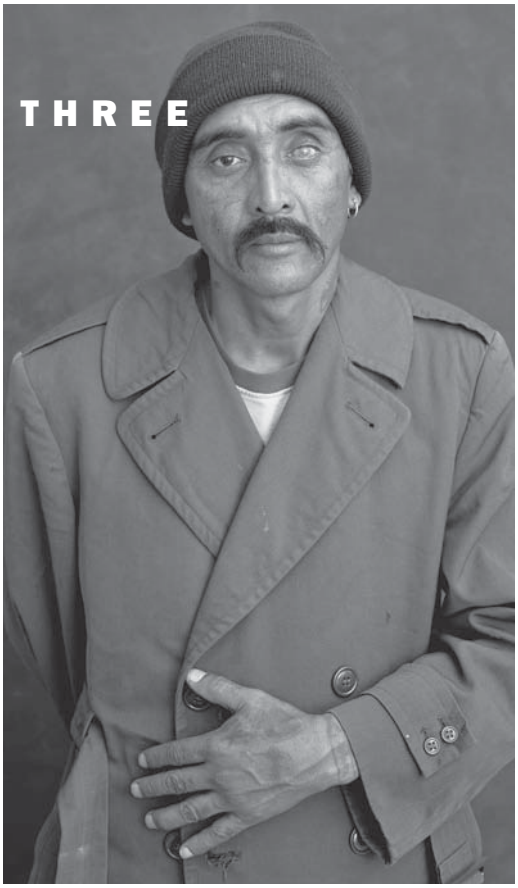
Our nation's public mental health system is complex, bridging inpatient and community-based health services, housing and economic support programs, vocational and social supports, and the criminal justice system, among others. Because of this complexity, it is extraordinarily challenging to accurately assess not only its overall quality, but also the effectiveness of each component and the extent to which the components successfully interact.

As noted earlier, the lack of reliable outcome data generally limits the ability to measure the effectiveness of state services. Plans and policies may exist, but they do not necessarily translate to implementation. Evidence-based practices may be intended, but fall short of fidelity standards.

With those caveats in mind, this report provides the best comprehensive, comparative assessment of state mental healthcare systems to date. State-by-state narratives in Chapter 5 go beyond existing state data and shed light on each state's qualitative performance.

The following chapter provides a summary of NAMI's findings. It outlines national trends in mental health system performance, common strengths and weaknesses, the unique challenges faced by some states, and some exciting areas of innovation.

CHAPTER THREE



The State of Public Mental Health Services Across the Nation

State by state, this assessment of our nation's public mental health services finds that we are painfully far from the high-quality system we envision and so desperately need. While some states are making consistent efforts to improve, the great majority are making little or no progress. NAMI's principal finding is clear: the state of mental health services in this country is simply unacceptable.

A Mostly Dismal Report Card

As in 2006, our nation earned an overall grade of D. Yet there are certainly some improvements across the country to be noted:

- Fourteen states increased their overall score over the past three years; one more state earned a B; and two fewer states failed outright.
- In many cases, NAMI found state mental health agencies making valiant efforts to improve systems and promote recovery despite rising demand for services, serious workforce shortages, and inadequate resources.
- Many states are adopting better policies and plans, promoting evidence-based practices, and encouraging more peer-run and peer-delivered services.

But these improvements are neither deep nor widespread enough to improve the national average. The grades for almost half the states (23) remain unchanged since 2006, and 12 states have fallen behind.

The *top*-performing states—and there were only six of them—received a B grade (see Exhibit 3.1). Yet even these states are hardly in a position to celebrate since there is no doubt that many of their residents living with serious mental illnesses are not receiving the services and supports they need. Further, while the "B states" scored better than others on a series of measures, their performance shares a critical limitation with all the states: they do not know what share of people in need their systems serve,[1] or how well people fare once they are served. It is a tragic reality that no state in the nation is able to pass this true test of a mental health system's performance.

As in 2006, the majority of states earned a C or a D grade (18 and 21 states, respectively). These states present a mix of strengths and weaknesses as their category-specific grades reveal (see Table 3.1). Finally, NAMI finds that public mental health care systems in six states are failing outright—in few of the categories we examined are they performing at even the lowest acceptable levels. These six failing states include South Dakota, which chose not to participate in the survey.

Indeed, this report card is dismal. Without a significant commitment from our nation's leaders—in Washington, among governors, and in state legislatures—state mental health agencies will continue to struggle to provide even minimally adequate services to people living with serious mental illnesses.

[1] To do so would require comprehensive state- or community-wide needs assessments, not simple state-level estimates of the number of adults with serious mental illness.

A Closer Look at State Performance

As in 2006, NAMI assessed state efforts in four broad categories: health promotion and measurement; financing and core treatment/recovery services; consumer and family empowerment; and community integration and social inclusion. In each category, described below,

Exhibit 3.1 **Grading the States 2009: Overall State Grades**

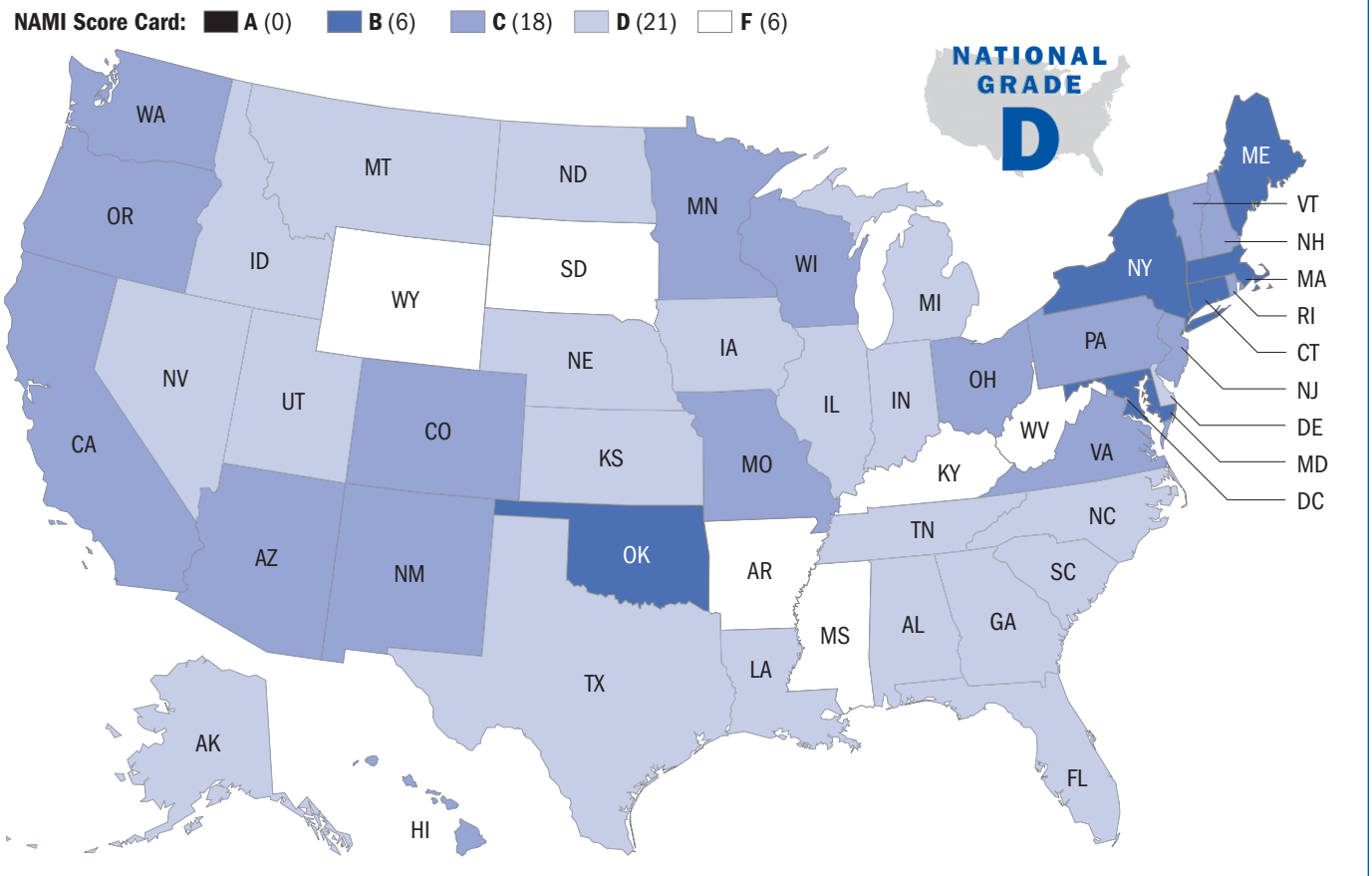


Table 3.1 NAMI's Grading the States 2009: Summary of State Grades

2006 Grade		2009 Grade	2009 Category Grades			
			I	II	III	IV
D	***USA (mean)***	***D***	***D***	***C***	***D***	***D***
B	Connecticut	**B**	B	B	A	C
B	Maine	(6 states)	B	B	B	B
C	Maryland		B	B	B	C
C	Massachusetts		B	B	C	C
—	New York		C	B	B	C
D	Oklahoma		B	C	C	C
D	Arizona	**C**	D	B	B	C
C	California	(18 states)	B	C	D	B
—	Colorado		F	B	C	D
C	DC		D	B	D	C
C	Hawaii		D	B	D	D
C	Minnesota		D	C	C	D
C	Missouri		C	C	D	D
D	New Hampshire		C	C	D	D
C	New Jersey		C	C	B	D
C	New Mexico		C	C	F	D
B	Ohio		C	C	C	B
C	Oregon		C	B	F	B
D	Pennsylvania		D	C	C	D
C	Rhode Island		D	C	D	D
C	Vermont		C	C	C	D
D	Virginia		C	C	C	D
D	Washington		D	B	F	D
B	Wisconsin		D	B	C	D
D	Alabama	**D**	F	C	D	F
D	Alaska	(21 states)	D	C	F	F
C	Delaware		D	D	F	D
C	Florida		F	D	D	C
D	Georgia		D	C	C	C
F	Idaho		F	D	D	D
F	Illinois		D	C	C	D
D	Indiana		D	D	D	D
F	Iowa		D	D	F	D
F	Kansas		D	C	D	D
D	Louisiana		D	D	D	D
C	Michigan		F	B	D	D
F	Montana		F	C	D	F
D	Nebraska		F	D	F	F
D	Nevada		F	D	D	F
D	North Carolina		D	C	F	C
F	North Dakota		F	D	D	F
B	South Carolina		F	C	C	F
C	Tennessee		D	C	C	D
C	Texas		F	D	F	D
D	Utah		F	C	C	D
D	Arkansas	**F**	F	D	F	F
F	Kentucky	(6 states)	F	D	D	F
D	Mississippi		F	F	C	F
F	South Dakota		F	F	F	F
D	West Virginia		D	F	F	F
D	Wyoming		F	D	F	F

Notes: The four categories are (I) health promotion and measurement; (II) financing and core treatment/recovery services; (III) consumer and family empowerment; and (IV) community integration and social inclusion. For more details on each state's results, see Chapter 5. Colorado and New York did not respond to NAMI's 2006 survey of state mental health agencies.

there is a broad overview of the states' performance and the significance for the field, key findings, and some exciting areas of innovation. Individual state results are presented in detail in Chapter 5.

Category I—Health Promotion and Measurement

In this section of the survey, NAMI investigated whether states are focusing on wellness and survival, collecting and using data on key services, seeking parity of insurance coverage for mental health disorders, and addressing critical workforce shortages. States were asked to provide basic information about the services they provide, demonstrate solid planning in several areas, and provide evidence of quality data collection.

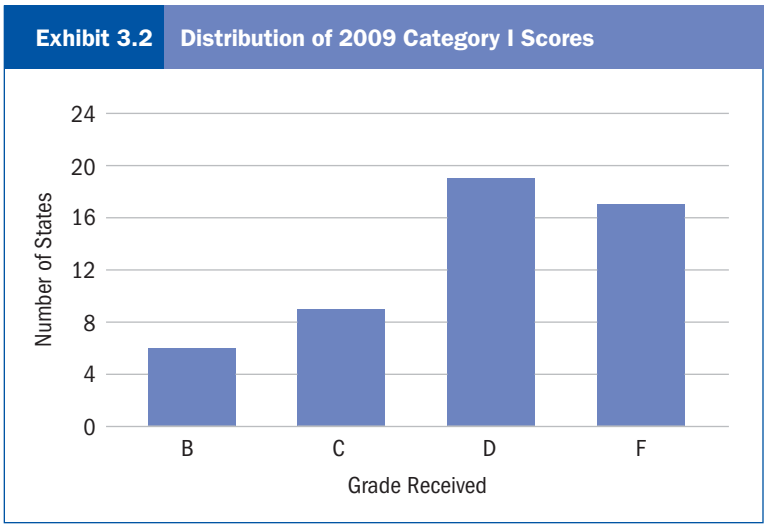
On the whole, states performed quite poorly in this category. The results are illustrated in Exhibit 3.2.

With 70 percent of states scoring a D or an F in this category, it is quite clear that the field has not been investing in health promotion, data gathering, or workforce activities at nearly the level that is needed. Key findings from across the states suggest specific action steps for states that want to improve their performance.

Finding #1: States are Not Focusing on Wellness and Survival for People with Serious Mental Illnesses

People living with mental illnesses often die prematurely from largely preventable cardiovascular diseases and accidents, or by suicide.[2] This well-established fact should compel state mental health and allied agencies to take concrete steps to prevent the negative side effects of medications, to promote healthy lifestyles, address high rates of smoking in the population, and fully integrate mental and physical health care services, among other things.

Exhibit 3.2 Distribution of 2009 Category I Scores



What do the state-by-state data show?

States' exceedingly low grades in this category indicate a need for a true culture change in the mental health field's promotion of health and wellness. Only eight states earned top scores for efforts to integrate mental health and general health care, nine states include suicide prevention among their state mental health system performance measures, and 11 states have relatively strong morbidity/mortality reduction plans.[3] On a more positive note, 27 states have funded smoking cessation programs in public psychiatric hospitals and/or community-based mental health treatment settings.

The NASMHPD Medical Directors Council has broken new ground in this area with the 2006 release of a seminal report on morbidity and mortality and, more recently, with reports on smoking cessation, obesity, and health monitoring. Yet state efforts to translate these conceptual imperatives into real improvements for the people they serve are incomplete at best. In no state was NAMI able to find comprehensive, integrated, and preventive action, or outcome measurement related to wellness and survival. Most states do not even study causes of death among people with serious mental illnesses (instead they tend to track only suicides or hospital-based deaths). At this juncture, the field is wide open for any state to emerge as a national leader in health promotion.

Where can innovative practices be found?

- **New Hampshire** is piloting the *In Shape* program, which uses a fitness and nutritional trainer to help

[2] Joseph Parks et al. (eds.), *Morbidity and Mortality in People with Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, 2006). Available at http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf.

[3] These states are (integration with general health care) California, Massachusetts, Missouri, New Hampshire, Ohio, Oklahoma, Oregon, and Wisconsin; (suicide prevention) California, Colorado, Illinois, Maryland, Nebraska, New Mexico, New York, Ohio, and Oklahoma; and (mortality reduction) Connecticut, Maine, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey, New York, Ohio, Oklahoma, and Oregon.

individuals with serious mental illnesses address metabolic syndrome (a group of risk factors that includes obesity, insulin resistance, and hypertension, and a common side effect of many antipsychotic medications).

- **Connecticut, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New York, Ohio, Oklahoma,** and **Oregon** are actively working on these issues by piloting strategies such as posting nurses at community mental health centers, linking their record systems with physical health providers, offering smoking cessation programs, and screening individuals for emerging diabetic concerns.

Finding #2: States do Not Have Adequate Data on Critical Mental Health Services

A high-quality mental health system supports a carefully balanced and adequate supply of care across a continuum of services. It is particularly important that there are no shortages on either end of the continuum. When a full spectrum of community-based services is not available, people are sent to—and languish in—emergency rooms, hospital beds, jails, and nursing homes, and those facilities become overcrowded. The overcrowding, in turn, forces people back into the community to face the same shortage of services that led to their inappropriate institutionalization in the first place.

To break this vicious cycle, states and localities must provide services adequate to those in need in their communities. To do that, they must be able to accurately identify needs, the extent of services provided—especially those that are evidence-based—and system effectiveness.

What do the state-by-state data show?

Across the country, states show an extremely limited capacity to provide data on their service delivery. In this survey, only 15 states reported reasonably comprehensive data on the number of evidence-based practices (EBPs) offered,[4] and only 11 states were able to share any type of data on how long it takes to get an inpatient psychiatric bed through an emergency room.[5]

While 42 states were able to provide some information on the *number* of inpatient psychiatric beds they have, the remaining eight states were unable to report at all on this critical component of their mental health systems.[6] The reality that some states cannot account for the number of psychiatric beds in their systems is astounding given the crisis in acute psychiatric care in communities across the country.[7] NAMI used other data sources and analysis strategies to try to capture this information. These results are discussed below under Category II.

[Recovery means...] "Staying alive and feeling like you have achieved a quality of life that allows some level of independence with adequate supports that are available as needs change."

—Consumer from Tennessee

Where can innovative practices be found?

- In **Arkansas,** all community mental health centers use a standard data collection instrument to report uniform data to the state mental health agency. As part of this data system, mental health centers screen for substance use disorders and substance abuse providers screen for mental illness. Congress applauded Arkansas' data system in 2008.
- In **Alaska,** the Alaska Psychiatric Institute (API) has an "API dashboard" on its Web site where it posts a host of quarterly performance measures—including rates of patient injury, elopement, medication errors, 30-day readmission, seclusion and restraints—along with national comparison data. The dashboard is available at http://hss.state.ak.us/dbh/API/dashboard.htm.
- **California's** Department of Mental Health has combined resources from a federal Data Infrastructure Grant and the state's Mental Health Services Act to modify its data systems so it can

[4] Connecticut, Hawaii, Iowa, Maryland, Michigan, New Jersey, New Mexico, New York, Oklahoma, Rhode Island, Wisconsin, Maine, Massachusetts, North Dakota, and Tennessee.

[5] Arkansas, Connecticut, Delaware, Florida, Georgia, Maine, Maryland, Massachusetts, Mississippi, Missouri, and Rhode Island.

[6] In this category, NAMI also examined and scored psychiatric hospital accreditation. Based on information from the American Hospital Association and follow-up calls, 14 states were found to have at least one state psychiatric hospital that is not accredited by the Joint Commission (and received no credit on this criterion): DC, Florida, Idaho, Iowa, Louisiana, Mississippi, Missouri, Montana, Nebraska, North Carolina, Oregon, South Dakota, Wisconsin, and Wyoming.

[7] The President's New Freedom Commission on Mental Health, Subcommittee on Acute Care, defined acute care as short-term (with a median length of stay of approximately 30 days or fewer), 24-hour, inpatient care, and emergency services provided in hospitals, as well as treatment in other crisis and urgent care service settings.

report on evidence-based practices and better track the number of individuals receiving integrated treatment for mental health and substance use disorders. All county systems have been modified to collect and report these data.

Finding #3: Few States have Public Health Insurance Plans that Adequately Meet the Needs of People with Serious Mental Illnesses

More than 45 million Americans have no insurance coverage for health care,[8] and millions more are "just a pink slip away" from losing their coverage. More than one in four uninsured adults has a mental illness and/or substance use disorder.[9]

Without coverage, people with serious mental illnesses can be financially devastated by the cost of the care. While public mental health systems are a vital safety net for the uninsured, they serve only a fraction of those in need—and often only those determined to be disabled or severely impacted by their mental illness. People who remain untreated—or under-treated—live with worsening conditions and eventually overwhelm our country's emergency departments, hospital wards, and public systems.

What do the state-by-state data show?

NAMI's survey asked state mental health authorities if their state had a plan to cover the uninsured (other than a high-risk pool or expansion of Medicaid eligibility)[10] and whether it offered equivalent inpatient and outpatient benefits for mental illnesses and/or substance use disorders. Only 13 states[11] offered plans to cover the uninsured that met, or nearly met, this standard. As a partial step, 16 states[12] have passed legislation to extend the age for dependent coverage (including non-students), allowing some parents to cover young adult children under their policies. This is an important option because three-quarters of all lifetime cases of mental illness occur by age 24, and treatment early in life can reduce long-term disability.[13]

Where can innovative practices be found?

- **Arkansas, Connecticut, Indiana, Maine, Maryland, Massachusetts, Minnesota, Oklahoma,** and **Vermont** all have state plans to cover the uninsured, and also provide coverage for inpatient and outpatient mental health and substance abuse treatment that is equal to coverage for other health concerns.[14]
- **Minnesota,** a model for the nation, provides a uniform benefit package for mental illness and substance use disorders in all state-funded insurance plans, including MinnesotaCare, its program for the uninsured. The benefit package covers an array of effective and intensive services, including Assertive Community Treatment (ACT), mental health crisis intervention and stabilization, intensive residential treatment, and rehabilitative mental health services.
- **Vermont**'s Catamount Health plan provides equivalent coverage for mental health and substance abuse treatment and provides chronic care management for depression. One of the plan carriers also offers chronic care management for anxiety disorders, bipolar disorder, posttraumatic stress disorder, schizophrenia, and substance use disorders. Out-of-pocket costs are waived for needed treatment of chronic conditions.
- **Maine** has one of the lowest uninsured rates in the nation, and the state's Dirigo health plan provides equal coverage for mental illness and substance use disorders.

Finding #4: Private Insurance Plans Often Lack Sufficient Coverage for Mental Health and Substance Use Disorders

Private health insurance plans frequently provide less coverage for mental illnesses (and substance use disorders) than for other conditions. Limiting coverage in this way

[8] Kaiser Commission on Medicaid and the Uninsured, Health Insurance Coverage of the Total Population (2007). Retrieved on January 25, 2009 from www.statehealthfacts.org.

[9] Mary Giliberti et al., *Coverage for All: Inclusion of Mental Illness and Substance Use Disorders in State Healthcare Reform Initiatives* (Arlington, VA: National Alliance on Mental Illness and the National Council for Community Behavioral Healthcare, 2008). Available at http://healthcareforuninsured.org/wp-content/uploads/Full.pdf.

[10] NAMI excluded Medicaid expansions here because the report covers Medicaid elsewhere, and we excluded high-risk pools because they are generally not helpful to people with mental illness due to their high cost.

[11] See first bullet under "innovative practices."

[12] Colorado, Connecticut, Delaware, Florida, Indiana, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, Texas, Utah, and Washington.

[13] National Institute of Mental Health (NIMH), "Mental Illness Exacts Heavy Toll, Beginning in Youth," press release, 6 June 2005, http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml.

[14] Four additional states that come close to meeting this standard are New Hampshire, New Mexico, Washington, and Hawaii.

prevents many people with serious mental illnesses from obtaining the care they need, and the cost is ultimately borne by emergency departments and overburdened public systems.

Ensuring that mental health and substance use disorders are covered equitably under insurance plans is known as establishing "parity." With the recent passage of federal parity legislation, more than 113 million people across the country stand to gain equivalent benefits for mental health or substance use disorders if their insurance plans already covered these conditions. For most plans, the legislation will take effect in January 2010. However, many citizens will be left out because the law does not cover individually purchased plans or employer-sponsored group plans that insure 50 or fewer people.

As a result, comprehensive state parity laws are still needed and should, at a minimum, require that a broad range of mental health and substance use disorders be covered equally with other medical conditions, with no unequal treatment, financial limitations or requirements, and no exclusions for individual or small group plans. Further, these laws should not allow plans to be exempt from parity requirements due to cost increases. Finally, parity laws should include key patient protections that ensure timely, equitable, and appropriate access to care, such as a uniform definition of medical necessity that promotes access to treatment for mental illnesses and substance use disorders, and requirements for adequate numbers and availability of mental health and substance abuse providers, including specialists.

What do the state-by-state data show?

Most states have some form of parity law governing private insurance plans, yet few of these laws result in coverage that is truly equitable or comprehensive. For the purposes of this analysis, the highest scores went to states that require equivalent coverage for a broad range of mental health and substance use disorders, and do not allow unequal cost sharing (e.g., higher co-pays for mental health services than for other services) or small group or cost increase exemptions. Only four states in the nation met these modest criteria (see Table 3.2).

Nine states have laws that offer equivalent benefits with no unequal cost sharing or small group or cost increase exemptions, but they limit benefits to specified serious mental illnesses. Another 10 states have parity laws that allow unequal cost sharing for mental health coverage and/or allow small group exemptions and/or allow cost increase exemptions. Twenty-five states have parity laws that specify minimum or maximum benefits for mental health conditions and/or allow mental health coverage to be optional; some of these may also have small group exclusions, cost increase exemptions, and unequal cost sharing. Two states, Alaska and Wyoming, do not have any parity law at all. Idaho enacted parity for serious mental illnesses in 2006, but it is limited to state employees.

Where can innovative practices be found?

- **Connecticut, Minnesota, Oregon,** and **Vermont** have the most comprehensive parity laws in the nation, covering a broad range of mental health and substance use disorders, without unequal cost-sharing or small group or cost increase exemptions. **Connecticut** and **Vermont** stand out because their laws apply to individual policies in addition to group plans.
- **Vermont** enacted legislation in 2007 to strengthen its parity law by adding several patient protections. Among these is a requirement that utilization review and other administrative and clinical protocols do not deter timely and appropriate emergency hospital admissions.

Table 3.2 State Mental Health Parity Laws

Parity benefits for broad range of mental health and substance use disorders	Connecticut, Minnesota, Oregon, and Vermont
Parity benefits for serious mental illness	California, Delaware, Hawaii, Montana, New Hampshire, New Jersey, North Carolina, South Dakota, and Virginia
Small group exclusions, unequal cost sharing, and/or cost increase exemptions	Colorado, Maine, Massachusetts, Missouri, New Mexico, New York, Ohio, South Carolina, Washington, and West Virginia
Minimum or maximum benefits specified and/or optional mental health coverage	Alabama, Arizona, Arkansas, DC, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Nebraska, Nevada, North Dakota, Oklahoma, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, and Wisconsin
No parity law (or applies only to state employees)	Alaska, Idaho, and Wyoming

Finding #5: Most States have Inadequate Plans for Developing and Maintaining the Mental Health Workforce

Across the country there is a critical shortage of qualified mental health personnel—from psychiatrists and nurses to social workers and other direct service providers. Yet without a well-trained, appropriately sized, and demographically diverse workforce, most efforts at mental health system transformation are likely to fail.

Workforce development is a comprehensive, complex, and labor-intensive process that must simultaneously address recruitment, retention, training, education, and performance. It requires coordination among diverse stakeholders (such as universities and colleges, provider systems, workforce investment boards, state labor departments, and consumer and family advocates), a commitment to ongoing planning, and, most importantly, sustained action.

What do the state-by-state data show?

Few states have comprehensive workforce plans. In reviewing the plans submitted, NAMI looked for evidence of a broad range of workforce goals, specification of desired outcomes and timelines, and exemplary planning approaches that could serve as models for other states. Of 35 states that reported some type of workforce-related activities, only six achieved the highest rating for an overall workforce plan and only five received the highest rating for a workforce diversity plan.[15] Three states—Alaska, California, and Connecticut—received the highest rating in both categories.

Where can innovative practices be found?

- **California,** one of the top ranking states, has a workforce development plan that grew out of Proposition 63 and the resulting Mental Health Services Act.[16] The plan clearly identifies goals, objectives, actions, performance indicators, and measurement strategies. It also integrates diversity goals, rather than addressing this issue separately, or as an afterthought.
- **Connecticut** supports a comprehensive workforce plan that is embedded in a set of broader reform activities catalyzed by a SAMHSA Mental Health Transformation State Incentive Grant. The plan specifies actions, performance measures, and timelines for achieving milestones across multiple initiatives. These initiatives address consumer employment in the behavioral health workforce, parent leadership development, higher education curriculum reform, recruitment, and supervisor skill training.
- **Alaska** has created a comprehensive approach to behavioral health workforce development that brings together state agencies, the public university system, the Tribal health systems, and other key stakeholders, and provides resources through a dedicated mental health trust.
- In May 2007, **Maryland**'s legislature established a Workgroup on Cultural Competency and Workforce Development for Mental Health Professionals. The workgroup was charged with completing a "comprehensive assessment of diversity in the mental health workforce, and develop(ing) a plan for achieving it." Recommendations were submitted to the legislature in January 2008 and included timelines for initiating a number of recommendations during 2008.
- The **Massachusetts** diversity plan, while more traditional in nature, is a model for how to thoroughly document a clear set of goals, strategies, and measures in this critical area.

Category II—Financing and Core Treatment/Recovery Services

In this part of the survey, NAMI investigated the availability and accessibility of core mental health treatment services, reimbursement for these services through state Medicaid programs, the severity of current shortages in the mental health workforce, and state efforts to improve the cultural competence of their mental health care systems. States were asked to report the number of people with serious mental illness served, along with information about Medicaid coverage, medication access, and the availability across the state of a variety of evidence-based practices (NAMI looked most closely at the per capita

[15] The six top-scoring states for overall workforce plans were Alaska, California, Connecticut, Missouri, Oklahoma, and Virginia. The five states with the best workforce diversity plans were Alaska, California, Connecticut, Maryland, and Massachusetts.

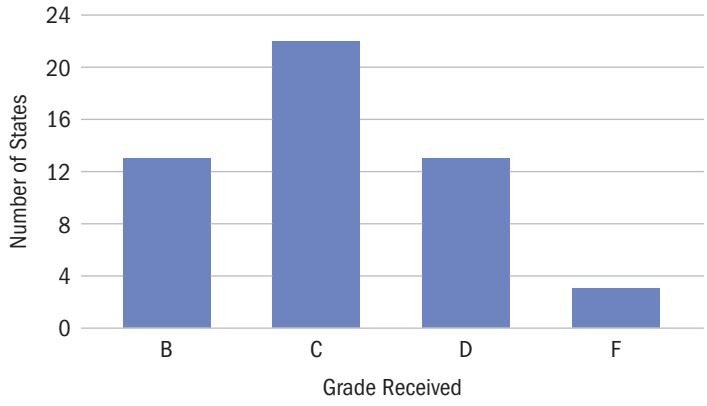
[16] In November 2004, California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA). The MHSA increases funding, personnel, and other resources for county-run mental health programs by imposing a one percent income tax on personal income in excess of $1 million. The new tax has generated more than $4.1 billion in additional revenues for mental health services through the end of Fiscal Year (FY) 2007-08 and is anticipated to generate an additional $1 billion in FY 2008-09 and $914 million in FY 2009-10.

availability of ACT and inpatient psychiatric beds). States also provided their cultural competence plans.

Performance in this category was stronger than Category I, although still quite mediocre. The results are illustrated in Exhibit 3.3.

With 43 percent of states earning a C grade, and almost one-third (31 percent) earning a D or an F, there is still considerable room for improvement. Three key findings from NAMI's assessment of financing and core treatment/recovery services provide clear direction for states.

Exhibit 3.3 Distribution of 2009 Category II Scores



Finding #1: States' Mental Health Financing Decisions are Often Penny-wise, Pound-foolish

Effective mental health services—like any other type of service—cannot be achieved without adequate funding. Yet few states put enough money into their public mental health systems to ensure services for all, or even most, of the people who need them. On average, state mental health agencies serve just over one-quarter (27.9 percent) of all adults with serious mental illnesses (this ranges from under 15 percent served in Vermont to more than 55 percent served in New York).[17] Even with these small shares of individuals served, states often respond to fiscal troubles by *reducing* mental health budgets even though the need for these services rises during economic downturns and other crises.

Although Medicaid pays for more mental health services than any other public or private source, burdensome requirements and processes in the Medicaid program can make it difficult for states to bill for—and get adequately reimbursed for—effective services such as ACT and peer supports. The level of a state's own investment in health care can also have a limiting effect on the amount of Medicaid reimbursement for which it is eligible.

In the final analysis, state mental health budgets and financing strategies represent choices and reflect—perhaps more accurately than any other indicator—a state's priorities, values, and political will. In today's distressed economic climate, states must focus intently on whether they are truly serving and protecting their most vulnerable citizens.

What do the state-by-state data show?

State mental health agencies consistently identified budgetary constraints and financing among their top challenges. NAMI queried states about the financing of specific key services and was surprised to learn that some state Medicaid programs still do not reimburse providers for basic services (or components of services) such as ACT (seven states), targeted case management (seven states), and mobile crisis services (seven states). Even more states do not cover peer specialists (19 states), language access services (25 states), and permanent supported housing (28 states). This substantially increases the burden on state coffers.

> *"Recovery is the understanding and acceptance of one's mental illness and the willingness to develop and implement safety care and life plans that bridge the chasms created by the illness."*
>
> —Consumer from Oklahoma

Although research shows that failing to adequately fund mental health services results in a need for significantly greater expenditures down the road, many states are still choosing to cut immediate costs by limiting access to needed services for people with serious mental illnesses. Many states are still charging patient co-payments (13 states), limiting the number of prescriptions per

[17] These calculations are based on states' reports of the number of unduplicated adults with serious mental illness they serve and state-specific estimates of the total number of adults with serious mental illness. For scoring purposes, states were ranked on this measure, divided into quartiles and given an unweighted score of one to four points. States in the lowest quartile (receiving one point) were Arizona, Colorado, Delaware, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Rhode Island, Vermont, Virginia, and Wyoming. States in the top quartile (receiving four points) were Alaska, DC, Hawaii, Iowa, Massachusetts, Mississippi, Montana, Nebraska, New Jersey, New York, North Carolina, Oregon, and West Virginia.

month (14 states), and limiting access to medications by restricting the number of "approved" prescription drugs, adopting "fail first" policies, and/or requiring prior authorizations for medications (28 states).[18]

In other states, cost cutting is taking place at a broader level. West Virginia and Rhode Island have decided to contain costs by radically redesigning their Medicaid programs in ways that put recipients at risk of losing needed care. In West Virginia's redesigned Basic Plan, mental health services[20] and inpatient hospital psychiatric services are simply not covered. Rhode Island has received broad authority from the federal government to redesign its Medicaid services as long as it significantly limits Medicaid spending through 2013. However, if Rhode Island runs out of its allotted state funds before this five-year mark, it will lose federal matching funds, and the state will have to either pay the program's full cost or dramatically cut services.

"Lo mejor es que tienen un equipo de ACT el cual me ayudó mucho a recobrar las riendas de mi vida."[19]

—Consumer from New York

Where can innovative practices be found?

- In addition to having the lowest rate of uninsured people in the country (3.7 percent of non-elderly adults), **Massachusetts** has also ensured that people receive quality care through its for-profit Medicaid carve-out (called Massachusetts Behavioral Health Partnership). It has done this by aligning payments with good clinical outcomes, so there is less incentive to deny care in order to save money.
- **Minnesota's** state health program for the uninsured (known as MinnesotaCare) has the most expansive outpatient mental health benefits of any state. The result of a remarkable combination of statewide planning, additional system investments, and creative financing, all state-funded insurance plans offer a uniform benefit package for mental illness so that individuals who lose Medicaid coverage and become eligible for the state's program can retain their benefits.

[18] These are the numbers of states that received less than full scores on the related items in our survey.

[19] Translation: "The best thing is that they have an ACT team, which helped me a lot to recover the reins of my life."

[20] Limited psychiatrist/psychologist services are covered under Specialty Care.

Finding #2: States are Not Adequately Providing Services that are the Lynchpins of a Comprehensive System of Care

As noted earlier, a high-quality mental health system is characterized by the availability of a continuum of services across inpatient and community settings. While advances in mental health treatments (and the provision of comprehensive, community-based supports) may reduce the number and length of inpatient hospitalizations for many people with serious mental illnesses, it is clear that there will always be a need for inpatient services. Inadequacies on one end of the continuum of care put unsustainable pressure on services at the other end.

Two critical services representative of what is needed on both ends of an effective continuum of care are Assertive Community Treatment (ACT)—an evidence-based, outreach-oriented, community-based treatment model that uses a 24/7 multi-disciplinary team approach—and inpatient psychiatric beds. These services, like all mental health services, also require an adequate mental health workforce to deliver them.

What do the state-by-state data show?

There is no consensus in the field on how much ACT, or how many inpatient psychiatric beds, communities should have. In fact, the answer depends on what other resources are available. Less ACT may be needed if communities have more case management and certified clubhouses. Similarly, the more ACT, short-term crisis stabilization beds, and other step-down beds there are in a community, the fewer inpatient beds will be needed.

Some researchers have called for enough ACT to serve 50 percent of people with serious mental illnesses.[21] Even with a much more conservative goal of 15 percent, states are not in the ballpark. Only seven states—Colorado, Connecticut, DC, Hawaii, Michigan, Rhode Island, and Wisconsin—reported having enough ACT to reach 15 out of every *1,000* people with serious mental illness.[22] Thirteen states report ACT at less than three people per 1,000 adults with serious mental illness, and five states report no ACT at all.[23]

[21] Gary S. Cuddeback et al., "How Many Assertive Community Treatment Teams Do We Need?" *Psychiatric Services* (American Psychiatric Association, 2006), 1803.

[22] To assess the availability of ACT across states, NAMI took states' reports on the number of people served with ACT (or estimated this number for states reporting numbers of ACT teams only). See appendix for details on how per capita ACT rates were scored. We are not confident that all of these ACT teams adhere to well-established fidelity standards.

On the inpatient side, NAMI's review of data on psychiatric beds from the American Hospital Association's annual survey reveals that there are about 113,988 psychiatric beds for adults across the country (see Table 3.3).[24] This is down from an estimated 126,849 beds in 2000, and 197,139 beds in 1990.[25]

Looking at the availability of beds per capita, there are 10.8 beds per 1,000 adults with serious mental illness. Across states this ranges from more than 15 beds per 1,000 adults with serious mental illness (in DC, New Jersey, Mississippi, New York, Delaware, and Nebraska) to fewer than eight (in Arizona, Florida, Rhode Island, Michigan, Nevada, South Carolina, Montana, and Ohio).[26]

As with ACT, there is little consensus on the minimum number of psychiatric inpatient beds communities should have available. One recent study suggests a minimum of 50 public psychiatric beds per 100,000 residents (which translates into roughly 9.3 beds per 1,000 adults with serious mental illness).[27] But even this suggested minimum threshold assumes that effective community-based services and assisted outpatient treatment programs are available, which is not the case.

Furthermore, NAMI's estimates include private psychiatric hospital beds (about 16 percent of the total) and forensic beds (i.e., beds for individuals who are awaiting trial, determined by the court to be incompetent to proceed to trial, or who are found not guilty by reason of insanity). In some states, such as California, the vast majority of state public psychiatric beds are forensic beds, meaning very few "civil" beds are available.

States must have an adequate mental health workforce to deliver critical services. Analyses of the mental health workforce by the Sheps Center document significant shortages across the country: while only one in five counties (18 percent) has an unmet need for nonprescribers, nearly every county (96 percent) has an unmet need for prescribers. In examining and scoring workforce availability, NAMI ranked states according to the severity of their mental health workforce shortage and divided them into four equal groups (or quartiles). States with the highest shortages got the lowest score for "workforce availability" and vice versa. With 96 percent of all counties experiencing prescriber shortages, it is clear that even states in the top quartile for workforce availability are still experiencing shortages.[28]

Where can innovative practices be found?

- **Rhode Island** has expanded its ACT program with the addition of RI ACT II—a less resource-intensive model for individuals who do not need the full level of ACT services. **Ohio** funds a forensic Assertive Community Treatment (F-ACT) team that serves people with serious mental illness upon release from prison.
- The **Georgia** Crisis and Access Line (GCAL) is an innovative mechanism for tracking available psychiatric beds. A toll-free, 24/7 phone service staffed by licensed clinicians who can make appointments anywhere in the state, GCAL tracks (in real time) the state's psychiatric bed capacity and works with emergency departments across the state to ensure people in need have access to available beds.

Finding #3: States are Not Ensuring their Service Delivery is Culturally Competent

As noted in Chapter 1, research confirms that people from minority racial and ethnic communities have less access to mental health services, are less likely to receive these services, and often receive poor quality care in treatment.

[23] Arizona, Arkansas, Georgia, Iowa, Kentucky, Louisiana, Missouri, Nevada, New Mexico, Tennessee, Utah, Vermont, and Washington (fewer than three per thousand) and Alaska, Mississippi, Kansas, North Dakota, and Wyoming (no ACT or ACT teams reported).

[24] The AHA surveys all hospitals in the United States, and identifies these hospitals from multiple sources including state hospital associations, the Joint Commission, and the Centers for Medicare and Medicaid Services. Because their database includes information on the total number of staffed beds *even for hospitals that do not respond to their survey*, we are confident that the majority of the beds in state psychiatric hospitals are captured in their data. The data also include inpatient psychiatric beds in other state- and county-owned hospitals and non-profit and investor-owned community-based hospitals.

[25] None of these figures include beds in federal (VA and other) hospitals, of which there were about 4,700 in FY 2007. Estimates for 2000 and 1990 are from Table 19.2 in Ronald W. Manderscheid and Joyce T. Berry (eds.), *Mental Health, United States, 2004* (Rockville, MD: Substance Abuse and Mental Health Services Administration, DHHS Pub No. (SMA)-06-4195, 2006). Available at http://mentalhealth.samhsa.gov/publications/allpubs/sma06-4195/chp19table2.asp.

[26] For scoring purposes, NAMI looked at the distribution across all states of adult inpatient psychiatric beds (per 1,000 adults with serious mental illness) and divided states into four equal groups (or quartiles). States in the top-most quartile (with the most beds per capita) were: DC, New Jersey, Mississippi, New York, Delaware, Nebraska, Connecticut, Massachusetts, Wyoming, Missouri, South Dakota, Maryland, and North Dakota. States in the bottom-most quartile (with the fewest beds per capita) were: Colorado, Texas, Vermont, Oregon, Washington, Ohio, Montana, South Carolina, Nevada, Michigan, Rhode Island, Florida, and Arizona.

[27] E. Fuller Torrey et al., *The Shortage of Public Hospital Beds for Mentally Ill Persons* (Arlington, VA: Treatment Advocacy Center, 2008). This assumes an overall prevalence rate for serious mental illness of 5.4 percent.

[28] States with the most severe shortages are: Alabama, Arkansas, Idaho, Indiana, Iowa, Mississippi, Nebraska, Nevada, South Dakota, Texas, Utah, West Virginia, and Wyoming. States with the least severe shortages (relative to other states) are: California, Connecticut, DC, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and Virginia.

Table 3.3 Grading the States 2009: Inpatient Psychiatric Beds in US Hospitals in FY 2007 (1)

State	State & Local Psychiatric Hospital Beds	Other State & Local Government Hospital Beds	Non-Government & Not-for-Profit Hospital Beds	Non-Government & Investor Owned Hospital Beds
Total (All States)	53,857	8,078	34,133	17,920
District of Columbia (DC)	817	0	131	104
New Jersey	3,685	127	1,747	210
Mississippi	1,553	225	148	568
New York	6,071	1,628	3,547	407
Delaware	323	0	45	92
Nebraska	716	0	259	0
Connecticut	777	25	810	0
Massachusetts	897	247	1,300	598
Wyoming	166	31	0	86
Missouri	1,342	72	983	702
South Dakota	244	0	176	0
Maryland	1,230	0	1,157	25
North Dakota	140	0	150	34
Pennsylvania	2,214	0	2,785	971
Kansas	692	128	337	0
Virginia	1,593	132	516	860
Hawaii	202	28	151	0
Indiana	1,172	201	886	386
New Hampshire	224	0	182	84
Alabama	990	399	107	584
Minnesota	1,147	134	581	0
Louisiana	874	285	188	675
Wisconsin	1,225	0	813	0
Idaho	215	63	70	237
Oklahoma	450	77	653	402
Georgia	2,539	129	610	462
Illinois	1,830	56	1,892	649
Tennessee	972	59	678	857
West Virginia	240	26	404	147
Maine	152	0	359	0
Kentucky	535	32	695	463
Utah	449	114	80	140
North Carolina	1,611	382	770	413
New Mexico	357	10	10	302
Iowa	223	210	542	0
Alaska	80	12	49	74
Arkansas	202	26	481	348
California	4,885	1,521	2,070	1,815
Colorado	860	53	300	140
Texas	3,108	275	1,270	2,410
Vermont	54	0	137	0
Oregon	739	31	349	0
Washington	1,216	105	342	115
Ohio	1,420	134	1,560	206
Montana	214	0	92	0
South Carolina	506	179	191	444
Nevada	401	0	18	257
Michigan	625	101	1,625	307
Rhode Island	0	0	282	0
Florida	1,342	622	1,235	1,261
Arizona	338	199	370	85

Notes: (1) Excludes all children's hospitals. Data represent "staffed beds," beds regularly available (those set up and staffed for use) within the reporting period.
(2) Estimates developed by Charles E. Holzer, III, Ph.D. of the University of Texas Medical Branch and Hoang T. Nguyen, Ph.D. of LifeStat LLC (see http://psy.utmb.edu/).

Source: FY 2007 AHA Annual Survey Database. Health Forum, an American Hospital Association affiliate, 2008. Reported prepared by AHA Resource Center, November 2008.

All Non-Federal Hospital Beds	Number of Adults with Serious Mental Illness (SMI), FY 2007 (2)	Non-Federal Psych. Beds Per 1,000 Adults SMI	Non-Federal Psych. Beds Per 1,000 Adults SMI—Rank	Federal Government Hospital Beds	Federal & Non-Federal Hospital Beds
113,988	10,590,429	10.8		4,660	118,648
1,052	22,811	46.1	1	0	1,052
5,769	258,617	22.3	2	0	5,769
2,494	125,269	19.9	3	0	2,494
11,653	672,924	17.3	4	490	12,143
460	28,652	16.1	5	0	460
975	60,744	16.1	6	0	975
1,612	108,730	14.8	7	0	1,612
3,042	210,815	14.4	8	732	3,774
283	19,733	14.3	9	203	486
3,099	222,596	13.9	10	106	3,205
420	30,351	13.8	11	15	435
2,412	175,173	13.8	12	116	2,528
324	24,131	13.4	13	0	324
5,970	448,455	13.3	14	175	6,145
1,157	95,110	12.2	15	125	1,282
3,101	261,959	11.8	16	22	3,123
381	32,435	11.7	17	27	408
2,645	226,713	11.7	18	0	2,645
490	42,818	11.4	19	0	490
2,080	186,541	11.2	20	411	2,491
1,862	167,810	11.1	21	388	2,250
2,022	182,593	11.1	22	82	2,104
2,038	188,057	10.8	23	18	2,056
585	54,375	10.8	24	0	585
1,582	147,343	10.7	25	47	1,629
3,740	348,789	10.7	26	87	3,827
4,427	420,841	10.5	27	165	4,592
2,566	246,003	10.4	28	32	2,598
817	81,214	10.1	29	0	817
511	51,248	10.0	30	16	527
1,725	181,441	9.5	31	19	1,744
783	82,362	9.5	32	21	804
3,176	334,855	9.5	33	96	3,272
679	71,674	9.5	34	30	709
975	104,922	9.3	35	21	996
215	23,650	9.1	36	0	215
1,057	116,435	9.1	37	73	1,130
10,291	1,180,000	8.7	38	28	10,319
1,353	157,828	8.6	39	8	1,361
7,063	832,795	8.5	40	0	7,063
191	22,712	8.4	41	10	201
1,119	137,345	8.1	42	0	1,119
1,778	218,585	8.1	43	184	1,962
3,320	418,207	7.9	44	370	3,690
306	38,961	7.9	45	0	306
1,320	170,022	7.8	46	15	1,335
676	88,540	7.6	47	42	718
2,658	348,154	7.6	48	412	3,070
282	37,739	7.5	49	17	299
4,460	660,443	6.8	50	31	4,491
992	220,909	4.5	51	26	1,018

Providing culturally competent services can reduce such disparities in treatment and outcomes. Mental health systems must be sensitive and responsive to people's unique cultural circumstances, including race and ethnicity, national origin, ancestry, religion, age, gender, sexual orientation, physical disabilities, and specific family or community values and customs.

What do the state-by-state data show?

Only five states—Arizona, California, Connecticut, Hawaii, and Massachusetts—have exemplary cultural competence plans and activities, can provide significant evidence that they are implementing cultural competence initiatives, and demonstrate progress. Cultural competence plans in these states include:

- Consumer, family, and community involvement in the planning process
- Race/ethnicity-specific penetration and retention rates
- Cultural competence standards and requirements for service contracts and quality management plans
- Cultural competence training components for staff, contractors, and other stakeholders
- Measurable cultural competence performance indicators, outcomes, and timetables
- Language access components

The top-performing states also have full-time cultural competence directors or coordinators. Further, they have a plan for reducing disparities in care for minority communities, and they routinely include cultural competence and/or diversity activities in other areas of their system (such as cause-of-death studies, wellness plans, suicide prevention efforts, and workforce development).

Nine "average effort" states[29] have cultural competence plans that include most of the evaluated components, evidence of some progress and implementation of cultural competence initiatives, a staff person leading cultural competence efforts, and some activities aimed at reducing disparities in care (although many lack an actual disparities plan). These states promote cultural competence among providers, usually by hosting cultural competence trainings, but show little evidence of cultural competence and/or diversity components in other areas of the system.

Eighteen "partial effort" states[30] either do not have a cultural competence plan (but show evidence of some effort in this area), or have a plan that is substandard. In these plans there is no in-depth strategy for implementing the identified goals or identified performance measures, and/or the state cannot show any evidence of progress or follow-through. Some of these states are currently developing cultural competence plans or have identified this as a pressing goal.

Eighteen states showed "little or no effort" to develop cultural competence.[31] They have no cultural competence plan nor do most have a disparities plan. They are very limited in their promotion of cultural competence among providers, and if they do have wellness, workforce, or suicide prevention plans (or cause-of-death studies), most do not break out data by race/ethnicity.

Another troubling indicator of poor performance in this area is that of the 10 states with the largest shares of racial/ethnic minorities (meaning 39 percent or more of the population), only Hawaii, California, and Arizona have made significant inroads in becoming more culturally competent. The remaining seven (New Mexico, Texas, Mississippi, Maryland, Georgia, Nevada, and New York) urgently need to improve their levels of cultural competence and their efforts to meet the mental health needs of minority groups (see Table 3.4).

Table 3.4 Cultural Competence Scores of States with Largest Shares of Racial/Ethnic Minority Populations

State	Percent of Population Racial/Ethnic Minority	Cultural Competence Score Out of Max. 3 (Unweighted)
Hawaii	58.9%	3
New Mexico	57.1%	1
California	55.5%	3
Texas	51.2%	0
Mississippi	40.2%	1
Maryland	40.1%	2
Georgia	40.1%	1
Arizona	39.7%	3
Nevada	39.2%	1
New York	39.0%	1

Notes: Not listed in the table is the highest share of racial/ethnic minorities at 67.3 percent in the nation's capital, Washington, DC (it scored two out of three on this dimension). Population data are from the 2006 American Community Survey (ACS), US Census Bureau. Available at http://www.census.gov/acs/.

[29] Colorado, DC, Illinois, Louisiana, Maryland, North Carolina, Oregon, Pennsylvania, and South Carolina.
[30] These are Alabama, Delaware, Georgia, Mississippi, Missouri, Nevada, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Rhode Island, Tennessee, Utah, Vermont, Virginia, and Washington.
[31] These are Alaska, Arkansas, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Montana, Nebraska, New Hampshire, Texas, West Virginia, Wisconsin, and Wyoming.

Where can innovative practices be found?

- In **California,** the Department of Mental Health requires all county mental health programs to develop comprehensive community Cultural Competence Plans and to report annually on progress. The Mental Health Services Act also requires county plans to report on specific communities that have been identified as facing significant disparities, and requires the development of programs to address these disparities.
- In **Massachusetts,** cultural competence is deeply embedded in the state mental health infrastructure. In addition to a Multicultural Advisory Committee (a subgroup of the State Mental Health Planning Council), there are multicultural/diversity committees in each Department of Mental Health area, including the central office. Representatives from these committees comprise a Cultural Competence Action Team (CCAT) that leads these efforts throughout the system.
- In **Connecticut,** the Department of Mental Health and Addiction Services (DMHAS) funded and worked with Yale University faculty to study health disparities in its inpatient mental health and substance use treatment facilities. The study focused on access to care issues, service quality, and outcomes. DMHAS is now conducting another study focused on health disparities in community-based programs.

Category III—Consumer and Family Empowerment

In this section of the survey, NAMI investigated whether and how states provide real opportunities for consumer and family education and empowerment. States were asked to provide information about policies relating to consumer and family monitoring teams, mandated membership on state Pharmacy and Therapeutics (P&T) committees, and support of family, peer, and provider education programs. Results in this category also reflect findings from NAMI's "Consumer and Family Test Drive" (CFTD), in which NAMI volunteers assessed the ease with which individuals can get practical information over the telephone and via the Web sites of state mental health agencies. States performed quite poorly in this category. The results are illustrated in Exhibit 3.4.

With almost 60 percent of states earning a D or an F grade, and many others earning a C, it is safe to conclude that consumer and family empowerment has not been a high priority across the country. Repeated calls by the New Freedom Commission and others to address this

Serving Our Combat Veterans: A Mixed Performance

The nation's military forces in Iraq and Afghanistan have some distinct characteristics:

- Half are members of the National Guard, or Reserve members of the regular forces.
- They are older, and tend to be married with jobs and families.
- They are typically from rural America.
- Many have served multiple tours in Iraq and/or Afghanistan.

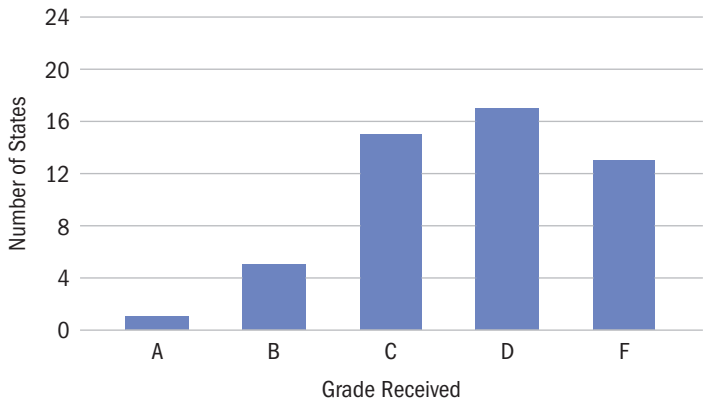
A startlingly high percentage of these veterans are coming home at risk of posttraumatic stress disorder and depression.[32] Military sexual trauma, untreated substance abuse, marital discord, and high divorce rates are also being reported. NAMI believes state mental health agencies, the Department of Veterans Affairs, and qualified private mental health practitioners must work together to help these individuals, and their families, obtain the readjustment and transitional mental health services and supports they need.

We have a long way to go. In 27 states, public mental health agencies deliver few, or no, services specifically designed for National Guard members or their families (note that other state agencies, such as the state National Guard bureaus, may be providing counseling and debriefing services). On the positive side, mental health agencies in 10 states have implemented extensive service delivery, referral, and coordination initiatives, and another 13 are either beginning, or planning, to provide significant services to Guard members and their families.[33]

[32] Terri Tanielian and Lisa H. Jaycox (eds.), *Invisible Wounds of War: Psychological and Cognitive Injuries, their Consequences, and Services to Assist Recovery* (Santa Monica, CA: RAND Corporation, 2008). Available at http://www.rand.org/pubs/monographs/MG720/.

[33] States with extensive services in this area are California, Connecticut, Maine, Maryland, New Hampshire, New Jersey, New Mexico, New York, North Carolina, and South Carolina. Those that are planning or just starting to deliver services are Alabama, Alaska, Arkansas, Colorado, Illinois, Iowa, Missouri, Nebraska, Ohio, Oklahoma, Utah, West Virginia, and Wyoming.

Exhibit 3.4 Distribution of 2009 Category III Scores



critical issue have clearly gone unheeded. Key findings from across the country suggest specific action steps for states that want to improve their performance.

Finding #1: Information from State Mental Health Agencies is Not Readily Accessible

Information is power. A high-quality, consumer- and family-driven mental health system requires coherent and easily navigated sources of information. The CFTD was developed by NAMI for its 2006 report to determine how easy it is for a consumer and/or family member to gather basic information from a state mental health agency's Web site and/or phone service (e.g., where to go for immediate help, how to access recovery and wellness treatments and activities, or how to apply for Medicaid). Frustration over not being able to access needed information adds to the burden of mental illness, and diminishes the ability of consumers and family members to play an active role in treatment.

What do the state-by-state data show?

States across the country performed very poorly on the CFTD: more than two-thirds (68 percent) were unable to score even half the total possible points. State mental health agencies are clearly not relaying basic information to people who need their services. Overall, phone and Web site accessibility were grossly inadequate. More specifically, the CFTD survey found that state information systems lack cultural and linguistic competence. Information on mental illnesses and their treatment could be found in a non-English language *only with great difficulty,* if at all.

The survey also revealed that phone services tend to be superior to Web sites, suggesting that states have not invested in making their electronic interfaces user-friendly. In addition, communication between information and referral services (such as 411 and Directory Assistance) and state mental health agencies needs significant improvement. Test drive volunteers were repeatedly provided with incorrect phone numbers.

The five top-ranked states (for combined phone and Web scores) were Virginia, Massachusetts, Connecticut, Maine, and Tennessee. Of these, Virginia, Massachusetts, and Maine had made significant gains since the CFTD was first done for NAMI's 2006 report. Of the five bottom-ranked states—Arkansas, California, Washington, Oregon, and New Mexico—two (Arkansas and New Mexico) remained as poorly ranked as they had been in the last report, while California, Washington, and Oregon lost ground. States that were best at conveying information over the phone were Virginia, South Carolina, South Dakota, Colorado, and Kentucky. The top scoring states for relaying information through their Web sites were Minnesota, Virginia, Massachusetts, Texas, and Maine.

Where can innovative practices be found?

- In **Virginia,** which ranked first in the combined CFTD score, the 211 service[34] has interpreters available for three-way calls in more than 100 languages.
- In **Massachusetts,** which ranked second overall, the state Web site offers a great deal of information for veterans.

Finding #2: States are Not Creating a Culture of Respect

Just like consumers of any health care service, people with serious mental illnesses should be treated with respect and dignity: they should be informed about their medical conditions, consulted about treatment options, and play an important role in planning for, and implementing, steps toward recovery. When consumers and

[34] In July 2000, the Federal Communications Commission (FCC) reserved the 211 dialing code as an easy-to-remember and universally recognizable number that could refer, and sometimes connect, individuals and families to a wide variety of community-based and government health and human service agencies. Information about 211 services is available at www.211.org.

families feel scorned or badly treated, they may avoid the services they need. Indeed, SAMHSA has identified respect as one of 10 fundamental components of recovery:

> Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.[35]

Provider education is critical to changing the culture of disrespect that pervades many public mental health systems. Another key is recognizing that people living with mental illnesses and their families are often *de facto* members of the mental health workforce. The self-care, family member care, peer support, and hands-on programming they provide can be among a system's most therapeutically productive and cost-effective resources.

What do the state-by-state data show?

In state after state, consumers and family members who participated in NAMI's Web-based survey commented on the lack of respect they experience from the provider organizations tasked with helping them.[36]

States vary in the extent to which they promote peer-run services. They also tend to be more supportive of peer and family education programs than of provider education programs with significant consumer and family involvement. One explanation is that peer- and family-focused programs have been around longer, so there is greater demand for these programs. It may also be more challenging and expensive to engage mental health providers.

Twenty-two states earned top scores for their substantial support of family education programs,[37] and 15 states received high scores for their support of peer education programs.[38] Only six states (Connecticut, Oklahoma, South Carolina, Utah, Vermont, and Wisconsin) demonstrated excellence in provider education programs.

Where can innovative practices be found?

- **Maryland** is nationally known for its extensive collaboration with its statewide mental health consumer education and advocacy organization, On Our Own of Maryland. The collaboration has resulted in an anti-stigma project (which includes a series of four workshops and a video entitled "Stigma...in Our Work, in Our Lives"), and a multi-faceted recovery-training project offering workshops designed to promote empowerment, knowledge, and self-determination for mental health consumers.
- The **North Dakota** Consumer and Family Network employs peer staff in each of the state's eight regions who are working to increase consumer involvement in policy development, education, and recovery promotion efforts. The Network's statewide consumer conference in March 2009 demonstrated the state's increased focus on consumer empowerment.
- **West Virginia** uses federal mental health block grant funds to support the West Virginia Mental Health Consumers Association (WVMHCA), which is internationally known for its Leadership Academy. WVMHCA provides alternative, nontraditional services including transitional housing, supportive employment, peer support programs (including groups at state hospitals), and a peer support specialist certification program.
- In **Connecticut,** the state's largest public psychiatric facility offers an orientation class for all new employees that is taught by consumers currently hospitalized there. Feedback reveals that the orientation program has been very well received.

Finding #3: Consumers and Family Members do Not Have Sufficient Opportunities to Help Monitor the Performance of Mental Health Systems

A mental health system that is truly consumer-centered and consumer- and family-driven involves individuals and families in the design, implementation, and evalu-

[35] Substance Abuse and Mental Health Services Administration, *SAMHSA Issues Consensus Statement on Mental Health Recovery,* (Rockville, Md., February 16, 2006), available at http://www.samhsa.gov/news/newsreleases/060215_consumer.htm.

[36] Findings from this Web-based survey were not scored and are not part of states' grades. They were used to provide critical background information and context for other sources of information that NAMI scored.

[37] These are Arizona, California, Colorado, Connecticut, Florida, Illinois, Indiana, Maryland, Massachusetts, Minnesota, Mississippi, Missouri, Montana, New Jersey, North Carolina, Ohio, Oregon, South Carolina, Utah, Vermont, Virginia, and Wisconsin.

[38] These are Arizona, Connecticut, Georgia, Illinois, Indiana, Kansas, Maine, Minnesota, Missouri, New Hampshire, New York, Oklahoma, Tennessee, Vermont, and Wisconsin.

ation of all services. States that are serious about empowering people with serious mental illness require that consumer and family teams be involved in conducting inspections and monitoring conditions in inpatient and community-based treatment settings, authorize these teams to conduct unannounced visits, and reserve one or more seats for consumers and family members on state Pharmacy and Therapeutics (P&T) committees and other bodies with real decision-making authority.

What do the state-by-state data show?

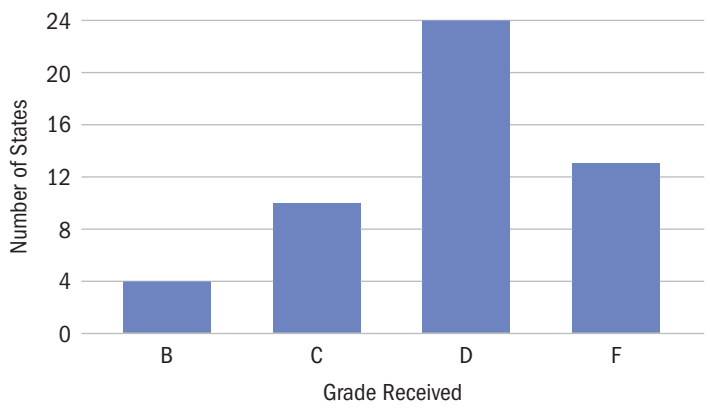
Only four states—Arizona, California, Connecticut, and Pennsylvania—require that consumer and family monitoring teams review conditions in state or county psychiatric hospitals, other inpatient facilities, *and* community-based mental health programs (including conducting unannounced visits or inspections). At the other end of the spectrum, 24 states[39] do not require (or authorize) such monitoring teams in *any* mental health service setting. The remaining states require monitoring teams in only some treatment settings and/or do not give them the authority to conduct unannounced visits.

Where can innovative practices be found?

- **Pennsylvania** mandates that each county create and operate consumer and family satisfaction teams within its Medicaid managed care systems. The teams interview individuals about their experiences with mental health and substance abuse services, and report this information back to multiple stakeholders. When problems are identified, providers must develop quality improvement plans, and they are closely monitored to see that these plans are implemented.
- **Arizona** law requires regional Human Rights Committees (mandated to include consumers and family members) to conduct regular site visits to the state hospital, all other inpatient facilities, and community-based mental health agencies that provide residential environments for consumers. The committees are permitted, but not required, to conduct visits to other non-residential community-based programs.

[39] Alaska, Arkansas, DC, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Massachusetts, Michigan, Nevada, New Hampshire, New Mexico, North Carolina, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Virginia, West Virginia, and Wisconsin.

Exhibit 3.5 Distribution of 2009 Category IV Scores



Category IV—Community Integration and Social Inclusion

In this section of the survey, NAMI investigated whether states are able to meet the needs of people with serious mental illnesses when those needs extend beyond the traditional purview of state mental health agencies. States were asked to provide information about the availability of housing resources, criminal justice-related interventions, and public education efforts.

States performed more poorly in this category than in any preceding category. These results are illustrated in Exhibit 3.5.

With the fewest number of states earning a B grade, and almost 75 percent earning a D or an F, it is clear that mental health systems remain isolated within state governments, even though collaboration with other agencies is vital to their success. Key findings from across the states suggest specific ways in which states can begin building necessary bridges.

Finding #1: Few States are Developing Plans, or Investing the Resources, to Address Long-term Housing Needs for People with Serious Mental Illnesses

A decent, safe, affordable, and permanent place to live—that reflects an individual's housing preferences—is a cornerstone of recovery for people with serious mental illnesses. Unfortunately, the extremely low income of many

in this population is a significant barrier to stable housing. The solution is both very simple and extraordinarily challenging: make sure people with serious mental illnesses have access to permanent housing subsidies that ensure affordable rents and, when needed, provide ongoing support services to help them stay housed.

In recent years, the federal government has dramatically reduced the number of new, permanent rental subsidies available. As a result, state mental health systems have had to be much more assertive and strategic in engaging state and local housing officials in partnerships that will support consumers. Successful approaches typically include some direct investment of mental health system funding in housing-related activities (e.g., funding for housing specialists or bridge rental subsidies that can leverage Section 8 Housing Choice Vouchers). Leadership from the top of the mental health system is usually necessary to achieve these partnerships.

What do the state-by-state data show?

States were assessed in this area on a number of criteria:

- Whether they have a recent and mental health-driven housing plan
- Whether the plan includes quantifiable milestones or outcomes and timetables for reaching goals
- If they have real partnerships with other state agencies involved in housing
- The numbers and types of dedicated or innovative financing mechanisms available to support permanent supportive housing for people living with serious mental illnesses

It is clear that much work remains to be done when it comes to planning for, and financing, permanent and affordable housing for people with serious mental illness. Twenty states earned less than one-quarter of the maximum total points in this area. Among the majority of remaining states, there was little evidence of significant commitment to housing issues. Even states with the strongest plans and partnerships find housing to be a major challenge.

The three states with the highest overall housing scores—California, Washington, and North Carolina—each pursue different tactics and resource allocation strategies, but they all demonstrate recent and strong investment in an evidence-based, permanent supportive housing model, and have long-term vision and aggressive plans for the use of mental health and housing system resources.

Eleven states[40] scored more than half the possible points in this area. While these states have a sustained and recent history of strategic planning and investment of mental health system capital and/or rental subsidies to create permanent supportive housing for consumers, these efforts are not at the scale achieved by the three highest-scoring states.

Unfortunately, many states still continue to rely primarily on federal housing subsidies, which can only be provided to consumers who meet a very narrow definition of homelessness. While these subsidies are vitally important for consumers who can qualify, a comprehensive, policy-driven housing strategy must also assist those who are *at-risk* of homelessness.

Where can innovative practices be found?

- **California's** laudable achievements in expanding permanent supportive housing opportunities represent the gold standard in state mental health housing policy and practice. Through the enactment and implementation of Proposition 63 (the Mental Health Services Act), state mental health leaders and stakeholders have effectively engaged citizens, local communities, government housing officials, and the non-profit sector in a successful campaign that assures the housing needs of people with mental illness are a top priority.
- **Washington's** recent housing activities also deserve recognition. In late 2007, the state completed a comprehensive housing strategic plan with clearly specified goals and multiyear outcomes, as well as a commitment of dedicated housing resources to ensure affordability for the lowest-income consumers.
- **North Carolina's** Department of Health and Human Services, in partnership with the state housing finance agency, has created highly integrated housing opportunities in federal-tax-credit-financed properties across the state. Recognizing the shortage of federal subsidies, North Carolina also provides substantial state rental subsidy funding to assure that tenants pay no more than 30 percent of income for rent.

[40] Connecticut, Hawaii, Louisiana, New York, Ohio, Tennessee, Arizona, Indiana, Nebraska, Pennsylvania, and New Jersey.

- **Louisiana** and **Pennsylvania** have developed policies and approaches that promote highly integrated permanent housing opportunities for consumers. They are prioritizing strategies and housing models that create a small number of permanent supportive housing units within "mixed income" affordable housing properties across the state.
- **Nebraska** and **Indiana** have both developed ambitious and long-range strategic housing plans with specified timelines to guide their housing activities. Both states have dedicated specific housing resources—either capital funds or permanent rental assistance—to achieve the goals adopted in the plan.
- **Tennessee** continues to significantly expand housing opportunities through its strong statewide network of dedicated housing specialists. The state mental health system's investment in housing has focused on individuals who have developed the knowledge, skills, and local relationships necessary to successfully leverage substantial amounts of housing capital and rental subsidy funds.

Finding #2: Effective Diversion from the Criminal Justice System is More Common, but Remains Scattershot without State-level Leadership

One of the most visible indicators of our mental health system's failure is the fact that more than 450,000 Americans with a recent history of mental illness are incarcerated in U.S. jails and prisons.[41] Many of these people are there for misdemeanors or crimes of survival, and their mental illness may end up prolonging their stay. When the mental health system functions poorly, the criminal justice system too often becomes the default provider of treatment and care for people with serious mental illnesses. This mode of operation is inhumane, ineffective, and expensive.

Efforts to address this tragic problem can encompass a range of strategies, including cross-training of criminal justice and mental health personnel, pre- and post-booking jail diversion efforts, and provision of services designed to support people reentering communities following incarceration.

[41] Doris J. James and Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates* (Washington, DC: U.S. Department of Justice, Bureau of Justice Statistic, Bureau of Justice Statistics Special Report, 2006).

What do the state-by-state data show?

In most cases, the state mental health agency has not taken a lead in addressing the growing crisis in the nation's jails and prisons. However, in almost every state, local mental health advocates have worked at the city and county levels to build collaborations between criminal justice leaders and mental health providers. These collaborations have resulted in a wide range of programs to prevent incarceration. For example, in 47 states, communities have created police Crisis Intervention Team (CIT) programs to teach law enforcement personnel appropriate responses to people with mental illness, and to foster collaborative efforts that divert individuals in crisis into treatment instead of arrest and incarceration. While CIT programs can be found scattered across the country, only a handful of states (Colorado, Connecticut, Florida, Georgia, Maine, Ohio, and Utah) have *statewide* efforts characterized by strong collaborations among state mental health officials, the judicial system, law enforcement agencies, mental health providers, and advocates.

Approximately 200 communities in 43 states have created mental health courts: specialized dockets for defendants with mental illness who are charged with misdemeanors or, in some cases, felonies. These courts operate in partnership with mental health and substance abuse systems as well as individual providers to offer court-supervised treatment as an alternative to incarceration.

Where can innovative practices be found?

- **Ohio, Florida, Connecticut, Utah, Georgia, Maine,** and others support collaborations that coordinate statewide CIT programs. These collaborations include criminal justice leaders, mental health providers, state and local leaders, and mental health advocates. In many states, these efforts have spun-off into legislation and advocacy for increased services to prevent incarceration.
- **Idaho, Nevada, New York, Ohio,** and **Georgia** have mental health court "learning sites," designed to help neighboring states and communities start their own mental health courts. In 2008, **Buffalo, New York** founded the nation's first mental health court specifically for veterans.
- **Ohio** is a leader in funding *forensic* Assertive Community Treatment (F-ACT) teams through the Department of Corrections, while **Indiana** is a

leader in training correctional staff about mental illnesses and crisis intervention. **New York** has enacted a law to limit segregation of prisoners with serious mental illnesses and instead provides them with treatment.

- In **Florida,** advocates pushed through legislation to redirect dollars from the criminal justice system into mental health and substance abuse services. In **Tennessee,** the Department of Mental Health and Developmental Disabilities funds criminal justice/mental health liaisons in every region of the state.

Finding #3: Most States are Beginning to Provide Public Education on Mental Illness, but Stigma Remains a Major Concern

Public misconceptions about mental illnesses—and the people who live with them—are commonplace. Many are not aware that mental illnesses can be treated and that recovery is possible; others assume people with mental illness are incompetent or violent. These misperceptions create rifts in communities and can cause people with mental illnesses to avoid critical care. The full inclusion and support of people living with serious mental illness can be possible only when the communities in which they live are free of the stigma and discrimination that are rooted in ignorance.

What do the state-by-state data show?

The good news is that 49 states have at least the beginnings of public education and anti-stigma efforts underway (Minnesota and South Dakota are the exceptions). Further, 26 states were able to provide details of activities (often statewide) that provide information to the public on mental illnesses and help combat common myths.[42] Three states—Mississippi, New Jersey, and New York—scored highest on this measure.

Although these results can be seen as positive, perceptions and attitudes remain a significant barrier in every state. Indeed, one of the most persistent themes of comments NAMI received through its Web-based survey of consumers and family members was a disheartening lack of respect, dignified treatment, and sense of hope from some of the very systems and people who are supposed to help. While treatment and supports are important tools in recovery, hope is a keystone. It is critical that states do much more to ensure a respectful and collaborative approach in providing mental health services.

Where can innovative practices be found?

- Building on the Ad Council's national campaign for young adults called "What a Difference a Friend Makes," **Mississippi** has established regional teams of advocates, providers, and public figures that are linking this campaign to their anti-suicide efforts. The state has also developed and videotaped a series of vignettes to spark community discussions, written, produced, and marketed radio and television public service announcements (PSAs), obtained extensive media coverage, and recruited local celebrities as spokespeople.[44]
- In **New Jersey,** the Governor's Council on Mental Health Stigma held a logo and Public Service Announcement (PSA) contest and customized its outreach efforts for employers, law enforcement, faith communities, health providers, and veterans.[45] In all of its activities, the theme is "Respect, Understanding, and Change," with an emphasis on wellness and recovery.
- In **New York,** immediately following the 9/11 tragedy, the Office of Mental Health launched *Project Liberty* to counter the myths and stigma that might prevent people—especially first responder police

> *"Yo no veo ningún interés de parte de las agencias pertinentes. Tengo que leer mucho y educarme acerca de las leyes que protegen a las personas con enfermedades mentales para así poder ir a los lugares correctos y buscar ayuda y con todo y esto no encuentro apoyo; no se si es porque somos hispanos y nos ven con prejuicio o si es asi con este tipo de pacientes."*[43]
>
> —Consumer from South Carolina

[42] These were Alabama, Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Iowa, Kansas, Maine, Maryland, Massachusetts, Mississippi, Missouri, New Jersey, New Mexico, New York, North Dakota, Ohio, Oklahoma, Oregon, Tennessee, Virginia, West Virginia, and Wisconsin.

[43] Translation: "I don't see any interest from the pertinent agencies. I have to read a lot and educate myself about the laws that protect people with mental illnesses to be able to go to the correct places and look for help and with all that I don't find support; I don't know if it's because we're Hispanic and they see us with prejudice or if it's like that with this type of patient."

[44] Available at http://www.dmh.state.ms.us/anti_stigma.htm.

[45] Available at www.nj.gov/mhstigmacouncil.

Civil Rights Violations and Abuses

People living with mental illnesses want, deserve, and need safe, high-quality, and respectful care. Mistreatment not only violates their human rights but also diminishes their trust in helping systems. In calculating the grades for this report, NAMI deducted points for states with independently documented cases of abuse, neglect, unsafe conditions, or inappropriate placements for people with serious mental illnesses. Two sources were used for this information:

- *U.S. Department of Justice (DOJ) investigations under the Civil Rights of Institutionalized Persons Act (CRIPA):* DOJ investigates state mental health facilities for allegations of abuse and neglect and evaluates safety and quality concerns and publishes lists of its ongoing investigations, including findings letters (available at http://www.usdoj.gov/crt/split/cripa.php). States penalized for an open DOJ CRIPA investigation were: California, Connecticut, DC, Georgia, North Carolina, Oregon, and Vermont.
- *Olmstead Lawsuits:* In the landmark Supreme Court case *Olmstead v. LC,* 527 U.S. 581 (1999), the Court ruled that states must provide community mental health services for hospitalized individuals who are ready for discharge. The plaintiff, LC, waited in a hospital for an extended time despite being ready for community placement. Olmstead litigation against a state denotes serious concerns that limited access to community services is resulting in overuse of hospitals, nursing homes, and other institutional settings. States penalized for an open Olmstead lawsuit were: Connecticut, Florida, Illinois, New Jersey, New York, Pennsylvania, and Wyoming.

In truth, these two measures reveal only a fraction of the mistreatment occurring in the American mental health system. Until our system is fully safe, responsive, individualized, transparent, and accountable, some of our most vulnerable citizens will continue to suffer needlessly.

and firemen—from seeking help.[46] New York has become a resource to other states and worked closely with the **Louisiana** Department of Mental Health in the aftermath of Hurricane Katrina.

Moving Forward: Key Avenues for Improvement

Grading the States 2009 has some good news to report: in parts of the country, state mental health systems are moving in a positive direction. Since our 2006 survey, 14 states have modestly improved their grades, and two fewer states are failing outright. The survey has also identified pockets of innovation and promising practices that should inspire and guide states toward much-needed improvements, including:

- Exciting pilot programs are testing innovative treatment strategies.
- New legislation and regulations are responding to on-going challenges.
- Strategic and innovative plans are addressing workforce diversification and development needs.
- Strong partnerships are emerging with criminal justice and other systems, agencies, advocates, and consumer groups.
- Public education efforts are working to decrease stigma and establish full inclusion for people with serious mental illness.

And yet, it is clear that the innovations and improvements are painfully few and far between. Given the urgent nature of our mental health system's failures, even those states with high scores and innovative practices cannot rest on their laurels.

States' grades should be viewed as a helpful tool for viewing the overall picture. But as this chapter has demonstrated, a closer look brings into sharp focus three areas in which our state mental health systems are objectively failing:

1. **Service Delivery.** Across the states, this report finds that there are not enough services and supports for those who need them. Further, the services that are provided are neither routinely comprehensive in scope nor provably effective. The culture of service delivery perpetuates stigma and stereotypes, thereby diminishing its own chances for effectiveness: there is little respect for the consumer or acknowledgement of diversity; consumer inclusion and participation are inadequate; and communication is exceptionally poor. Finally, mental health services are not effectively linked to other systems resulting in cost shifting and

[46] Available at http://nyc.gov/html/doh/html/liberty/english.html.

A Special Note on Poor Rural and Frontier Communities

Mental illness affects Americans in every part of our country. Our poor rural and frontier areas are particularly vulnerable to ineffective and inadequate service delivery. Distressingly, states with the largest shares of people living in persistent poverty (most commonly found in rural and frontier areas) are among the lowest performing in this analysis.[47] These states are Mississippi, Louisiana, New Mexico, Kentucky, Alabama, Texas, Missouri, Georgia, South Dakota, and South Carolina.[48] None of these 10 states scored higher than a C overall, and 70 percent scored a D or an F grade (compared to 38 percent of all states scoring a D or an F).

Rural and frontier poverty presents unique and complex challenges for public mental health systems. As one recent report explains:

> Rural areas (areas characterized by low population density, limited and fragile economic base, cultural diversity, high level of poverty, limited access to cities) have incidents of serious mental and behavioral health problems (depression, suicide, alcohol and substance abuse) equal to or greater than urban areas. Equally troubling is the insufficient volume and range of services available to treat mental and behavioral health problems in rural areas. Not only do rural areas have shortages of behavioral health professionals and specialized behavioral health services, but the turnover rate for service providers is high, and providers that remain often express feelings of isolation from other health professionals. These conditions are exacerbated in isolated rural and frontier areas and areas with concentrations of poverty and migrant and seasonal farm workers.[49]

Many rural communities also face growing ethnic and cultural diversity, deteriorating infrastructure, limited employment opportunities, a severely limited workforce, and a declining population base. All of these factors make for a very challenging environment in which to build an effective mental health service system. A lack of funding for evidence-based practices developed specifically for rural areas, the higher cost of service delivery in rural areas due to low volume of patients, and the long distances that service providers and consumers must travel are also significant barriers.

Strategies for Overcoming the Challenges

There are rural and frontier communities around the country that have done remarkable work in linking formal and informal supports, and in adapting best practice interventions to successfully support people with serious mental illness. These communities are testing strategies such as creating multiservice centers and establishing "hub-and-spoke" models with outreach and referrals both to and from outlying rural and frontier areas. More remote areas with very limited capacity may also succeed with mobile outreach units, enhanced transportation, and increased telemedicine capacity.

However, from a national perspective, the success stories are few and far between. Recognizing this, NAMI supports the need to "rural proof" public policies that guide the development and transformation of mental health services. Rural proofing is a process by which policies are carefully and objectively examined to determine differential impacts for rural areas. When necessary, policy adjustments are suggested that take rural needs into particular consideration and ensure, as far as possible, equal access to public services for rural communities.[50]

[47] "Persistently poor" counties are those in which 20 percent or more of the population has been found to be poor in every decennial Census since 1960.
[48] E-mail communications with staff of the Economic Research Service, U.S. Department of Agriculture, October 1, 2008.
[49] Donald Sawyer et al., *Rural and Frontier Mental and Behavioral Health Care: Barriers, Effective Policy Strategies, Best Practices* (Waite Park, MN: National Association for Rural Mental Health, 2006).
[50] DARD, *Rural Proofing of Policies Across the Northern Ireland Civil Service, Annual Report 2005-2006* (Belfast, Northern Ireland: Department of Agriculture and Rural Development, 2006). Available at www.dardni.gov.uk/rural-proofing-annual-report-2005-2006.pdf.

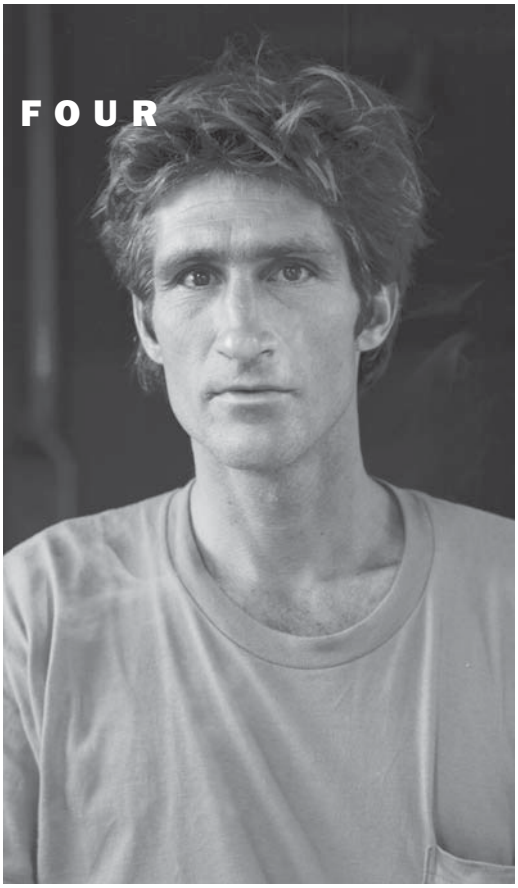
"dumping" of consumers on those ill-equipped to support them.

2. **Data Gathering and Performance Assessment.** The truest measures of a state mental health system are quite simple: the share of people in need who are served, and how well those people fare. To design and implement high-quality mental health systems, states and localities must be able to accurately identify the needs in their communities, and track the use and effectiveness of services they provide. And yet this report finds that the gaps in states' collection, compilation, and monitoring of data are consistently both wide and deep—service availability and system capacity are often unknown, and service effectiveness is truly a mystery to most state mental health systems.
3. **Building Public and Political Will.** In the three years since NAMI last surveyed the states—a period of relative prosperity and economic strength across the country—few mental health systems made progress of any real significance. Among other things, this is a troubling indicator of a lack of public and political will to take-on the challenges in effectively serving people with serious

mental illnesses. The current economic crisis makes our lack of resolve in this area even more frightening. Without public and political will, conditions for those with serious mental illness will most certainly deteriorate.

These three critical areas represent not only where we have failed, but also the avenues for improvement we must pursue. Urgent action is needed. Chapter 4 outlines NAMI's policy recommendations for states and the nation.

CHAPTER FOUR



Policy Recommendations

As Charles Dickens wrote, "it was the best of times, it was the worst of times." This is an apt description for public mental health services in the United States today. While we have seen significant advances in the development and use of proven treatments for people with serious mental illnesses, the very existence of these treatments perpetrates a cruel irony on the many consumers (and families) who do not have access to them.

This report documents significant shortages of evidence-based and promising practices in virtually every state in the country. In some places, desperately needed services are not available at all.

We Cannot Afford More Failure

With proper treatment, services, and supports, the lives of people living with serious mental illnesses can be substantially improved; recovery is indeed possible. *Grading the States 2009* follows in the footsteps of the New Freedom Commission, the National Academy of Sciences' Institute of Medicine, and the U.S. Surgeon General in identifying a specific set of actions to achieve success. And yet, as a nation, we are not taking these steps. Year after year, we continue to fail to support many of the most vulnerable among us.

The costs of our failure to provide adequate services to people with serious mental illnesses are also well known: disproportionate dependence on public income supports and medical benefits; over-reliance on costly treatments in emergency

rooms; high rates of incarceration in America's jails and prisons; and low rates of employment.[1]

To address these concerns, and put our nation's public mental health system on the path to maximum efficiency and effectiveness, NAMI recommends that states and the federal government undertake these five actions:

1. Increase public funding for mental health care services
2. Improve data collection, outcomes measurement, and accountability
3. Integrate mental and physical health care
4. Promote recovery and respect
5. Increase services for people with serious mental illnesses who are at greatest risk

The following discussion briefly reviews the context for each of these recommendations and then identifies specific action steps in each area. Where possible, noteworthy state efforts are highlighted to encourage replication of promising practices.

NAMI's Recommendations for States and the Federal Government

1. Increase Public Funding for Mental Health Care Services

Where We're Failing

Adequate funding for mental health has long been a low priority for states:

- Although Medicaid spending has increased, non-Medicaid state spending has not kept pace.
- Growth in state mental health spending is slower than total growth in state government expenditures.[2]
- As the national economic crisis worsens, many states are making—or considering—even greater cuts to mental health services.

Taking Action

During difficult economic times, wise choices on spending must be made. Cuts to state mental health services are unwise because they inevitably lead to greater costs in other areas. States truly committed to investing in recovery should increase funding of public mental health services, while making sure that these funds are spent wisely on services that work.

In addition to state general funds, states across the country are finding creative and successful ways to generate new revenues or reconfigure existing resources to increase funding for mental health services.

Institute Modest Tax Increases

- California's Mental Health Services Act authorizes the state to levy a one percent tax on annual personal income exceeding $1 million. Funds are used to develop and implement innovative mental health services in the community.[3]
- Counties in Washington are authorized to impose a sales tax add-on of one-tenth of one percent to fund new mental health, chemical dependency, or therapeutic court services at the local level.[4]
- States such as Arkansas, Florida, Kentucky, North Carolina, and South Carolina, among others, are considering increases in taxes on cigarettes or alcohol (i.e., "sin taxes"). Revenues could be targeted to mental health funding, including smoking cessation programs and other similar interventions.

Reallocate Resources

- Connecticut and Florida reinvest dollars from their criminal justice systems into community-based services, housing for ex-offenders (including those with serious mental illnesses), jail diversion, and mental health services.[5]
- Kentucky finances an innovative jail mental health triage program through revenues generated from court costs and fees.[6]

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[1] Thomas R. Insel, "Assessing the Economic Costs of Serious Mental Illness," *American Journal of Psychiatry* 165(2008): 663.

[2] National Association of State Mental Health Program Directors, *FY 2005 State Mental Health Revenue and Expenditure Study Results,* 07-03 (2007): 4.

[3] California Department of Mental Health, Mental Health Services Act (Proposition 63). Available at http://www.dmh.cahwnet.gov/prop_63/mhsa/default.asp.

[4] Washington Institute for Mental Health Research and Training, *Sales Tax Provides Local Funding for Mental Health and Chemical Dependency Services*. Available at http://mhtransformation.wa.gov/pdf/mhtg/FS_Implementing5763.pdf.

[5] Reentry Policy Council, *Connecticut Implements Justice Reinvestment Strategy to Manage Prison Growth and Generate Savings,* November 30, 2006. Available at http://reentrypolicy.org/announcements/connecticut_implements_justice_reinvestment_strategy_to_manage_prison_growth.

[6] Kentucky Cabinet for Health and Family Services, *Telephonic Triage Services Provides Assistance for Kentucky Jails,* February 3, 2006. Available at http://chfs.ky.gov/news/triage.htm.

Establish Dedicated Trusts

- Alaska established a trust in perpetuity to fund systems improvement and innovative programs for people with mental illnesses.[7] The trust is financed through one million acres of land managed by the state to generate income to help pay for a comprehensive, integrated mental health program.[8]
- Oregon created a housing trust fund for people with mental illnesses through revenues generated from the sale of a state hospital.[9]

2. Improve Data Collection, Outcomes Measurement, and Accountability

Where We're Failing

In a time of economic crisis, it is critical that public funds are spent wisely. And yet, data collection in mental health—the basis for smart spending—lags far behind comparable efforts in other health care disciplines. Across the country, there is an extremely limited capacity to provide even the most rudimentary information on mental health services.

- Data are limited on the level of available services, how well services meet needs, and whether they achieve positive outcomes.
- Data are not standardized within or across states, making comparisons and the identification of useful avenues for improvement extremely difficult.
- Federal officials, state mental health agencies, and community providers continue to haggle over leadership, definitions, and strategies, resulting in repeated false starts and little forward progress.

Taking Action

Standardize Data Collection within States

- In Arkansas, all community mental health centers use a standard collection instrument to report uniform data to the state mental health agency.

Report on Evidence-Based Practices

- California's Department of Mental Health has combined resources from a federal Data Infrastructure Grant and the state's Mental Health Services Act to modify its data systems to better track individuals receiving integrated treatment. All county systems now collect and report this data.

Reestablish Priority for Mental Health Data Collection at the Federal Level

- Resource allocation within SAMHSA should support state- and small-area level estimates. In particular, the agency should support states in collecting data through the Behavioral Risk Factor Surveillance System (BRFSS).
- The Bureau of Justice Statistics should reinstate mental health questions in its periodic census of state and federal adult correctional facilities, and must support state-level estimates.[10]
- Systematic, state-by-state analysis of Medicaid claims data for people with serious mental illnesses should be conducted. This analysis should encompass general health care as well as all aspects of mental health care.

Track Wait-times in Emergency Rooms

- Very few states currently track the time it takes for an individual with a serious mental illness to access a psychiatric bed or alternative service after entering an emergency room. This information is essential if serious efforts are to be undertaken to address national problems that exist in access to crisis and acute psychiatric care.

Establish Firm Leadership

- As the federal agency responsible for overseeing public mental health services, SAMHSA must exert stronger leadership in developing meaningful outcomes measures and in enforcing good data reporting by state mental health systems, all of which receive federal funds.

3. Integrate Mental and Physical Health Care

Where We're Failing

Studies repeatedly document the link between mental and physical wellness: individuals with serious mental illnesses have a higher risk of serious medical problems

[7] Alaska Mental Health Trust. Available at http://www.mhtrust.org/.
[8] Alaska Mental Health Trust Authority, "Trust History." Available at http://www.mhtrust.org/index.cfm?section=about-us&page=Trust-History.
[9] National Alliance to End Homelessness, "Oregon's Office of Mental Health and Addiction Services." Available at http://www.endhomelessness.org/content/article/detail/1123.
[10] Until 2000, this census survey identified, for each state, the number of facilities that provided mental health screening and treatment, and the number of prisoners receiving these screenings and treatment services.

and often die prematurely.[11] And yet, NAMI was unable to find a single state mental health system with comprehensive, integrated, and preventive action (or outcome measurement) related to wellness and survival.

- Many people with serious mental illnesses lack access to medical care, particularly high-quality care.
- Psychiatrists and mental health professionals often fail to focus on the general health concerns of their patients; in primary care settings, mental health problems often go undiagnosed or untreated due to a lack of training and ongoing stigma.
- There is a substantial lack of cross staffing, communication, and coordination between mental health and other medical professionals.
- A number of states do not permit providers to bill Medicaid for mental health and general health care services on the same day.

Taking Action

Expand Pilot Programs that Link Physical and Mental Health

- New Hampshire's *In Shape* program, for example, helps individuals with serious mental illnesses address physical health risks associated with their medications.
- Connecticut, Maine, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New York, Ohio, Oklahoma, and Oregon are posting nurses at community mental health centers, linking their record systems with physical health providers, offering smoking cessation programs, and screening individuals for emerging diabetic concerns.

Other Recommendations for Improving Integration of Care

- Increase coordination of mental health care and general health care by, for example, locating primary care physicians at mental health centers or alternatively locating psychiatrists and other mental health professionals at general health clinics.
- Provide coverage of preventive care in private and public health insurance plans and increase use of health and wellness programs.

[11] Joseph Parks et al. (eds.), *Morbidity and Mortality in People with Serious Mental Illness* (Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council, 2006). Available at http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortaility%20-%20Final%2011-06.pdf.

4. Promote Recovery and Respect

Where We're Failing

People with mental illnesses are often dismissed as being incapable of making informed decisions or of shaping the course of their lives. NAMI's survey of states and consumers reveals the many ways in which this manifests itself:

- Many consumers are treated disrespectfully, or even abusively, by those charged with helping them
- Provider education is a low priority
- Peer-based services and supports are under-utilized and under-supported
- Vital life services, such as housing and employment support, are scarce and unnecessarily tenuous
- Mental health services frequently do not take into account a person's cultural or language background

Taking Action

Employ Peer Specialists

- Peer counselors and peer specialists should be an integral part of public mental health care service delivery systems. A number of states have taken positive steps in this regard by establishing educational and certification programs for peer specialists. Some states also reimburse certified peer specialists through their Medicaid programs. All states should adopt and expand these promising practices.

Fund Peer-Run Services

- Increasingly, states are funding consumer-run programs that provide services such as telephone warm lines, drop-in centers, and public education on mental illness and recovery.

Fund Peer Education Programs

- Many states fund peer education programs such as the Wellness-Recovery-Action-Plan (WRAP) program and Peer-to-Peer.

Provide Culturally and Linguistically Competent Services

- There are currently broad variations in the commitment of states to providing culturally and linguistically competent services. All states should make it a priority to improve in these areas. For example, states should move beyond the development of cultural competence plans to actual

statewide implementation, including documenting progress and clear outcomes.

Invest Resources in Reducing Human Rights Violations

- A number of states have taken positive steps to reduce or eliminate the inappropriate use of seclusion and restraints in their psychiatric treatment facilities. For example, Pennsylvania, through a combination of standard setting and staff education, has reduced the use of seclusion and restraints by 99 percent in its inpatient psychiatric treatment facilities.
- Two federal agencies, the U.S. Department of Justice and the U.S. Department of Health and Human Services, play important roles in enforcing civil rights protections for people with mental illnesses in institutional settings such as hospitals, nursing homes, and correctional facilities. Additional funding should be provided to enable these agencies to carry out these important functions.

Increase Employment Opportunities

- Supported employment is an evidence-based practice with proven effectiveness in helping consumers attain competitive employment and thereby enhance their recovery.[12] Unfortunately, supported employment and other meaningful employment opportunities are not available in many parts of the country. All state mental health agencies should enter into agreements with their vocational rehabilitation counterparts to collaborate on expanding supported employment and other employment opportunities for people with serious mental illnesses.

Increase Housing Opportunities

- Independent, affordable housing, with supports available, is a critical component of recovery. While the NAMI survey revealed a few examples of strong collaborative efforts between mental health and housing agencies, coordination and collaboration is too often lacking. State mental health agencies must become more involved with their state housing agencies to create a variety of community housing options.

[12] Robert E. Drake et al., "Best Practices: The Johnson & Johnson-Dartmouth Community Mental Health Program: Disseminating Evidence-Based Practice, *Psychiatric Services* 57 (2006): 302.

5. Increase Services for People with Serious Mental Illnesses Who are Most at Risk

Where We're Failing

In state after state, there are serious shortages of inpatient psychiatric beds and crisis stabilization programs for people with serious mental illnesses. Also lacking are appropriate mechanisms for responding to people with serious mental illnesses whose symptoms may preclude them from recognizing their need for treatment and therefore accessing services.

The cost to states, and the nation, of delayed or inappropriate responses to these individuals is extremely high.[13]

- Many community hospitals have eliminated their psychiatric beds for more profitable alternatives.[14]
- Jails and emergency rooms frequently end up as default providers of crisis care.

> *"El proveer servicios a los enfermos ayuda a que menos personas mueran por no estar estables. Los servicios son baratos en comparación con el costo del desempleo . . . y la hospitalización. El tratamiento del individuo es mucho más barato que la manutención de ese individuo en el sistema penal."*[15]
>
> —Consumer from Florida

Taking Action

Eliminate the "Institutions for Mental Diseases" (IMD) Exclusion

- This longstanding and discriminatory Medicaid provision prohibits use of federal Medicaid dollars for services for people (ages 22-64) in psychiatric hospitals. The IMD exclusion serves as a barrier not only to reimbursing care in psychiatric hospitals, but also to implementing Medicaid reimbursable home and community-based waivers

[13] Malcolm Gladwell, "Million-Dollar Murray: Why Problems Like Homelessness May Be Easier To Solve Than To Manage," *The New Yorker,* February 13, 2006, 96.

[14] David Klepper, "Kansas Panel to Explore Closing Three Mental Health Facilities," *Kansas City Star,* January 23, 2009; Liz Kawalczyk, "Hospital Network Will Cut Back," *The Boston Globe,* January 29, 2009; Kelly Brewington, "State Plans to Close Baltimore's Only Public Psychiatric Center," *Baltimore Sun,* January 28, 2009; Nathan Winters, "Missouri Hopes to Transfer Responsibility for Mental Health Center Services," *Missourian,* January 28, 2009.

[15] Translation: "Providing services to the sick helps so that less people die because they are not stable. The services are cheap in comparison with the cost of unemployment . . . and hospitalization. Treatment of the individual is much cheaper than maintenance of that individual in the penal system."

that have been very helpful to other Medicaid populations, such as people with developmental disabilities.

Implement a Coherent Response to Non-Adherence to Treatment

- States should implement a full set of strategies tailored to individuals whose symptoms may preclude them from recognizing that they are ill and thus participating in treatment. These strategies (which are described in Chapter 1 of this report) should include Assertive Community Treatment (ACT) programs, peer supports, Psychiatric Advance Directives (PADs), motivational strategies such as the LEAP program, treatment guardianships, and, as a last resort, court-ordered assisted outpatient treatment (AOT).

Adopt Incentives to Increase the Qualified Mental Health Workforce

- Essentially, the entire country is a mental health services professional workforce shortage area. Without adequate numbers of qualified mental health professionals, the provision of appropriate services to people with serious mental illnesses is impossible. Incentives to increase the mental health workforce, including competitive salaries, loan forgiveness programs for those who commit to service in the public mental health system, and administrative supports to decrease paperwork burdens on front-line mental health professionals, should be adopted.

Conclusion

In 2002, during a time of relative economic prosperity, the President's New Freedom Commission on Mental Health concluded that, "America's public mental health system is in shambles."[16] Today, with the nation's economy in distress, it might be easy to assume that meaningful improvements to the mental health system are nearly impossible. Yet, during difficult times, services are even more critical. Adoption of the recommendations set forth above would make significant strides towards creating a public mental health system that is both responsive to the people in need of its services and cost-effective. This opportunity for meaningful change cannot be missed.

[16] President's New Freedom Commission on Mental Health, "Interim Report to the President," October 29, 2002.

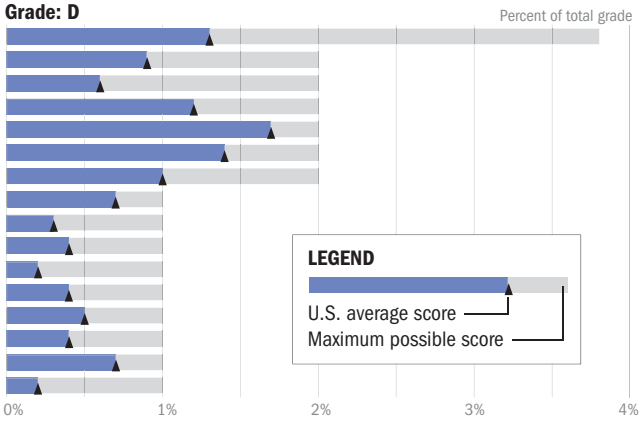
CHAPTER FIVE

State Report Cards

NAMI Score Card: UNITED STATES — Grade: D

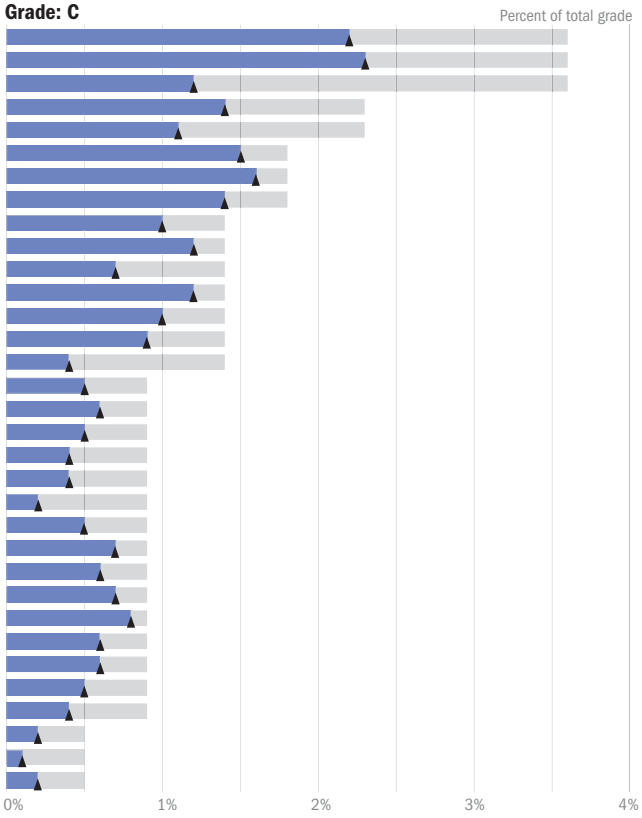
Category I: Health Promotion & Measurement — Grade: D

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



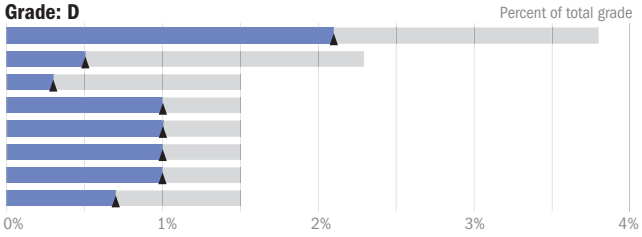
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



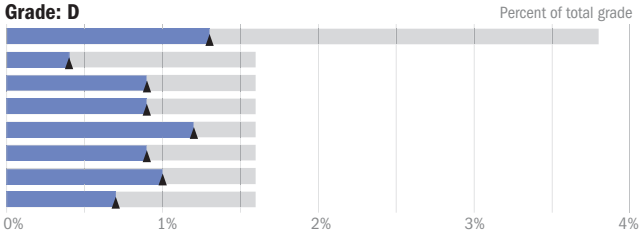
Category III: Consumer & Family Empowerment — Grade: D

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



United States

In 2006, the nation's mental health system earned a D. After three years, we remain stagnant, earning another D. This national grade (an average of the state grades) reflects our country's utter neglect of its most vulnerable citizens. The lack of improvement over time brings into sharp relief our complete failure to take charge of an ineffective system and begin to transform it.

There are certainly some positives to be noted. In many states, mental health agencies are building their workforces based on solid planning. They are adding evidence-based practices such as Assertive Community Treatment (ACT), increasing the availability of peer-provided services and supports, and working hard to coordinate with other systems, such as physical health, criminal justice, and housing.

But these improvements are neither deep nor widespread enough to improve the national average. And too often, innovative and energized state mental health directors are constrained by budget cuts, bureaucratic procedures, and outdated requirements. There are many critical "actors" in this system—SAMHSA, governors, state legislators, Medicaid Directors—and without a unified commitment to change and concerted efforts at coordination, little can be accomplished.

This paralysis can be readily seen in the long list of problems that have led to our nation's second consecutive grade of D. We have too few psychiatric beds, treatment services, and community-based supports for those who need them; people with mental illnesses are neglected until they reach the point of crisis, and are then dumped onto other systems. Across the nation, people with mental illnesses are unnecessarily incarcerated, homeless, out of work, and unable to access needed medicines. On top of it all, we have an extremely limited capacity to monitor and measure our own efforts—the very foundation of effective reform.

It need not be this way. The United States has made great strides in combating cancer, heart disease, HIV, and diabetes. We must make the same commitment to recovery for people with mental illness. In his Inaugural Address, President Obama said:

> The challenges we face are real, they are serious, and they are many. They will not be met easily or in a short span of time. But know this, America, they will be met.

The challenge of transforming our nation's mental health system must remain a priority among the many challenges the President envisions. As we take-on the economic crisis and tackle health care reform, we must ensure that our nation never again earns a grade of D for its treatment of people with serious mental illnesses.

The time has long since 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.

Michael J. Hogan, chair of the
New Freedom Commission on
Mental Health, 2003

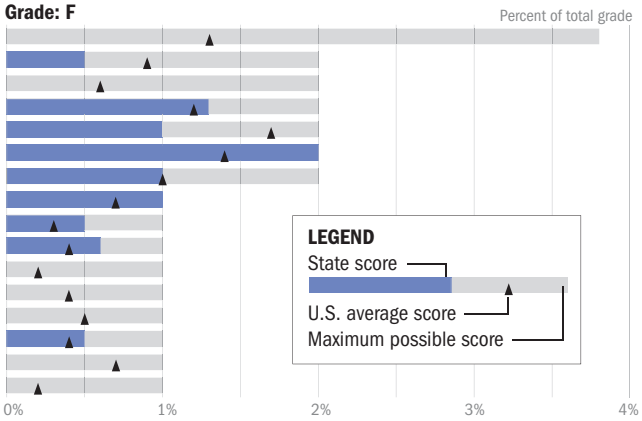
NAMI Score Card: ALABAMA

Grade: D

Category I: Health Promotion & Measurement

Grade: F

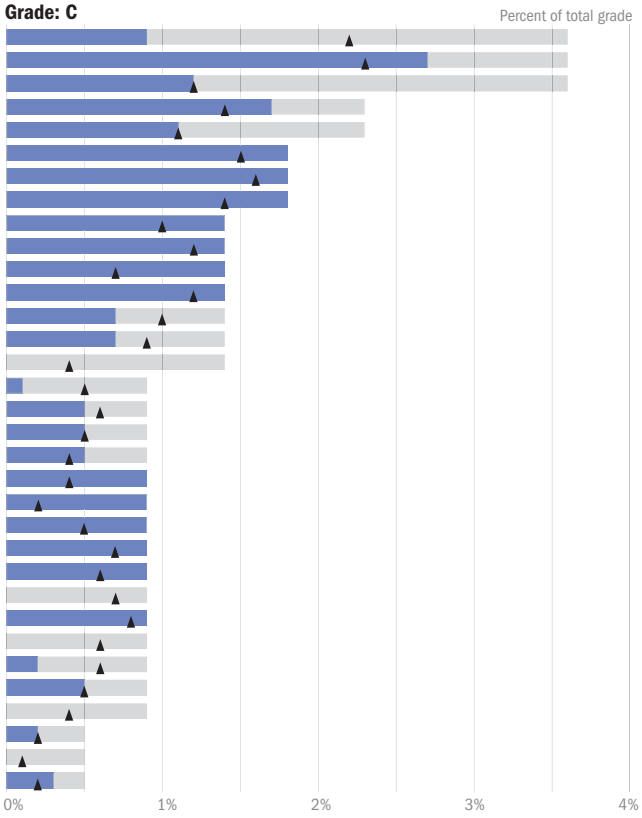
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

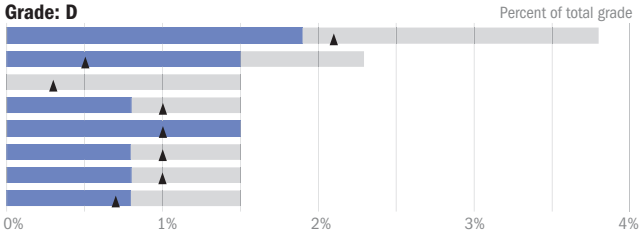
- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

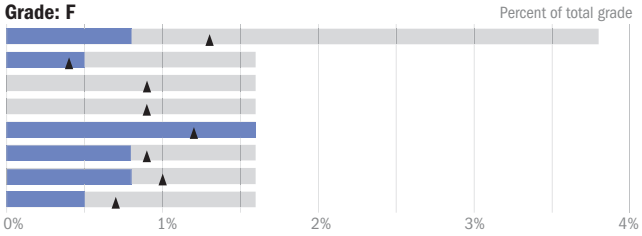
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: F

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Alabama

In 2006, Alabama's mental health care system received an overall grade of D. In three years, its grade has not changed.

The single defining element in the evolution of Alabama's mental health care system has been *Wyatt v. Stickney,* a class action lawsuit focused on the state's psychiatric hospitals that spanned nearly 30 years before finally being settled in 2000. The case sparked hope that Alabama finally was positioned to develop an excellent mental health care system to address both inpatient and community treatment needs. Sadly, this has not happened.

Some progress has occurred. The Alabama Department of Mental Health and Mental Retardation provided a three-year grant to the University of Alabama, Birmingham (UAB) to establish a Center of Excellence to help develop evidence-based and promising practices at selected sites throughout the state. The state funds six psychiatric residencies in both state medical universities in return for recipients working in the public mental health system. It has worked to reduce the use of restraints and seclusion in state hospitals, and the practice is now significantly below national levels. Five mental health courts have been established in Tuscaloosa, Birmingham, Bessemer, Montgomery, and Huntsville. The state has provided funding for police Crisis Intervention Team (CIT) training sessions in Birmingham, Dothan, Florence, Mobile, Montgomery, and Shelby County but, unfortunately, no Alabama counties or communities have implemented actual CIT programs to date.

Alabama seems stuck in perpetual debate over whether to invest in hospital care or community-based services. Shortages in acute and crisis care beds contribute significantly to large numbers of people with serious mental illnesses incarcerated in Alabama's jails and prisons. In many parts of the state, particularly impoverished rural counties, community-based services are virtually nonexistent. Severe shortages of mental health professionals compound these problems. Alabama has one of the lowest per capita ratios of psychiatrists in the country. Yet, inexplicably, the state appears to have no plan to address these shortages.

Innovations

- Reduction in use of restraints and seclusion in state hospitals
- Center of Excellence to develop statewide evidence-based practices
- Psychiatric residencies at state medical schools

Urgent Needs

- Address acute and crisis care shortages
- Integrated dual diagnosis treatment and supported employment
- Reduce workforce shortage of mental health professionals

Consumer and Family Comments

- *"I take it one day at a time and generally rely on family and friends instead of the doctors that are supposed to be there to help."*
- *"One of the most important things I receive is preventative care . . . that my support team catches a potential problem before it turns into a crisis."*
- *"There is a lack of coordinated care and follow up for those who live on their own . . . individuals fall through the cracks and often end up in a crisis and off of their medications. The providers do not work from a recovery standpoint."*
- *"We were able to get a case worker for our loved one. However, the case worker was so overworked and undertrained that it added to the confusion and frustration."*

Alabama is lagging in its implementation of programs using evidence-based practices. Although the state has a number of Assertive Community Treatment (ACT) teams, consumers and families report that many of these programs do not meet federal fidelity standards. Finally, the state has put few, if any, resources into jail diversion programs other than mental health courts, despite large numbers of citizens with serious mental illnesses who are incarcerated.

Poverty and historic bureaucratic inertia are major reasons for the D grade. Investment in the mental health system is inadequate, and implementation of programs that work remains scarce. Hospitals are filled beyond capacity, and shortages in acute care hospital and crisis beds have reached critical levels. Despite the landmark Wyatt case and positive rhetoric, the issue remains whether leadership and political commitment exist to build a truly first-rate mental health care system.

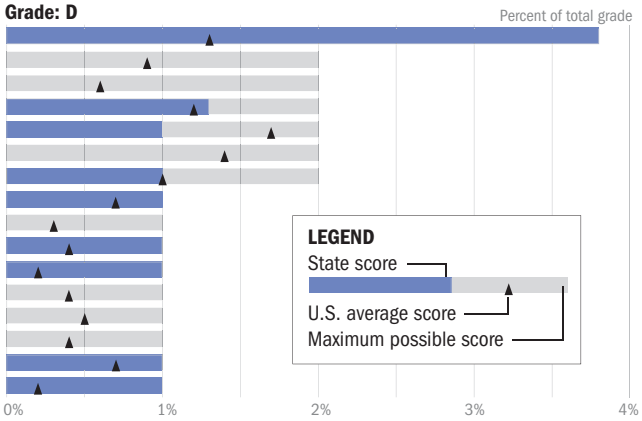
NAMI Score Card: ALASKA

Grade: D

Category I: Health Promotion & Measurement

Grade: D

- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
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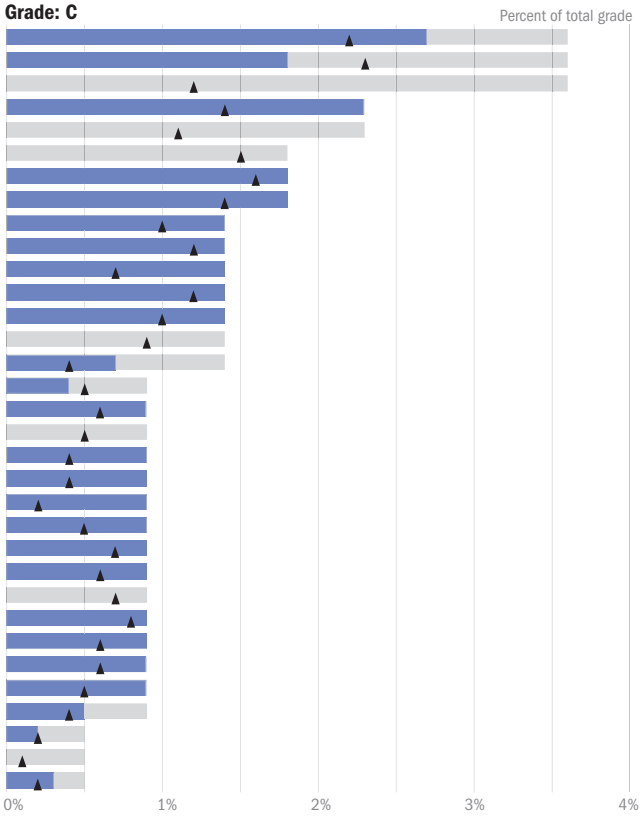
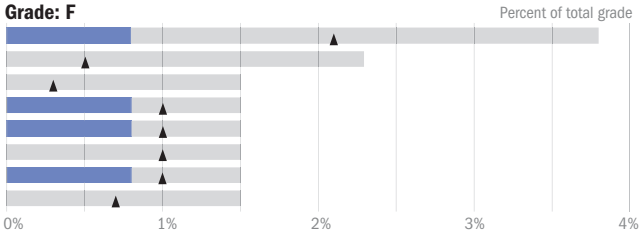


Category III: Consumer & Family Empowerment

Grade: F

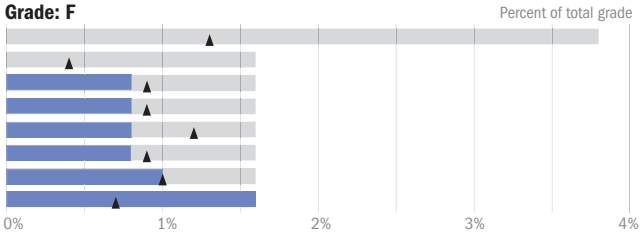
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: F

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Alaska

Alaska faces a number of challenges including dispersed geography, high rates of substance abuse and suicide, and an economy in steep decline. In this difficult climate, the mental health system is in crisis mode. It is a system that cannot afford more service reductions.

In 2006, Alaska received a D grade. Three years later, the grade is the same. The state offers a modest vision for moving forward, but results are difficult to assess. The state's efforts to address co-occurring mental health and substance abuse services exemplify this gap. Using a federal transformation grant, the Department of Behavioral Health has integrated and increased training and services. But from ground level, the reality is still a striking shortage of services, from substance abuse beds and trained dual-disorder professionals to billing limitations.

The Alaska Psychiatric Institute (API) in Anchorage is a strength of the system, although it faces hospital bed pressures and workforce issues. API offers an Internet-accessible dashboard that allows the public to review quarterly reports on important indicators of the facility's services, including patient satisfaction upon discharge, readmission rates, nursing overtime, and restraints and seclusions. The dashboard is a model of transparency and accountability for the nation to emulate.

In contrast, Alaska does not study statewide consumer mortality, a significant oversight in a system of shortages, rural challenges, and high suicide rates.

Alaska's Mental Health Trust Authority, which serves as an innovation generator, funds peer services, but peer specialists are not yet integrated into mental health centers on a paid basis. There is still room for improvement.

Alaska is behind the curve on the implementation of evidence-based practices, with no Assertive Community Treatment or support for family psychoeducation. It does not maintain fidelity to national standards for those few practices it has adopted. Transportation issues are central to access problems.

Criminalization of people with mental illness remains an issue. Five mental health courts exist, but are only beginning to reverse correctional responses to mental health concerns. Ironically, the lack of community-based mental health services results in cost-shifting to the correctional system that is more expensive, as well as inappropriate, for treatment of serious mental illnesses.

Innovations

- Transparent, Internet-accessible dashboard indicators
- Peer services
- Telemedicine efforts to rural areas

Urgent Needs

- Community-based services, including supported housing
- Increase access to services
- Address workforce shortage
- Suicide prevention

Consumer and Family Comments

- *"In Fairbanks, all group homes were closed."*
- *"I see the stress of client overload."*
- *"The providers do not educate the family members."*
- *"There are not enough providers who accept Medicaid."*

Across the state, there is a massive workforce shortage. Even in Fairbanks, there are times when there is no psychiatrist or psychiatric nurse available in the mental health center. The lack of professionals in many communities means there is little real hope for continuity of care and recovery. On the plus side, the state does use telemedicine to reach rural areas. There is also a good workforce development plan, but a plan alone is not enough.

Alaska has a very high suicide rate. The state has used federal funds for youth suicide prevention, but the legislature recently failed to fund a comprehensive five-year suicide prevention plan.

Funding and other resources are major challenges, with the system currently in crisis. For example, Anchorage Community Mental Health Center is overburdened and has to ration its uninsured care. Ketchikan has cut staff and services. Juneau has cut crisis services and beds. Fairbanks dramatically cut supported housing and moved people 300 miles to Anchorage before reopening some units.

Alaska needs leadership and political will to overcome the many problems in its mental health care system. Unless it makes sustained investment in the system a priority, the reality will remain grim for people with real needs.

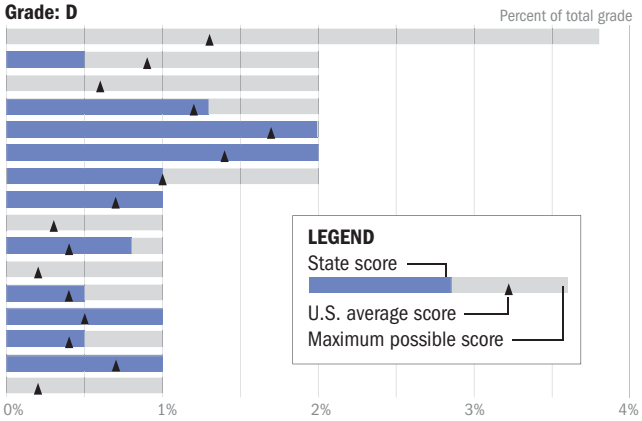
NAMI Score Card: ARIZONA

Grade: C

Category I: Health Promotion & Measurement

Grade: D

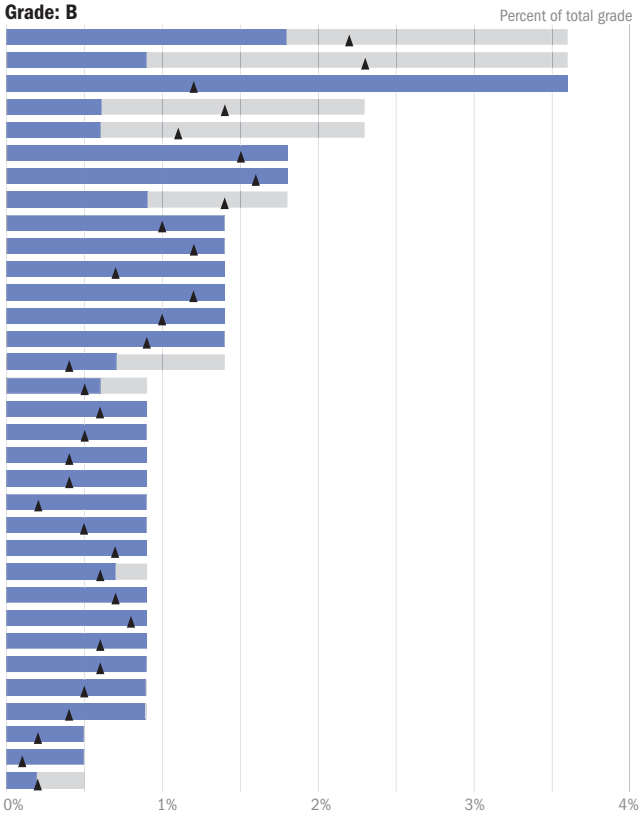
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: B

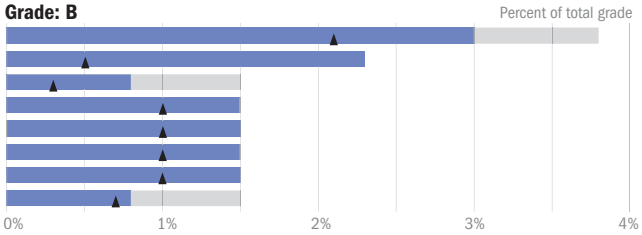
- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: B

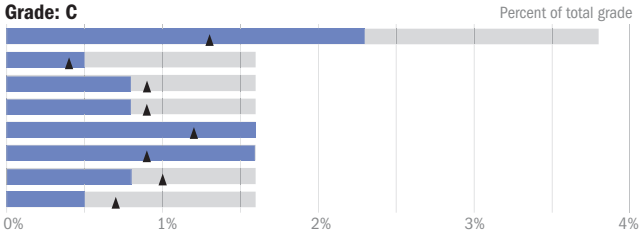
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: C

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Arizona

Innovations

- Cultural competence plan, tools, and online information
- Partnership between mental health and housing agencies
- Screening and treatment of co-occurring disorders in the criminal justice system

Urgent Needs

- Data on numbers of consumers served
- Stronger state oversight to ensure quality of services
- Greater availability of services
- Address workforce shortage, particularly in rural and tribal areas

Consumer and Family Comments

- *"When I first tried to get help after attempting suicide, I was told that I wasn't sick enough to qualify."*
- *"Having case managers with nearly 100 clients does not allow them to do anything but respond to emergencies. Until my family member has an emergency, there is no case management."*
- *"In the town I live in, the population is roughly 100,000. There are very few psychiatrists, and often there is a six to eight week wait to see one as a new patient."*

In 2006, Arizona's mental health care system received a grade of D. Three years later, it has improved to a C. The improvement is commendable, but the test will be whether progress can continue in the face of the current economic downturn.

One cannot give a complete overview of the Arizona mental health system without noting that Maricopa County (Phoenix), the fourth largest county in the nation, has been under court order. In 1989, the state Supreme Court ruled in *Arnold v. Sarn* that individuals with mental illness have a right to appropriate treatment.

The Department of Health Services' Division of Behavioral Health Services (DBHS) oversees the state system. It contracts with regional behavioral health authorities (RBHAs) to develop local networks of providers to deliver services, funding them in whole or in part. The state Medicaid program covers antipsychotic medications. A new partnership between the DBHS and the Department of Housing is working to increase access to permanent supportive housing using federal Housing Trust Fund dollars.

With a federal grant, Arizona is working to improve the screening and treatment of individuals with co-occurring disorders in the criminal justice system. It has also made progress on training peer support specialists and plans to continue this trend. It has developed a comprehensive cultural competence plan, useful cultural competence tools, and accessible online information.

Arizona also has established a strategic plan for stigma reduction, a statewide stigma reduction coordinating committee, and a "train the trainer program" for people with mental illnesses engaged in civic presentations and dialogues about stigma. The stigma reduction plan is good in concept, but its execution has been difficult.

Unfortunately, Arizona still struggles to provide timely, quality services to individuals with mental illness. Transition from ValueOptions to Magellan Health Services as the RBHA for Maricopa County has been very difficult. State health officials have repeatedly fined Magellan for failure to supervise case managers, follow clients, and coordinate care with primary care doctors. Although DBHS indicates that many of its programs are statewide, it was unable to provide the number of people served by these programs. Consumers and family members report much variation between communities in service availability and the degree of fidelity to evidence-based practices. The state also has mental health workforce shortages, particularly in rural and tribal areas.

Arizona faces the dual challenge of rapid population growth and a nearly doubled population of foreign-born individuals.

Arizona is trying to move toward a system that places greater emphasis on recovery, resiliency, and wellness, but state budget cuts could undo its progress. Arizona's citizens deserve a system that gets better than a C. With additional investment, further improvement could be within reach.

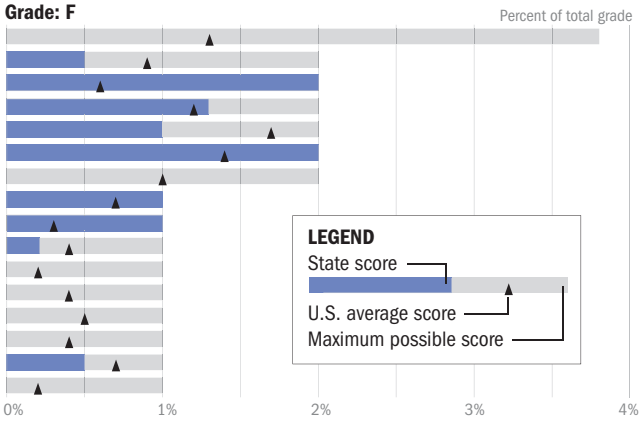
NAMI Score Card: ARKANSAS

Grade: F

Category I: Health Promotion & Measurement

Grade: F

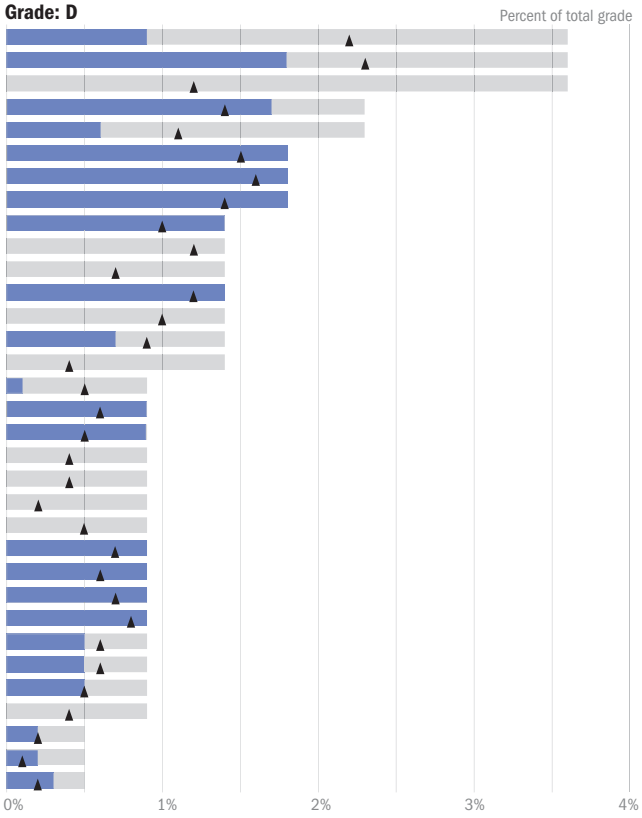
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

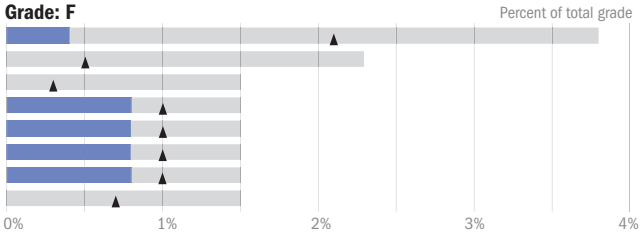
- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: F

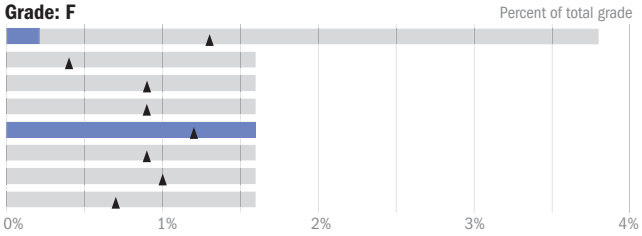
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: F

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Arkansas

In 2006, Arkansas received a D and now drops to an F. To some degree, the drop reflects the state's greater focus on children's services rather than the adult system of care over the last two years, but the lack of investment in evidence-based practices (EBPs) is a crucial failing. The complete absence of police Crisis Intervention Teams (CIT), jail diversion programs, and mental health courts relative to other states is another critical factor in the state's falling behind.

The Arkansas Division of Behavioral Health Services (DBHS) provides mental health services through contracts with 15 community mental health centers. Although the state is one of the poorest in the nation, very conservative budgeting is yielding an expected surplus of roughly $300 million in fiscal year 2009. Nonetheless, a constant lack of funding for adult community mental health over the past few years makes it difficult for the state to address the shortage of mental health services or EBPs. Unfortunately, lack of investment inevitably will lead to costs shifted elsewhere at state and local levels, such as to the criminal justice system.

The state's strengths include its data systems. Community mental health centers throughout the state use a data collection system to report uniform data to DBHS. In 2008, a Congressional briefing highlighted the system, and other states may adopt it. As part of the innovations, all the centers use a standard instrument to screen for substance use disorders, and substance abuse treatment providers must screen for mental illness.

Efforts are underway to improve inpatient care. In 2008, DBHS closed the old state hospital, except forensic services, and replaced it with a new hospital in Little Rock. The state hospital has a peer-run support group. The state has funded renovations at local community hospitals in underserved areas in order to open short-term acute care inpatient beds. DBHS is aware of the need for better community care and for jail diversion programs. Arkansas is also one of a minority of states that is funding mental health services for returning National Guard veterans and their families.

Nonetheless, EBPs—such as Assertive Community Treatment, supported employment, integrated dual diagnosis treatment, and supported housing—are extremely limited. Those programs that do exist often lack fidelity to national models.

The state does not restrict access to psychiatric medications under Medicaid but limits the number of other prescriptions per person to six per month—which may cause hardship for individuals with complex medical problems.

Unfortunately, Arkansas has few of the components necessary for a modern, evidence-based inpatient and outpatient mental health care system. If there is to be change and progress, improved planning, political leadership, and funding will be needed.

With the budget surplus offering the possibility of increased financial commitment, the desire for improvement within the mental health community, and Arkansas First Lady Ginger Beebe's personal interest in mental health issues, circumstances may nonetheless come together to make future improvement possible.

Innovations

- Data collection system
- Mental heath services for veterans
- Cross screening for mental illness and substance abuse

Urgent Needs

- Evidence-based practices
- Crisis services
- CIT and jail diversion
- Services for homeless persons

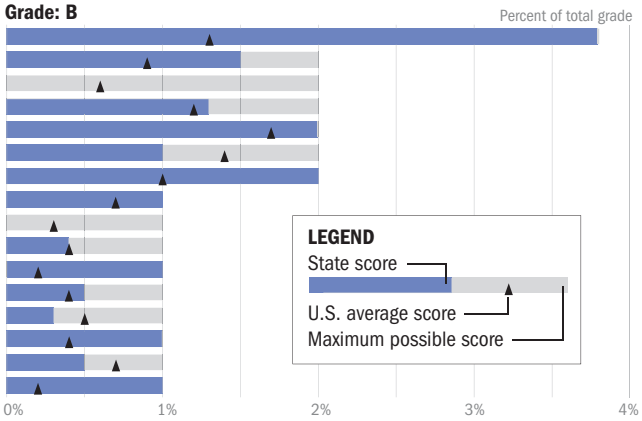
Consumer and Family Comments

- *"Assertive Community Treatment (ACT) is the best thing about mental health services in our state. But we need more funding for this. There are many people who need this service that are not being reached. They have more struggles and often become more ill."*
- *"It has been extremely difficult to find out what services and programs are available for my daughter. Even the mental health professionals are not much help."*
- *"Anyone who wanted real care was forced to seek help in another city, usually an hour and 30 minutes away."*

NAMI Score Card: CALIFORNIA — Grade: C

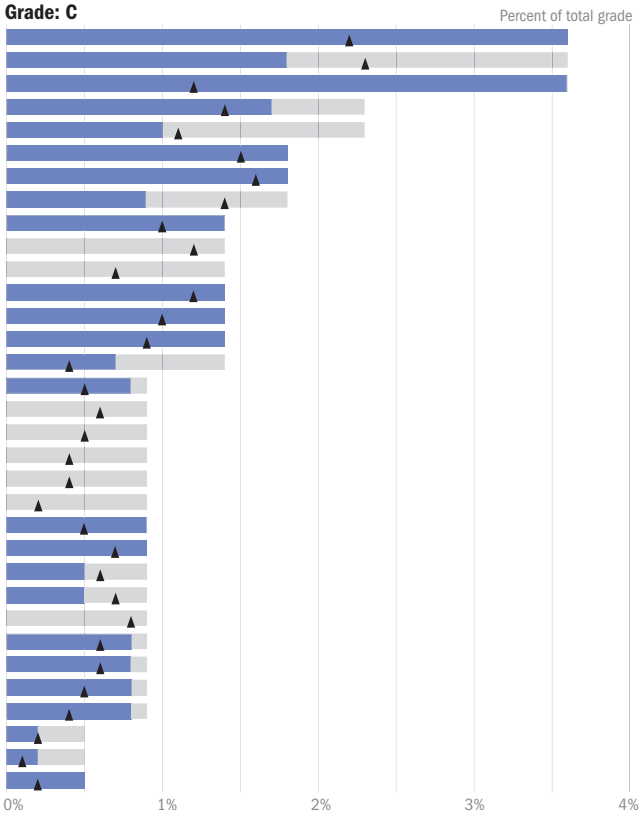
Category I: Health Promotion & Measurement — Grade: B

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



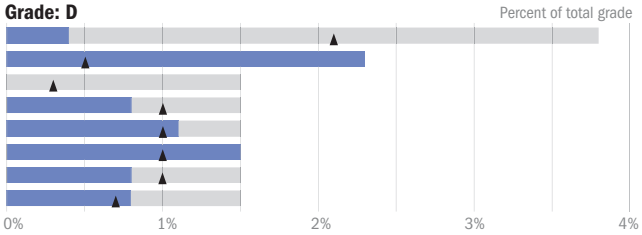
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



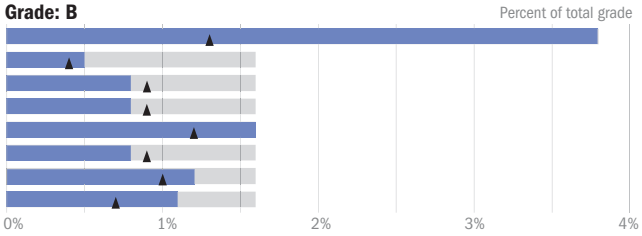
Category III: Consumer & Family Empowerment — Grade: D

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: B

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



California

In 2006, California's mental health care system received a grade of C. Three years later, it remains at that level. It is uncertain whether meaningful progress can occur in years ahead in the face of the state budget crisis.

California is both the most populous and diverse state in the nation. The mental health system has shown an ability to innovate, but it has also failed to meet major challenges.

The California Department of Mental Health (DMH) oversees a decentralized service system involving 58 county mental health agencies and two city agencies. Counties provide services directly or contract with providers and serve as the mental health managed care system for the state's Medicaid program (Medi-Cal). DMH allocates funds to the county-run system to provide stable funding for innovative programs. This structure allows flexibility to tailor programs to meet county-specific conditions, but also results in significant variations in access to, and quality of, services.

Several of California's good initiatives have encountered budget shortfalls and limited success. Proposition 63 (the Mental Health Services Act of 2004, or MHSA) created an innovative mental health services financing mechanism, but it has disappointed many advocates because of unintended consequences. A two-tiered system has resulted, in which new clients enter into newer MHSA programs such as Full-Service Partnerships that provide comprehensive services to people in great need, while longer-term clients receive reduced care based on restrictions in the law that prevent its funds from being used for existing programs. Of the $3 billion MHSA has generated, only about $725 million has reached the counties. There is no continuous funding stream, and distribution is often delayed.

In 2007, Governor Arnold Schwarzenegger eliminated funding for the state's Integrated Services for Homeless Adults with Serious Mental Illness program. However, DMH has been able to use MHSA funds to provide stable and affordable housing through an inter-agency housing program. Going into 2009, California faced a $42 billion budget gap and the prospect of massive cuts. Proposed cuts to Medi-Cal, already in crisis from inadequate reimbursements and a shortage of providers, would further limit access to care for people living with serious mental illnesses.

Notably, California has excelled in plans to develop a culturally competent mental health workforce and an overall system of culturally competent care. In 2008, the state released an exemplary, comprehensive five-year workforce development plan with specific goals for diversity and cultural competence.

California also has made strides in jail diversion with 40 mental health courts and many police Crisis Intervention Team (CIT) programs involving law enforcement. Even so, many people with mental illnesses remain in jails and prisons. Although California passed "Laura's Law" in 2003 to authorize court-ordered outpatient treatment, it is rarely used and has had little impact on "revolving door" issues with homelessness, hospitalizations, and the criminal justice system.

The U.S. Department of Justice continues to monitor inpatient care in California. Despite recent efforts to resolve problems, some abuse and poor conditions still exist in state hospitals. Since 90 percent of state hospital beds are used for forensic patients and sexual predators who have completed prison sentences, space for civil patients is limited.

Sadly, California's mental health care system is hostage to the state's massive budget crisis. For years, the system has seemed poised for progress, but now could easily find its foundation crumbling. Continued stagnation or slippage will be tragic for the lives of individuals and families who confront mental illness every day.

Innovations

- Mental Health Services Act interagency housing program
- Full-Service Partnerships for individuals with great need
- Cultural competency in workforce development

Urgent Needs

- Streamline Mental Health Services Act funding to counties
- Improve hospital care
- Reduce incarceration of people with mental illnesses

Consumer and Family Comments

- *"The county mental health service providers do an excellent [job] of meeting the needs of most clients given the barriers of too little funding, too little affordable housing, and a large dually diagnosed population requiring additional services."*
- *"What saved my life is no longer available in my county because of budgetary cutbacks."*
- *"Mental health clients are treated like second class citizens. Any time there are budget cuts, the funding is cut. They are the most needy and least represented class of people. To send them to jails and prison is outrageous."*
- *"Our Proposition 63 Mental Health Services Act monies have been targeted towards . . . new programs. Meanwhile, old time clients are living in below standard board and cares with very little access to programs and services."*
- *"De los pocos profesionales disponibles, algunos tienen conciencia y entienden o pertenecen a la cultura latina/hispana y hablan el idioma."**

* Translation: "*Of the few available professionals, some are conscious of and understand or belong to the Latino/Hispanic culture and speak the language.*"

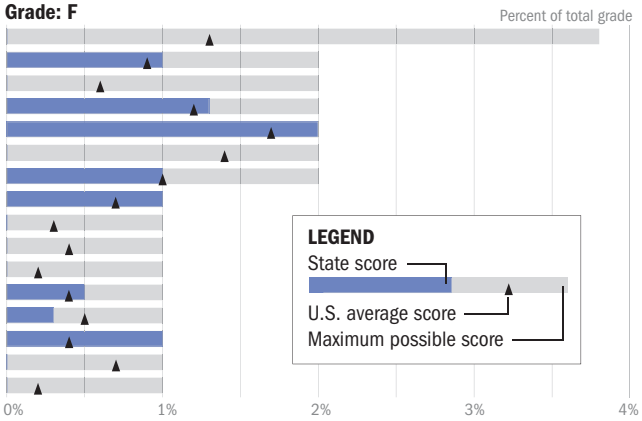
NAMI Score Card: COLORADO

Grade: C

Category I: Health Promotion & Measurement

Grade: F

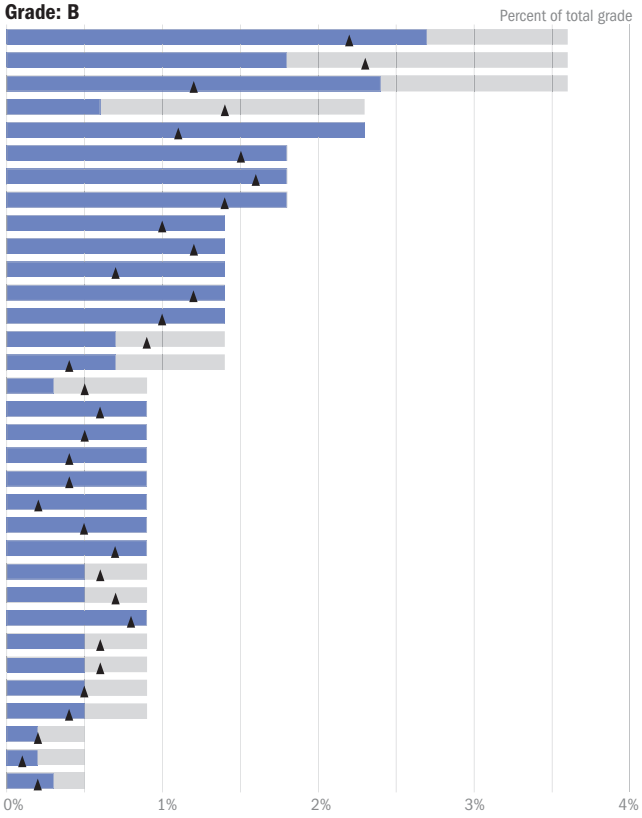
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: B

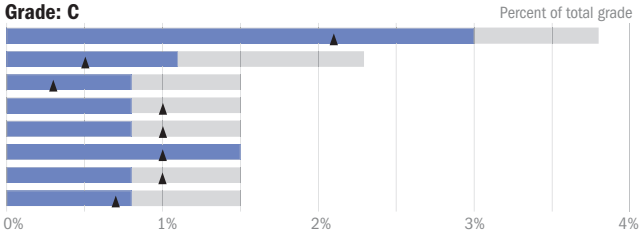
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: C

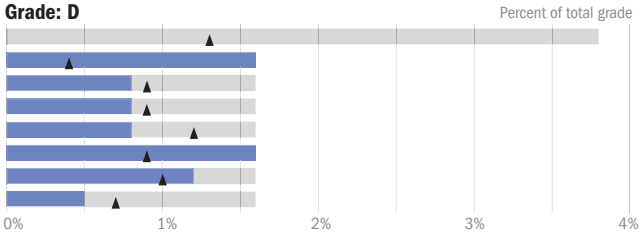
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs

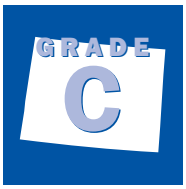


Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita





Colorado

Innovations

- "Data dashboard" initiative
- Connection to benefits legislation
- Expansion of parity legislation

Urgent Needs

- Crisis services
- Alternatives to incarceration
- Interagency health information systems
- Non-Medicaid mental health services

Consumer and Family Comments

- *"The people working at the county mental health center really care and do their best for each patient even when they are severely overloaded."*
- *"There is little care available if you have no insurance or Medicaid. Also, most people do not have a clue how to navigate the system . . . "*
- *"The inclusion of peer support specialists is the best thing that has ever happened in public mental health."*

In 2006, Colorado received a U grade for "unresponsive" because the Division of Mental Health (DMH) did not assign staff to complete the survey. Three years later, transparency has returned, and the state's mental health care system receives a C grade. It is a baseline to measure future progress.

Colorado has established an ambitious vision for integrated behavioral health services, as outlined in the 2008 report of the legislatively created Behavioral Health Task Force (the "1050 Task Force"). First Lady Jeannie Ritter is also a champion of mental health issues.

DMH provides mental health services through contracts with 17 community mental heath centers and a handful of specialty clinics. The Office of Behavioral Health and Housing oversees the state's two mental health institutes and its supportive housing and homeless programs. The Department of Health Care Policy and Financing (DHCPF) administers Medicaid-funded mental health services.

A key theme of the "1050 Task Force" recommendations is integration and coordination of services to reflect that mental illness, substance use, and other disorders are often co-occurring. The shift in emphasis is significant—particularly since it was not until 2006 that the state's Medicaid program provided an outpatient substance use treatment benefit. The state also expanded its parity law in 2007 to include substance use disorders and additional mental health disorders, including post-traumatic stress disorder (PTSD).

Colorado still lacks a process to permit enrollment of eligible persons with severe mental illness in the state's Medicaid program before a formal federal disability determination has been made. In 2008, however, the legislature passed a law to suspend, rather than terminate, Medicaid benefits for people sentenced to jail or prison—along with other measures to connect individuals with mental illness in the criminal justice system with public benefits.

Denver's Metro Crisis Triage Project also represents an effort to connect people with the correct crisis stabilization services rather than have them fall into the criminal justice system. The project holds promise for the metropolitan area, but underscores the state's lack of adequate crisis stabilization services, particularly in rural areas. Needs also extend beyond crisis services. Many communities struggle to provide evidence-based practices (EBPs) and supportive housing programs. For persons without Medicaid, access to mental health services is extremely limited. This leads to increased stress on other systems, such as jails and emergency rooms. While Colorado has successfully implemented police Crisis Intervention Team (CIT) training, it has only two operational mental health courts.

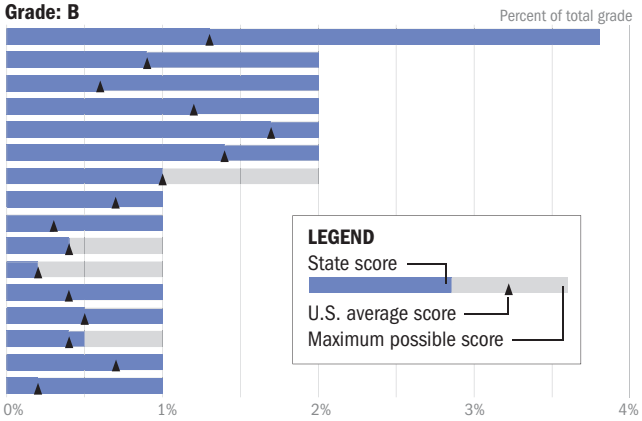
In addition, the state lacks uniform data collection for programs and monitoring of fidelity to EBPs. Fortunately, the Colorado Behavioral Healthcare Council has piloted a "data dashboard," and the state is beginning to assess program fidelity.

Colorado has a vision, but the state will need to invest the funds necessary to make "1050 Task Force" recommendations a reality.

NAMI Score Card: CONNECTICUT — Grade: B

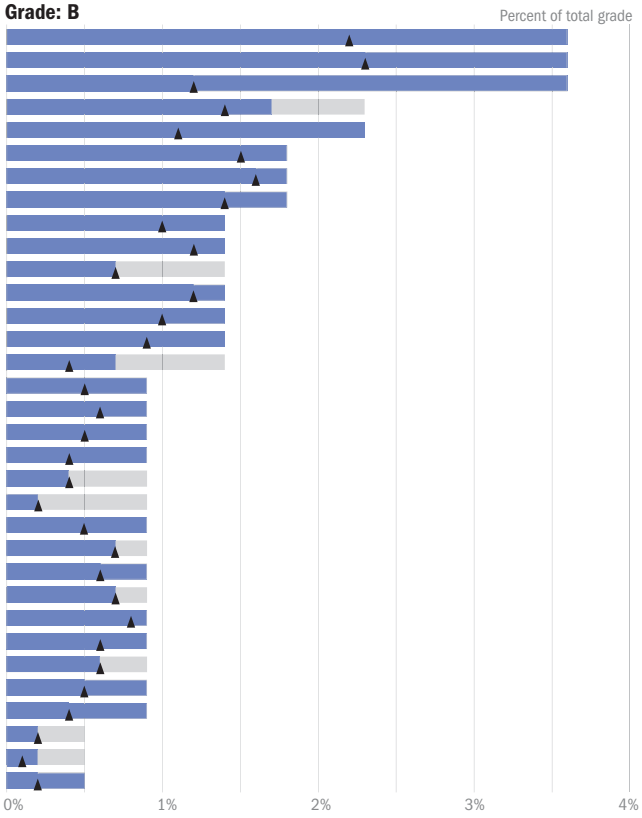
Category I: Health Promotion & Measurement — Grade: B

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



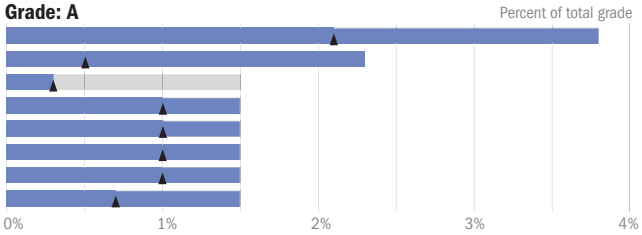
Category II: Financing & Core Treatment/Recovery Services — Grade: B

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



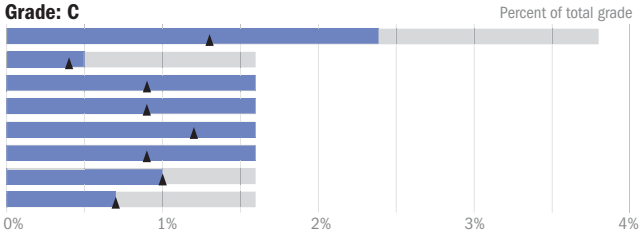
Category III: Consumer & Family Empowerment — Grade: A

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: C

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Connecticut

Connecticut is a state of paradoxes. It strives to provide an excellent mental health care system and boasts many good conceptual ideas and interagency collaboration with the criminal justice system. However, the state's Department of Mental Health and Addiction Services (DMHAS) uses the word "gridlock" to describe its own system capacity failures. Mental health gridlock leaves people stuck in places they do not need to be, which is expensive and disruptive.

In 2006, the state received a grade of B. Three years later, its grade has stayed the same.

DMHAS is attempting to address many issues, but the state's budget shortfalls parallel the collapse of Wall Street. The state's challenge is to improve during a recession what it could not achieve in better times. Overuse of nursing homes and correctional settings and a U.S. Department of Justice (DOJ) report in 2007 documenting problems at Connecticut Valley Hospital (CVH) highlight the system's capacity failures. An Olmstead lawsuit is pending over the nursing home issue because of the failure to provide the least restrictive, appropriate treatment environments in communities for people with mental illnesses.

DMHAS is ahead of the curve in framing the system's mission based on recovery and co-occurring disorder treatment strategies. Historically, the state has been successful at obtaining federal grants to improve the system. Yale University is an academic partner that informs DMHAS vision and programming. Evidence-based practices are a priority for the state.

DMHAS has made great strides in collaborating with the state's law enforcement and correctional agencies. Court support services, supervised diversionary programs, and probation officer training are concrete examples of this important collaboration.

DMHAS has also recently developed a Military Support Program, a creative and comprehensive approach to aid military personnel and their families.

Innovations

- Military Support Program
- Collaboration with Department of Corrections
- Emerging electronic records capacity

Urgent Needs

- Increase community-based services
- Housing as an alternative to more restrictive placements
- End nursing home warehousing

Consumer and Family Comments

- *"Good services are available but not nearly enough, and many are languishing in prison or on the streets."*
- *"Trying to find a psychiatrist after being released from a hospital was nearly impossible and remains a crisis."*
- *"My family member was dumped in a nursing home where, in spite of my efforts, he eventually died."*

CVH is also moving forward. In anticipation of the harsh DOJ report in 2007, key CVH staff were fired and replaced. CVH is piloting a promising electronic information Recovery Management System. Although CVH had four suicides in four years, improvements in staffing, training, and monitoring appear likely to reduce this risk going forward. Connecticut also plans to reduce the overuse of nursing homes for people with serious mental illnesses. During 2006-2007, more than $7 million was lost in federal payments to state nursing homes because too many people with serious mental illnesses were being inappropriately warehoused there.

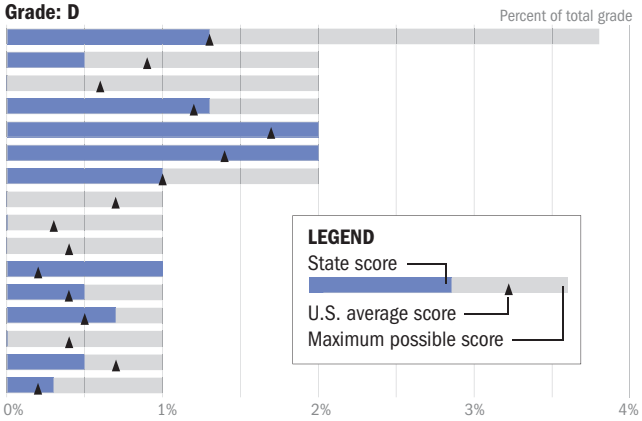
Connecticut's paradoxes do not inspire confidence among consumers and family members. The fact that the state receives a B reflects its sophisticated vision and willingness to address problems. However, for a person with schizophrenia stuck in a nursing home, or a family who loses a loved one to suicide inside a state facility, the system is failing.

Connecticut's citizens deserve far better.

NAMI Score Card: DISTRICT OF COLUMBIA (DC) Grade: C

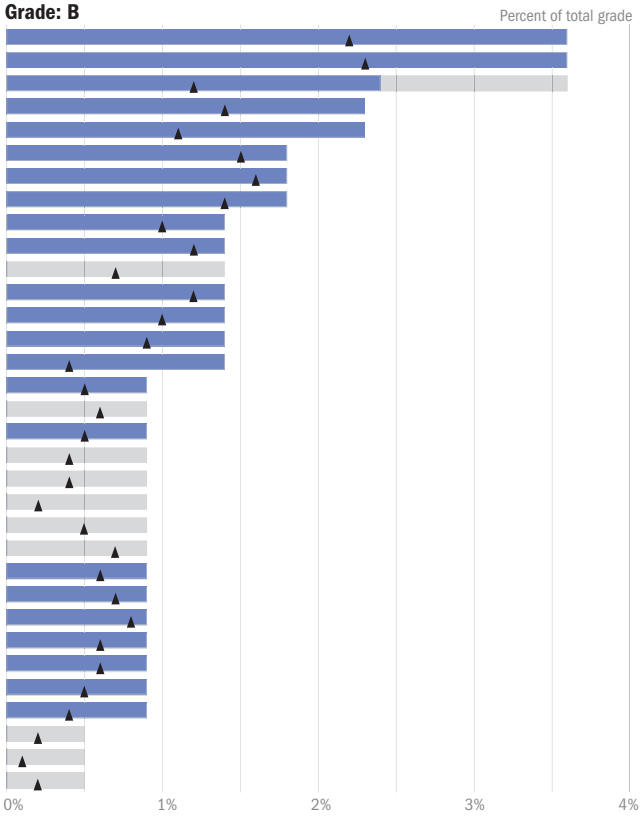
Category I: Health Promotion & Measurement — Grade: D

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



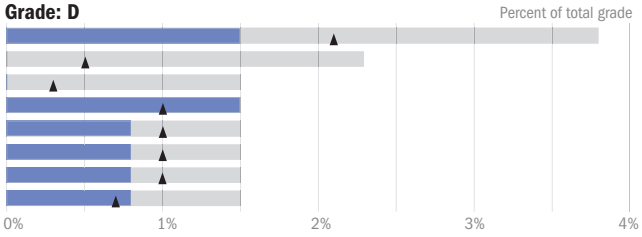
Category II: Financing & Core Treatment/Recovery Services — Grade: B

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



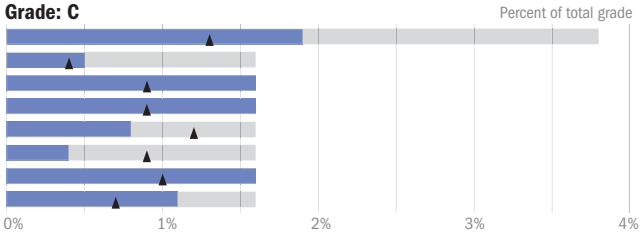
Category III: Consumer & Family Empowerment — Grade: D

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: C

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



District of Columbia (DC)

Innovations

- 300 new units of supportive housing
- Drop-in center with peer specialists

Urgent Needs

- Expand ACT programs
- Increase stable and affordable housing
- Improve and increase St. Elizabeth's staff recruitment
- Adopt CIT

Consumer and Family Comments

- *"Having an experienced professional provider is a must . . . That person must demonstrate compassion, respect, and a strong desire to help improve the lives of those he/she serves."*
- *"Not enough centers in the poorer parts of Washington, D.C. (SE section of the city)."*
- *"It's like an assembly line. Go to hospital, be discharged after one night with just bus fare and directions to the place to get meds, and that's it."*
- *"What's on paper does not translate to reality. The consumer remains a non-key player too often."*
- *"Everyone should be screened for mental illness when they are picked up by the police or EMS for any reason."*

In 2006, the mental health care system in the nation's capital received a grade of C. Three years later, its grade has not moved. It is not yet on firm ground, lacking both stable leadership and independence.

Development of the system has taken a tortuous path over the past 35 years. The U.S. District Court has been inextricably tied to its fate. In 1974, *Dixon et al. v. Williams* properly upheld the right of consumers to community-based services as an alternative to hospitalization. In 1987, the District acquired St. Elizabeth's Hospital from the federal government, putting it also under court oversight. In 1997, the District's failure to meet obligations of a consent order and implementation plan resulted in court-ordered receivership.

In 2000, transitional receivership was established. A year later, a final court-ordered plan was adopted, and the Department of Mental Health (DMH) was established as a cabinet-level agency in District government. Receivership ended in 2002 with appointment of a court monitor and specification of 19 performance measures, or "exit criteria." The District is still working to meet them. Following a U.S. Department of Justice review of inpatient care at St. Elizabeth's in 2005, the District signed a settlement agreement in 2007 with yet another timeframe for improving care.

DMH is making progress in developing a culturally competent system, a critical advance given the District's diverse population. DMH also has improved peer-run services by opening a drop-in center that includes peer specialists.

The District employs Mobile Crisis Teams as part of its emergency services. Additionally, DMH has a growing partnership with law enforcement. The Metropolitan Police Department is providing 16 hours of training for officers to better address individuals in psychiatric crisis, but has not moved toward adoption of formal police Crisis Intervention Teams (CIT), despite the recommendation of the Police Review Board.

DMH and the Department of Housing and Community Development have created 300 supportive housing units for people with serious mental illnesses. However, there is still a daunting, unmet demand for stable, affordable housing.

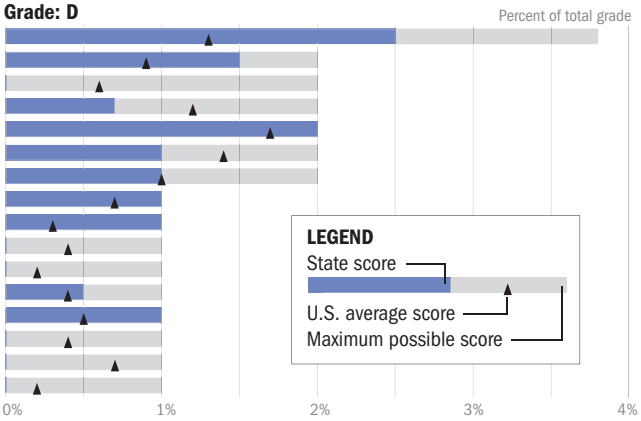
Beginning in the fall of 2009, the District is planning to transfer provision of mental health services from the D.C. Community Services Agency (DCCSA) to private agencies. DMH believes privatization will be more cost-effective, increasing the ability to serve more people with the same quality of care. This remains to be seen. One concern is the great need to increase capacity for Assertive Community Treatment (ACT) through certified providers. Another is whether the private sector can be relied upon to provide a full package of services compared to DCCSA.

The basic challenge for the District is to get out from under court oversight and move forthrightly on its own to build an effective mental health care system. In moving toward that goal, a C grade represents more stasis than progress. There is still much work to be done.

NAMI Score Card: DELAWARE — Grade: D

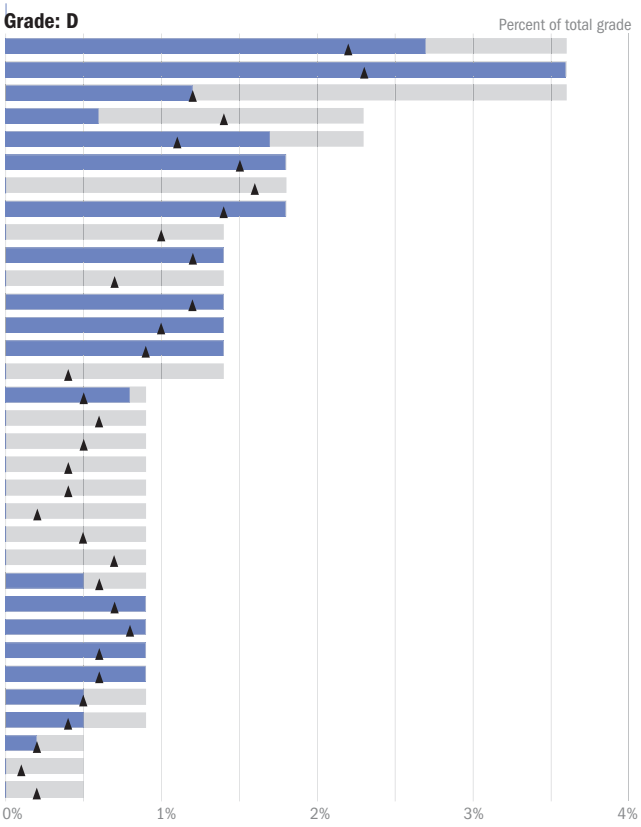
Category I: Health Promotion & Measurement — Grade: D

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



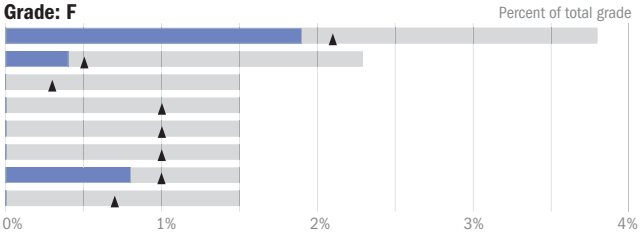
Category II: Financing & Core Treatment/Recovery Services — Grade: D

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



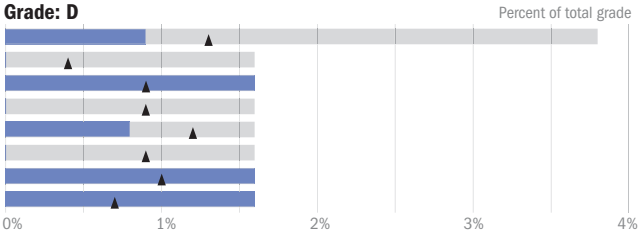
Category III: Consumer & Family Empowerment — Grade: F

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Delaware

In 2006, Delaware's mental health care system received a grade of C. Three years later the grade has dropped to a D, in part because of the lack of consumer-run programs and limited efforts to reduce the criminalization of people with mental illness. Delaware also has much work to do to strengthen community programs and to improve care at the state hospital.

The Delaware Division of Substance Abuse and Mental Health (DSAMH), within the Department of Health and Social Services, administers the state hospital, the Delaware Psychiatric Center (DPC), and four mental health centers that operate six sites. In addition, DSAMH contracts with private agencies for community mental health services.

For the last several years, public attention has focused on deplorable conditions and serious abuses at DPC. Three investigations of DPC during 2007-2008 resulted in several recommendations for improvement. The state has made significant progress in addressing the identified deficiencies. As the number of inpatient beds at DPC decreases, however, finding housing in group homes and supportive apartments is a challenge. Delaware is struggling to provide a full continuum of care that includes high-quality inpatient and community mental health services.

Some strong programs exist, and there are committed service providers in the system. Community programs provide integrated treatment statewide for people with co-occurring mental illness and substance abuse. Community mental health centers have treatment teams that follow Assertive Community Treatment (ACT) principles. A Mobile Crisis Intervention Unit serves the entire state. DSAMH also is encouraging collaboration between mental health and primary care providers.

Delaware has two mental health courts, which is a positive development; but, it lacks police Crisis Intervention Teams (CIT) and jail or prison reentry programs. Although the state no longer generally limits the number of prescriptions per person per month, it does restrict access to four specific psychiatric medications.

Innovations

- New state leadership
- Mobile crisis intervention teams
- Integrated dual diagnosis treatment

Urgent Needs

- Implement state hospital investigation recommendations
- Supportive housing
- Consumer-run programs
- Jail and prison reentry programs and CIT

Consumer and Family Comments

- *"I was provided with a therapist that I can see as often as I feel the need for, as well as an emergency number for after hours, staffed with people, not a machine."*
- *"Limited resources . . . poor communication about what is available . . ."*
- *"There is nothing positive about public mental health services in Delaware. The state does not provide enough access to treatment. Those living in the lower parts of Delaware do not have access to treatment at all."*
- *"More affordable, safe housing . . ."*

Funding for community-based programs has been stagnant over the past three years, while the cost of service delivery has increased, causing financial strain. Future funding for both DSAMH and community-based providers also is uncertain. Heading into 2009, Delaware expects to cut the state budget, including mental health care, by approximately 20 percent. The financial crisis threatens hopes to expand evidence-based practices and make other necessary reforms in the mental health care system.

Delaware has new leadership in 2009, which could play a critical role in turning the mental health care system around. Governor Jack Markell, Lt. Governor Matt Denn, and a new Secretary of the Department of Health and Social Services, Rita Langraf, all have proven interest in best practices and reform. However, only sustained political commitment and financial investment will produce the kind of progress that is needed.

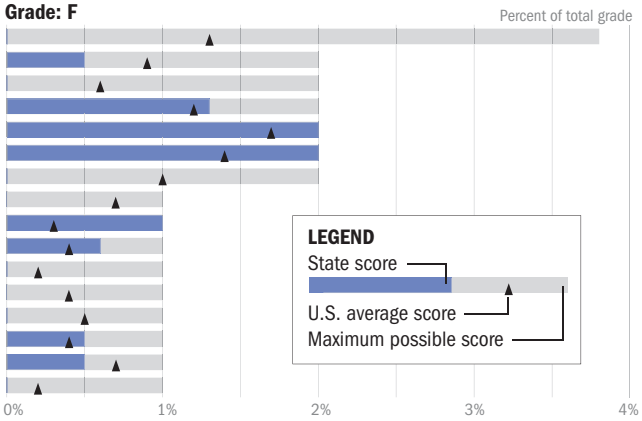
NAMI Score Card: FLORIDA

Grade: D

Category I: Health Promotion & Measurement

Grade: F

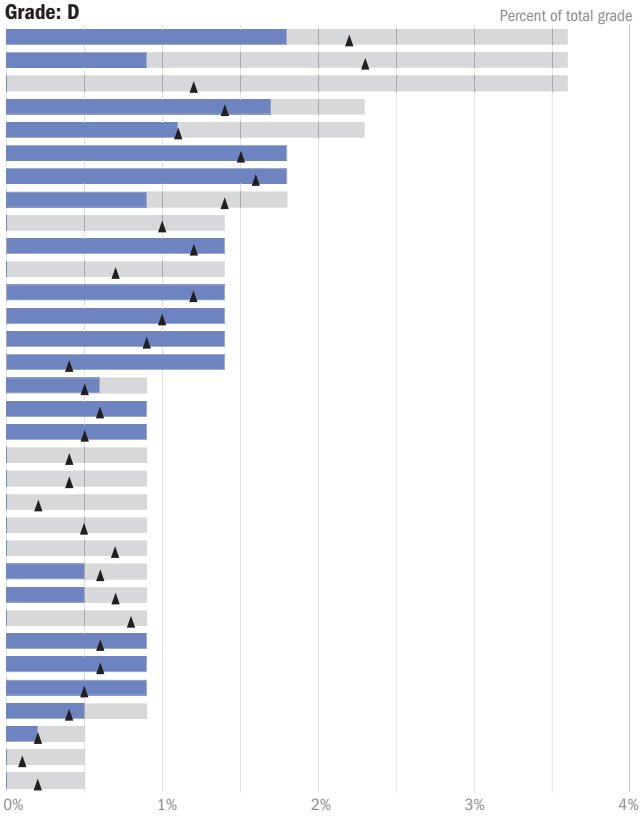
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

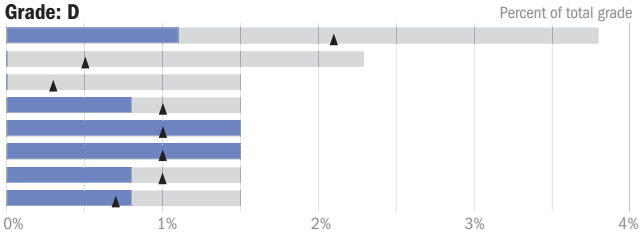
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

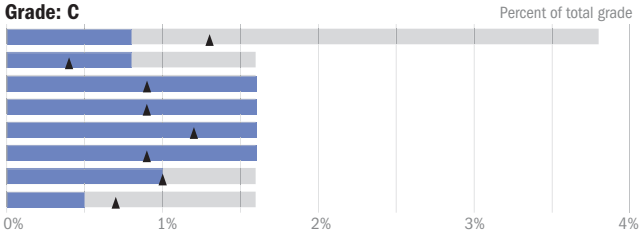
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: C

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Florida

Innovations

- Expansion of CIT and mental health courts
- Peer specialist training and certification program
- Substance abuse and mental health treatment integration

Urgent Needs

- Cultural competence and workforce development plans
- More inpatient psychiatric beds
- Services for underserved populations

Consumer and Family Comments

- *"The [ACT] team has been like a miracle . . . I can't say enough about these wonderful, dedicated people."*
- *"I am trying to make sure my son does not end up homeless, toothless, jobless, and on the streets."*
- *"If my mother had not fought with them on my behalf, I most likely would have committed suicide."*

In 2006, Florida's mental health care system received a grade of C. Three years later, as the need for public mental health services is growing, the state's grade has slipped to a D.

Florida has one of the biggest uninsured populations in the nation, 3.7 million, and Medicaid rolls are swelling with residents hit hard by the nation's economic crisis. At the same time, the state's budget shortfall in 2008 was over $3.4 billion. The Department of Children and Families (DCF), the agency that provides public mental health care, has been consistently under-funded.

Fourteen offices around the state contract with providers to deliver community mental health services, but typically people must be in crisis to secure services. Meanwhile, a high proportion of the state's scarce inpatient psychiatric beds are used to restore competency for people facing criminal charges. Many people who receive no or little mental health services enter the criminal justice system when they experience a crisis.

"Florida Partners in Crisis," a non-profit collaboration between public officials in the criminal justice system and mental health advocates, has taken bold steps to respond to the crisis in Florida's jails and prisons. It has advocated for the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant program, which provides state matching grants to counties for police Crisis Intervention Teams (CIT), mental health courts, and other programs to reduce the criminalization of people with mental illnesses. In addition, the state's Supreme Court justices have taken the lead drafting a plan for targeting intensive mental health services to people who are at the greatest risk of criminal justice system involvement.

Florida has made some progress in including consumers and families in planning and providing services. The state is developing a peer specialist training and certification program. Additionally, Florida has made mental health and substance abuse treatment integration a top priority by instituting a "no wrong door" policy and better integrating care. And, Florida has approximately 30 Assertive Community Treatment (ACT) teams, of varying quality, that strive for fidelity to national standards.

Despite these promising developments, Floridians living with mental illness face uphill battles to get appropriate services. State plans to cover uninsured residents exclude mental health and substance abuse treatment. And, a mental health insurance parity law remains stalled in the legislature. The state has no plans to address cultural competence or its shortage of mental health professionals.

While Florida hoped that Medicaid reform pilot programs in Duval and Broward Counties would increase flexibility and improve outcomes for recipients, a Georgetown University report found that, instead, services have been put at risk. Many managed care plans participating in the pilot programs provide inadequate crisis services, too few providers, and no medication coverage during emergencies.

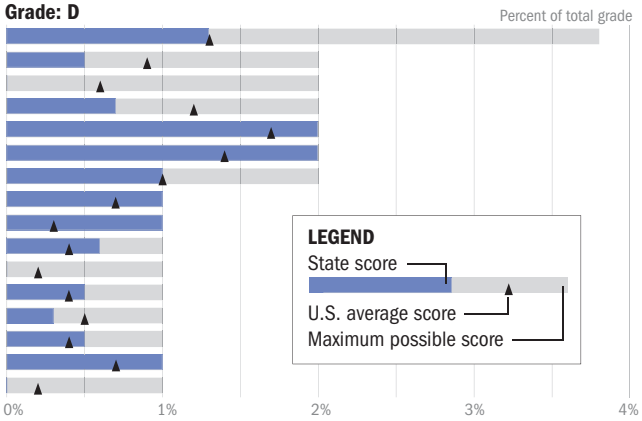
Florida faces tough choices in the coming years. Although the state Supreme Court and the criminal justice community are standing up for people with serious mental illness, DCF and the Agency for Health Care Administration are not. Instead of adding more prisons and jails, comprehensive mental health services are urgently needed.

Meeting this medical need will require leadership, political will, and sustained investment. It remains to be seen whether the state is up to the task.

NAMI Score Card: GEORGIA — Grade: D

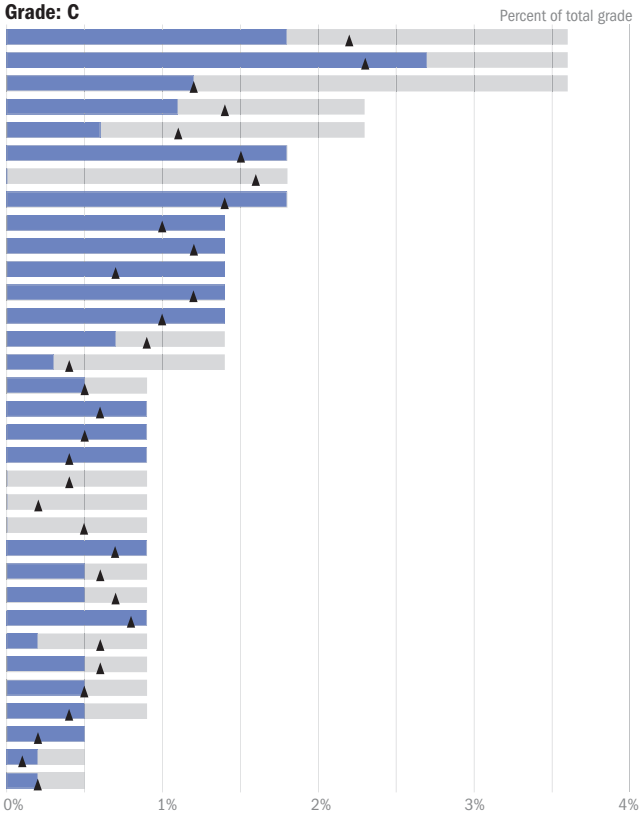
Category I: Health Promotion & Measurement — Grade: D

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



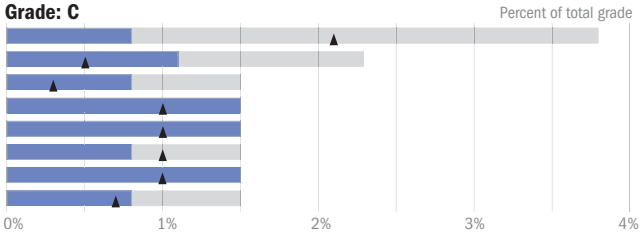
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



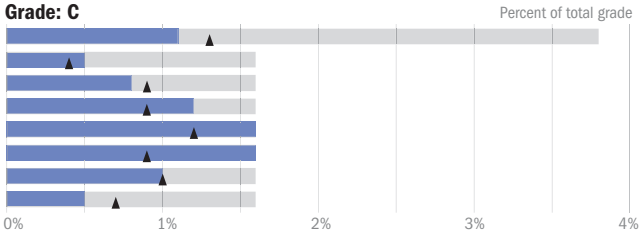
Category III: Consumer & Family Empowerment — Grade: C

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: C

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Georgia

Innovations

- Investigative reporting series leading to federal investigations of hospitals
- Georgia Crisis and Access Line
- Use of Medicaid funds for peer support specialists

Urgent Needs

- Strong leadership by governor and legislature
- Improve patient care and safety in hospitals
- Increase access to community-based services
- Employ evidence-based practices that meet fidelity standards

Consumer and Family Comments

- *"Our local [center] is wonderful—they care so much. But they are only given limited funds, limited personnel, limited tools. Our state does not reimburse them for many recovery based services. I do not know how our local providers remain upbeat when they are so beaten up . . . They are in their jobs because of their passion, certainly not for the money."*
- *"The system where I live works well for you when you are well, but I have my doubts as to how well it will work when I'm sick and can't advocate assertively for myself."*
- *"When things are going well . . . we have the local mental health facility available to us. But during crisis times . . . we have no one to turn to. He either ends up arrested . . . or we go through the horrible agony of having him committed to the hospital . . . As a family, we feel there is no hope for us."*

In 2006, Georgia's mental health system received a D. Three years later, it again receives a D. Even a D, however, cannot fully convey the horrendous scandal that has scarred the state, with consequences that are still unfolding.

On-going deficiencies in both inpatient and community-based services were blown-open in 2007 when an investigative series by the *Atlanta Journal-Constitution* revealed that over a five-year period, approximately 115 people in Georgia's seven state hospitals had died under suspicious circumstances, part of a broad pattern of inadequate care, neglect, and abuse.

The reporting led to investigations by the U.S. Department of Justice and federal Center on Medicare and Medicaid Services that found deficiencies and dangerous conditions in hospital psychiatric care, in part because of Georgia's lack of community services, which has contributed to the strain on hospitals. In January 2009, a legal settlement was reached, in which the state agreed to improve inpatient conditions. It remains to be seen whether this will truly happen.

Oversight of the mental health care system may change as a result of the state hospital scandal and ensuing state reviews. Governor Sonny Perdue's taskforce recommended a major restructuring of the Department of Human Resources that would give a new cabinet-level Department of Behavioral Health Services full responsibility for funding and implementation of mental health and substance abuse services. The proposal awaits legislative approval. While reorganization can be helpful, it will not—by itself—solve deeply-rooted problems or overcome insufficient services.

Despite its significant problems, Georgia has some important strengths. It is one of the leading states supporting police Crisis Intervention Teams (CIT). It has developed the capacity to link people to crisis services statewide by providing 24/7 live telephone response through the Georgia Crisis and Access Line (GCAL). The state was also an early supporter of peer support specialists, which are reimbursable through Medicaid, provided funding is maintained.

In response to the hospital scandals, the state passed legislation authorizing an ombudsman to investigate complaints and monitor safety issues in the mental health care system, although the legislature has not yet funded the office. Georgia also signed a voluntary Olmstead Compliance Agreement in 2008 to aid transition from institutional to community-based care. Both systems are in crisis because of budgetary restrictions, inpatient workforce shortages, and insufficient community resources needed to provide a continuum of care.

State budget cuts have decimated the community mental health care system. In 2008, the legislature invested approximately $11 million in additional funds for community mental health services; however, the executive branch shifted $8 million of the investment to unrelated children's services. Historically, Georgia has lacked proper oversight of community services and does not employ any fidelity measures for evidence-based practices. It has very little information regarding the number of programs or people served in the state, contributing to its deficiency in overall accountability.

Georgia has a diverse and growing population. It needs greater cultural competence and service access in rural areas. Access to psychiatric medications is restricted under the Medicaid program. The state has one of the strictest and most difficult prior authorization policies in the country. Providers and consumers complain about burdensome procedures to obtain appropriate treatment and services needed to maintain stability.

National and state-level economic woes have compounded a history of poor performance to create much uncertainty in Georgia today. Even though there appears to be sincere interest among top leadership in the state to address the myriad of problems in the mental health system, goodwill and departmental reorganization alone will not transform the system. Sustained leadership, political foresight and commitment, and significant investment of resources are greatly needed.

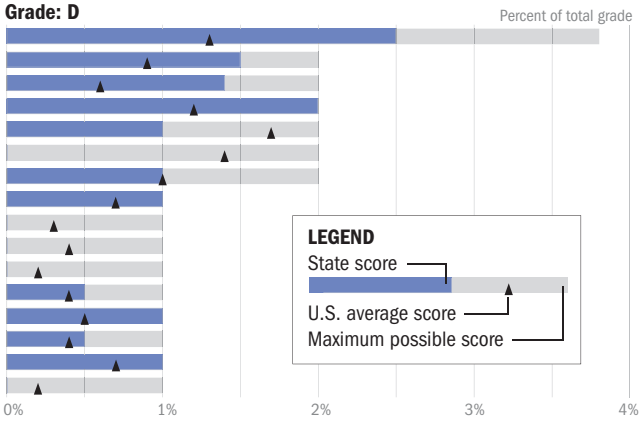
NAMI Score Card: HAWAII

Grade: C

Category I: Health Promotion & Measurement

Grade: D

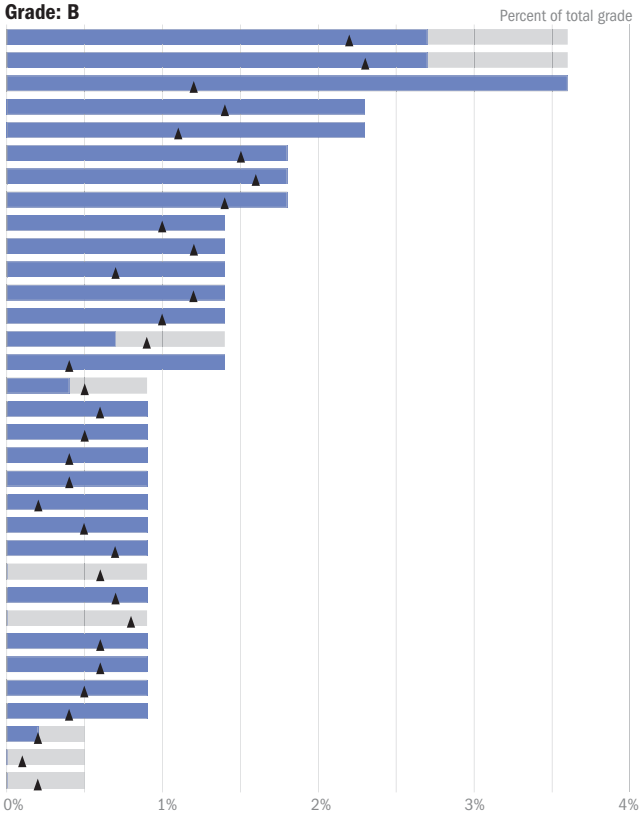
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: B

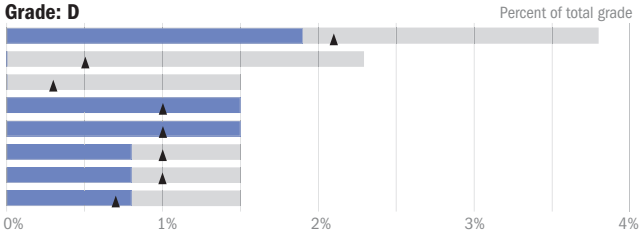
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

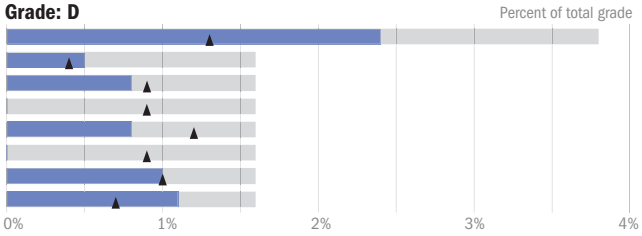
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Hawaii

Hawaii's mental health care system has improved substantially since its dismal days in the 1980s and early 1990s, but the state is now at risk of sliding backward. In 2006, Hawaii received a C grade that has not changed in 2009. However, the environment is changing.

Many factors were responsible for two decades of improvement: U.S. Department of Justice (DOJ) oversight, new money, a governor who spoke openly about the experience of having a family member with a mental illness, steady agency leadership, and the embarrassment that came from falling behind other states—resulting in clarity in defining issues. Unfortunately, all of these variables are under stress or no longer applicable.

In 2004, after many years of DOJ investigation and oversight, federal monitoring of Hawaii State Hospital ended. The state has since used a federal transformation grant to accelerate innovation in its community mental health system.

With a majority minority population, Hawaii has made cultural competence a core value of its service system. Because of the state's high cost of living, efforts to address a glaring need for housing and outreach to the homeless in this state are critical. The decision to end many Assertive Community Treatment (ACT) teams and fold the resources into community mental health is a step backwards.

Hawaii has tried to reduce criminalization of mental illness at every effective point of intervention in the criminal justice system, from police training to mental health courts to conditional releases, which help move people out of jail and into treatment. Nevertheless, virtually all patients at Hawaii State Hospital have some criminal justice involvement.

Problems are compounded by imminent transitions and the state's budget crisis. Dr. Tom Hester, who led much of the state system's renewal as chief of the state Adult Mental Health Division, departed in 2008 after six years of service. There is currently an acting director, but this individual also has other duties. Governor Linda Lingle leaves office in 2010 after two terms of support for mental health care advances.

Due to budget shortfalls, the state has frozen all hiring despite many unfilled positions. Lack of access to public-sector mental health professionals, especially psychiatrists and nurses, has reached crisis proportions in many parts of the islands. The number of psychiatrists has increased in the state overall, but many are in private practice and few practice outside the Honolulu urban corridor. Hospital beds are scarce for persons needing more than very short admissions, and community resources are stretched thin, especially outside of Honolulu.

Hawaii's challenge is to build more momentum to protect the gains made in the past two decades and to keep moving forward as the true test of its progress.

Innovations

- Leadership in cultural competence
- Efforts to decriminalize mental illness
- Mini-grants for peer- and family-led programming

Urgent Needs

- Restore and strengthen ACT programs
- Overcome inpatient bed shortage; expand community alternatives
- Improve workforce distribution to meet public and rural needs

Consumer and Family Comments

- *"The ACT team is being gutted . . . clients have been left shocked, disoriented, and apprehensive."*
- *"The only psychiatric facility in Kauai is horrific."*
- *"I have had services in Connecticut, Florida, California, and Texas—the best and most compassionate care in Hawaii."*

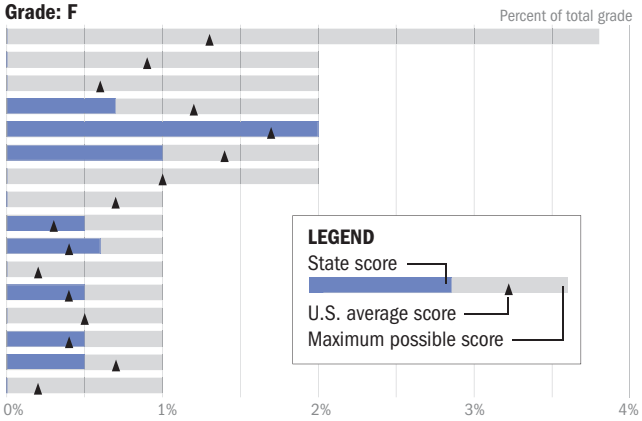
NAMI Score Card: IDAHO

Grade: D

Category I: Health Promotion & Measurement

Grade: F

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
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Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
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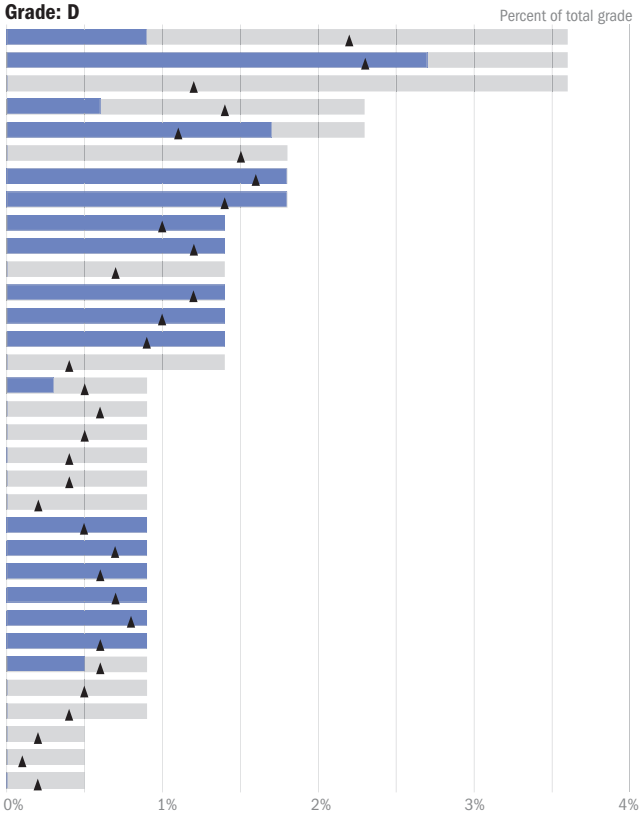
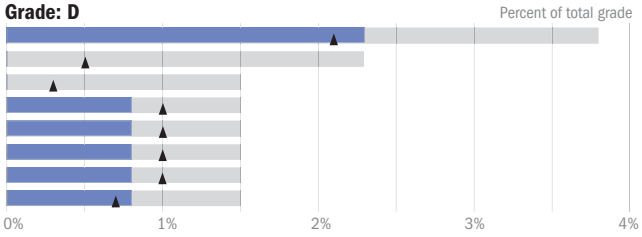
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

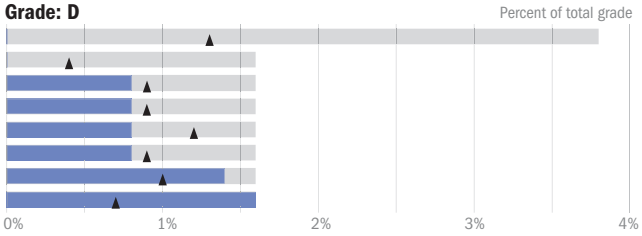
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Idaho

Innovations

- Leadership by criminal justice community
- Community Collaboration Grants
- Planning for peer specialist training and certification program

Urgent Needs

- System planning and accountability
- More inpatient psychiatric beds
- Housing
- Olmstead, cultural competence, and workforce plans

Consumer and Family Comments

- *"I think that the mental health professionals here work very hard, but there are too few doing too much."*
- *"There are practically NO rural services. All the money goes to Boise."*
- *"Intervention in Idaho seems to come only from court-mandated counseling or from someone who has taken an extreme action or been involuntarily committed. Preventive care is very hard to find."*

In 2006, Idaho's mental health care system received an F. Three years later, it receives a D, although the state still has steep mountains to climb. Unfortunately, state budget cuts threaten even this initial step forward. In 2008, a total of $52 million in state mental health dollars and federally-matched Medicaid funding, including mental health care services, was lost.

Since 2006, the Idaho legislature has funded Community Collaboration Grants for selected communities to implement projects such as telemedicine, transitional housing, integration of mental health and primary care, jail diversion, and police Crisis Intervention Teams (CIT). The legislature also funded a pilot project in Idaho Falls to provide treatment and supports to people with serious mental illnesses in jail and post-release from jail.

The state funded a pilot program for co-occurring disorders in a county jail. In 2008, Idaho began a statewide peer specialist training and certification program.

Although the legislature recently broadened the state's civil commitment statute, the success of this law depends on the availability of community-based mental health services and supports.

The Department of Health and Welfare (DHW) recently established a waiver that broadens the availability of mental health services for individuals beyond those with the most disabling "severe and persistent" mental illnesses. If implemented effectively, this policy could support early intervention for mental illness.

Eleven mental health courts have been established, which refer clients directly to Assertive Community Treatment (ACT) programs and psychosocial rehabilitation services.

Despite these developments, the state still has overwhelming needs. In 2008, a Western Interstate Commission for Higher Education (WICHE) report found the state mental health system to be highly fragmented. The quality and kinds of services vary greatly between regions within the state. The state's executive branch does a poor job of addressing this problem. Reforms, when they occur, are piecemeal, and Idaho provides little to no oversight of state and private service providers.

Additionally, there are gaps in planning and financing for mental health services. The WICHE report found excessive cost-shifting within and between the mental health care, substance abuse, and criminal justice systems; between the state and its counties; and between the state hospitals and community services. Moreover, Idaho has no plan to cover the uninsured adult population; no Olmstead plan; no plan to address appalling workforce shortages; no cultural competence plan; and an inadequate data system.

While evidence-based practices (EBPs), especially ACT and supported employment, have become more available to some, consumers and families report that ACT programs "promote" people prematurely out of services and "cherry pick" clients. Many other EBPs are not available at all.

Idahoans who need mental health services often languish in jails and prisons that are ill-equipped to meet their needs.

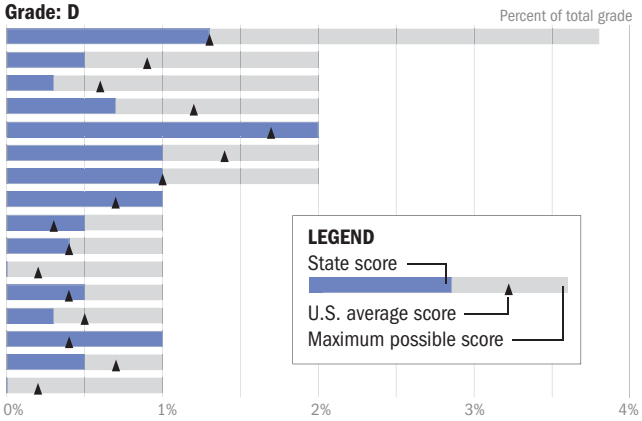
As a large state, with about a third of its population living in rural or frontier areas, Idaho desperately needs effective, accessible mental health services—and transportation to such services.

Idaho deserves credit for its efforts. With access to funding, communities in Idaho have shown that they can develop innovative programs. However, programs that reach only one community are not a substitute for a coordinated, statewide system. If progress is to be made, it is essential that Idaho keep working to create momentum for reform.

NAMI Score Card: ILLINOIS — Grade: D

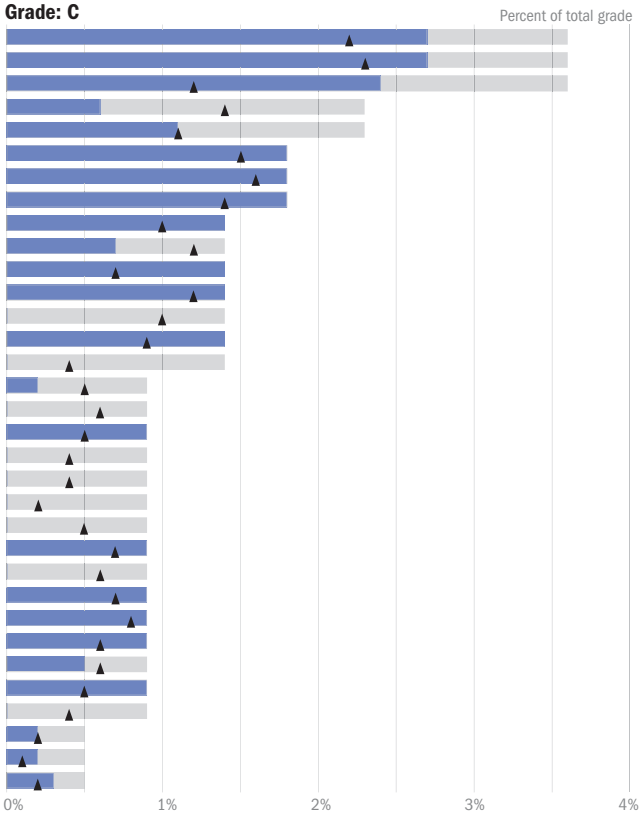
Category I: Health Promotion & Measurement — Grade: D

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



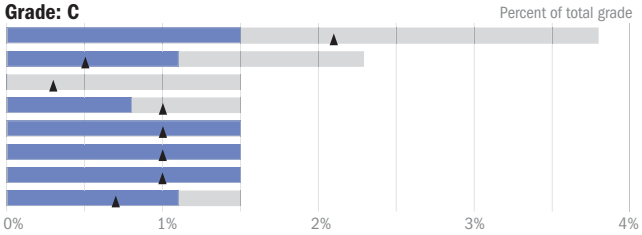
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



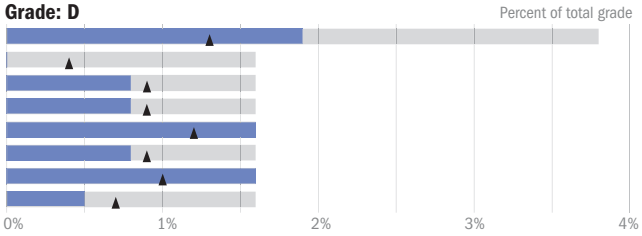
Category III: Consumer & Family Empowerment — Grade: C

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Illinois

Innovations

- CIT and jail diversion programs
- Peer education and peer supports
- Community education and awareness efforts

Urgent Needs

- Invest in services that meet evidence-based fidelity standards
- End warehousing in nursing homes
- Address problems with the new fee-for-services system

Consumer and Family Comments

- *"Illinois doesn't have a mental health system. Instead it has a few pockets of adequate services for some people, but there is little or no coordination among them. Access is murky and hard to find. Mental health services in Illinois are shamefully under-funded, and waiting lists are either long or closed."*
- *"The best thing about the public mental health system in Illinois is the amazing number of dedicated, caring people who work for very little pay."*
- "What services? Only community-based agencies provide competent service and they are under assault by . . . bureaucratic incompetence."

In 2006, Illinois' mental health care system received an F grade. Three years later, it has advanced slightly to a D—which is not much to be proud about.

Illinois leads the nation in numbers of people with serious mental illnesses warehoused in nursing homes. This fact casts a pall over the state's entire mental health care system.

The Illinois Department of Human Services' Division of Mental Health (DMH) is responsible for administering the system and has placed great emphasis on transformation. However, many people still do not have access to services, due to continuing state budget cuts in mental health services and agonizingly slow progress in converting the state's system for paying service providers from a grants-based model to a fee-for-service model.

DMH has emphasized the importance of implementing evidence-based practices in recent years and has made some progress. In 2008, 50 Assertive Community Treatment (ACT) programs were operating in different parts of the state, although concerns have been raised about whether these programs meet federal standards of fidelity.

Illinois also is making good progress on law enforcement training and jail diversion. Police Crisis Intervention Team (CIT) programs have been established in several cities. In Chicago, the CIT program, working in collaboration with community mental health providers, is a national model of excellence. Mental health courts exist in nine counties, and local mental health providers have worked closely with the courts to link individuals to services. DMH supports Data-Link programs in six counties that enable jails and community mental health centers to coordinate jail diversion and reentry services.

Additionally, Illinois is significantly investing in peer education and peer-provided services and supports. DMH has developed certification standards for peer recovery support specialists, with the goal of integrating them into the mental health workforce. The state also has established "Say it Out Loud," a multi-year education and awareness program designed to reduce stigma and discrimination and promote community acceptance for people with mental illnesses.

These areas of progress notwithstanding, Illinois' continuing reliance on for-profit nursing homes and segregated facilities known as "institutions for mental diseases" to house younger consumers is a major problem. A class action lawsuit is pending, alleging that the practice violates the Americans with Disabilities Act, which requires that people receive treatment and services in the least restrictive settings possible.

In addition to likely violating federal law, housing individuals in nursing homes for services makes no monetary sense. No federal Medicaid dollars are available to pay for these expensive placements, so the state bears 100 percent of the costs. Illinois seems to have finally realized this and is beginning to invest in supportive housing. The state also needs to increase community-based, intermediate, and long-term care options.

After many years of planning, DMH recently converted from a grants-based system of financing mental health services to a fee-for-service system. The conversion has not been smooth. Providers report long delays in payment for services that threaten their ability to stay in operation. If programs are forced to close down due to lack of operating capital, vulnerable consumers will suffer.

Other problems exist in Illinois. Access to mental health care is very uneven, particularly in the southern, rural parts of the state. Due to low salaries and low morale, there are severe shortages of qualified mental health workers—a problem that is especially serious in the state psychiatric hospitals.

Although Illinois' grade has improved slightly from an F to a D, the state faces fundamental structural problems in its mental health service system. Further budget cuts will only compound them. If these challenges are not addressed quickly, even the slightest momentum for reform may be lost.

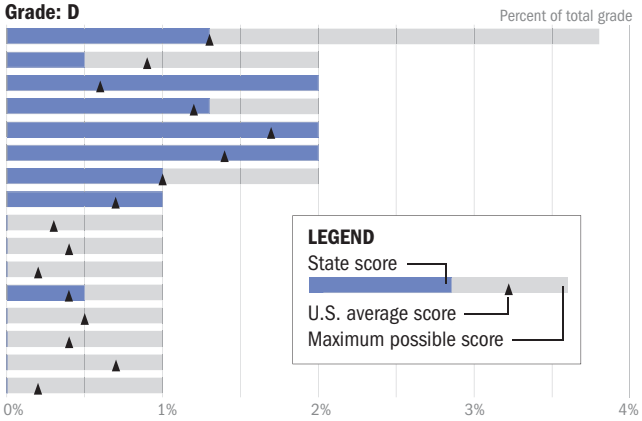
NAMI Score Card: INDIANA

Grade: D

Category I: Health Promotion & Measurement

Grade: D

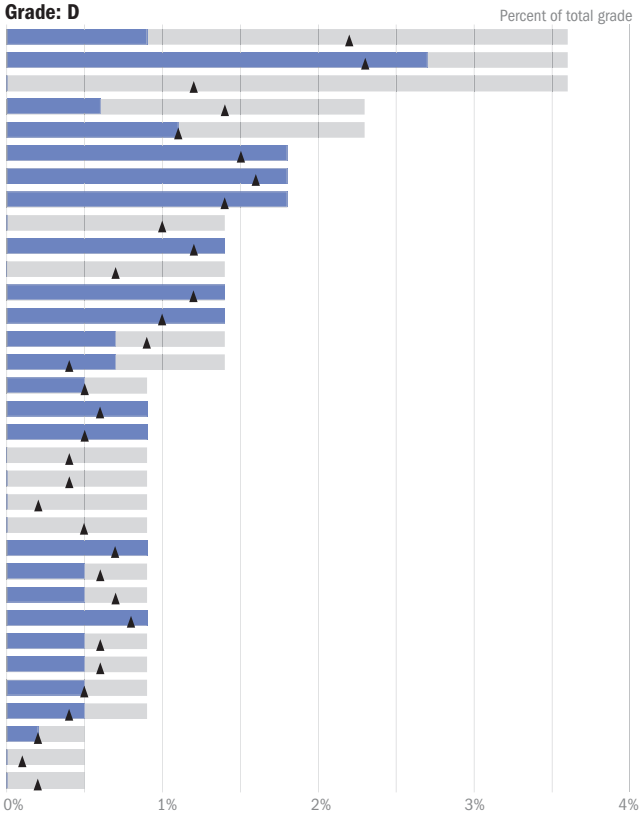
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

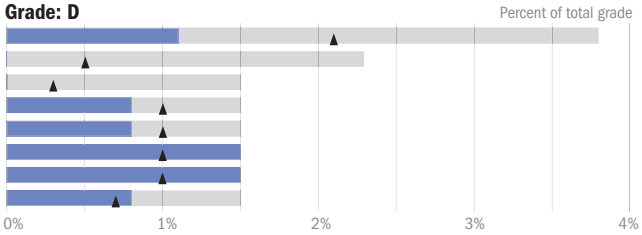
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

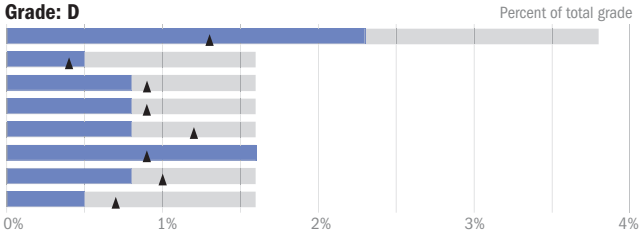
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Indiana

Innovations

- Expanding network of ACT and other evidence-based practices
- Consumer Satisfaction Report Card on community services
- Increase in CIT programs

Urgent Needs

- Fix problems with implementation of Medicaid managed care
- Reduce barriers to accessing psychiatric medications
- Post-booking jail diversion and reentry programs

Consumer and Family Comments

- *"Community Mental Health Centers do not have enough resources. The Medicaid system is TOO complex to use."*
- *"Plenty of information is available! Just no help!"*
- *"They do an excellent job, but they are hampered by a state government that doesn't care."*

Indiana is an enigma. In 2006, the state's mental health system received a D, but vision and desire for transformation seemed to exist. Three years later, Indiana's grade remains a D.

The Division of Mental Health and Addiction (DMHA) of the state's Family and Social Services Administration (FSSA) administers the system. The state's Hoosier Assurance Plan (HAP) contracts with public and private providers for mental health and addiction services for consumers who meet diagnostic and income criteria.

Indiana has a strong network of community mental health centers (CMHCs), and many have implemented evidence-based practices such as Assertive Community Treatment (ACT). Twenty-six CMHCs also operate supported employment programs, although only 15 currently meet federal fidelity standards.

Police Crisis Intervention Team (CIT) programs are taking root in the state. Ten counties or communities have them, and four more are planned. The Indiana Department of Corrections supports a NAMI prison education program in which correctional staff learn how to respond to inmates with mental illnesses.

In 2008, the state implemented the Healthy Indiana Plan (HIP), which provides insurance to non-Medicaid eligible individuals living at or below 200 percent of the federal poverty line. Although HIP includes parity for mental health and substance abuse benefits, covered services are quite limited.

Lack of affordable permanent housing for consumers is problematic. DMHA has developed a good long-range housing plan, with an initial commitment of funds. Proper implementation and funding of the plan are now necessary.

DMHA is commended for publishing a Consumer Satisfaction Report Card for its community mental health programs. It is an exemplary practice all other states should replicate.

Despite these positives, Indiana's system remains seriously deficient. Funding for community services has been flat and may decrease significantly in 2009 given a projected $763 million overall budget shortfall. A recent property tax reform may result in further limits on local services.

FSSA uses a Medicaid managed care system that has failed some consumers—denials of services have put people at risk, and community mental health providers have cash flow problems due to payment delays. Diminished services may be a result of more money being directed towards provider profits.

The psychiatric medication review system used in Indiana's Medicaid program limits access to medication for certain individuals. An advisory committee defines dosage levels, and non-compliant pharmacy claims are denied without inquiry. Appeals procedures are cumbersome and rarely used.

Indiana's population is becoming increasingly diverse, but DMH has done little to increase workforce cultural competence or reduce disparities in care for racial and ethnic minorities.

People with serious mental illnesses continue to be over-represented in Indiana's jails and prisons. There are only four mental health courts to provide post-booking jail diversion. Vital services for people reentering communities following incarceration—such as housing and employment—are lacking.

In 2006, Indiana's FSSA Secretary blamed the state's low grade on poor administration by previous leadership, implying that mental health services would improve under his watch.[1] Sadly, three years later, that has not happened. The mental health system in Indiana continues to have significant problems. If major budget cuts occur, a bad situation is likely to become even worse.

[1] Naseem Sowti, "D is for Dismal Report," *The Star Press,* (March 2, 2006, 1A).

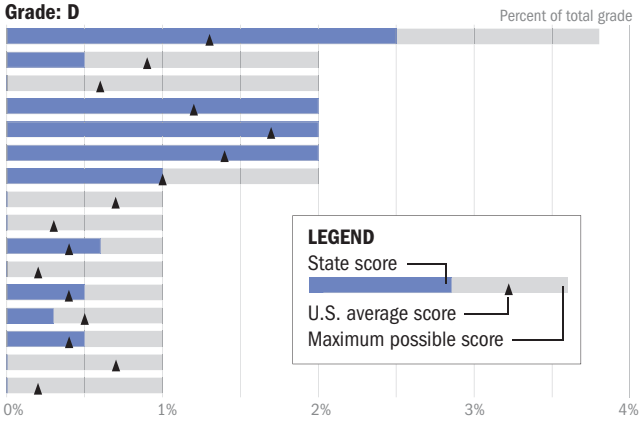
NAMI Score Card: IOWA

Grade: D

Category I: Health Promotion & Measurement

Grade: D

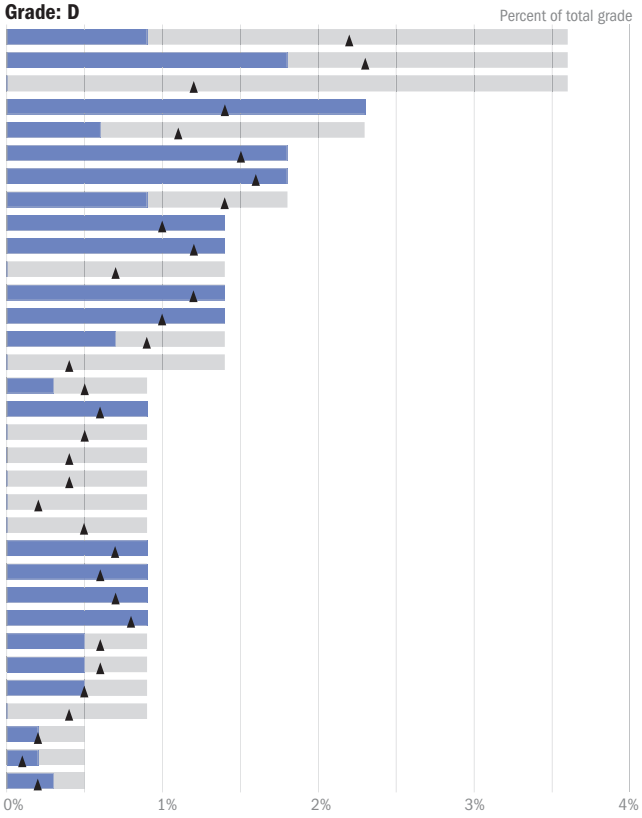
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

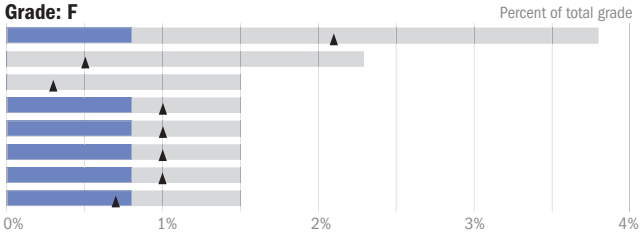
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: F

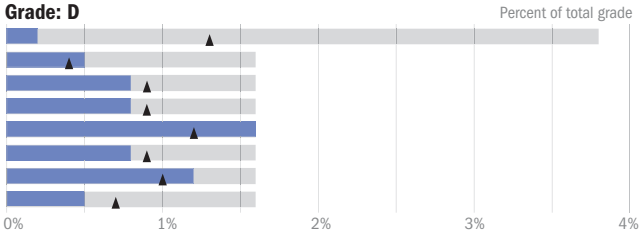
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Iowa

In 2006, Iowa's mental health care system received an F grade. Three years later, it receives a D. Iowa has charted a course for progress, but much work remains to be done.

Iowa's elected officials deserve credit for recognizing the need to improve the state's community mental health system. Governor Chet Culver and Lieutenant Governor Patty Judge have made improving access to services a key goal, and in 2007 the legislature called for stakeholders to make recommendations as part of a Mental Health Systems Improvement (MHSI) initiative. The initiative came on the heels of creating a new Mental Health and Disability Services (MHDS) division.

Iowa was the first state to implement the Medicaid 1915(i) option, which allows a state to provide an array of services, but restricts eligibility to persons who meet specific criteria and whose incomes do not exceed 150 percent of the federal poverty level. Unlike other Medicaid plans, it also allows a state to cap the number of individuals served. Stakeholder groups report a collaborative process and relatively smooth transition.

Medicaid-funded services are provided primarily through Magellan Behavioral Health and are overseen by the Iowa Medicaid Enterprise. Community-based mental health services remain highly decentralized in this rural state, with services largely controlled by 99 county governments. The system is a patchwork quilt, with services varying considerably throughout the state.

One helpful recommendation of the MHSI initiative, presented to the governor and legislature in 2008, is to establish core "safety net" services. These would include intensive case management, medication management, therapy, crisis response services, peer support services, and other evidence-based practices (EBPs).

The MHSI initiative includes a thoughtful workforce development plan to address the state's shortage of mental health professionals. If implemented, it would help the state meet its goals for adopting a range of EBPs. Iowa has struggled to expand EBPs such as Assertive Community Treatment (ACT). However, its handful of ACT teams can be commended for fidelity to the national model and successful reduction of lengths of hospitalization, incarceration in jails, and homelessness.

Innovations

- Mental Health Systems Improvement initiative
- Expansion of co-occurring disorders treatment
- Crisis services pilot projects

Urgent Needs

- Uniform statewide data collection system
- Crisis response and stabilization services
- Address mental health workforce shortage

Consumer and Family Comments

- *"The system is too confusing. It's impossible to know what happens from county to county in Iowa."*
- *"It takes forever to see anyone unless you commit a crime."*
- *"We have no hospitals that deal with mental emergencies. We waited several hours to find an open bed in a facility that could hold our family member. If our community can't house the mental emergencies in the local hospital, what are we to do?? Drive long distances . . ."*
- *"The supported housing program in our community is a wonder and is very important to our family member. It is a model for others across the state."*

A critical challenge is the lack of infrastructure to collect and analyze uniform statewide data. Lack of meaningful data effectively stifled stakeholder ability to make some recommendations as part of the MHSI initiative. Lack of progress on funding formulas has limited efforts to eliminate Iowa's "legal settlement" policy, which traditionally has required individuals who receive services to prove county residence for at least one year before they can receive help. The policy has been made less restrictive, but still impedes access to care.

In addition, Iowa faces shortages of permanent supportive housing, crisis services, and jail diversion programs.

The MHSI initiative represents a road map for progress, but it will require leadership and political will from the governor and the legislature to make it a reality. The challenge for Iowa is to move beyond a D grade. In the end, transformation of the state's mental health care system should save money through more cost-effective EBPs, which will better serve its citizens.

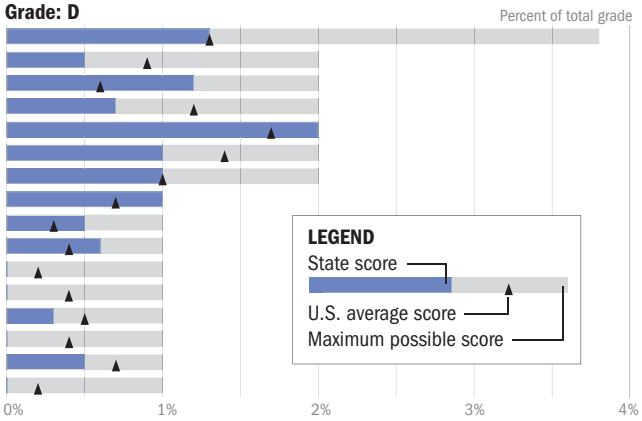
NAMI Score Card: KANSAS

Grade: D

Category I: Health Promotion & Measurement

Grade: D

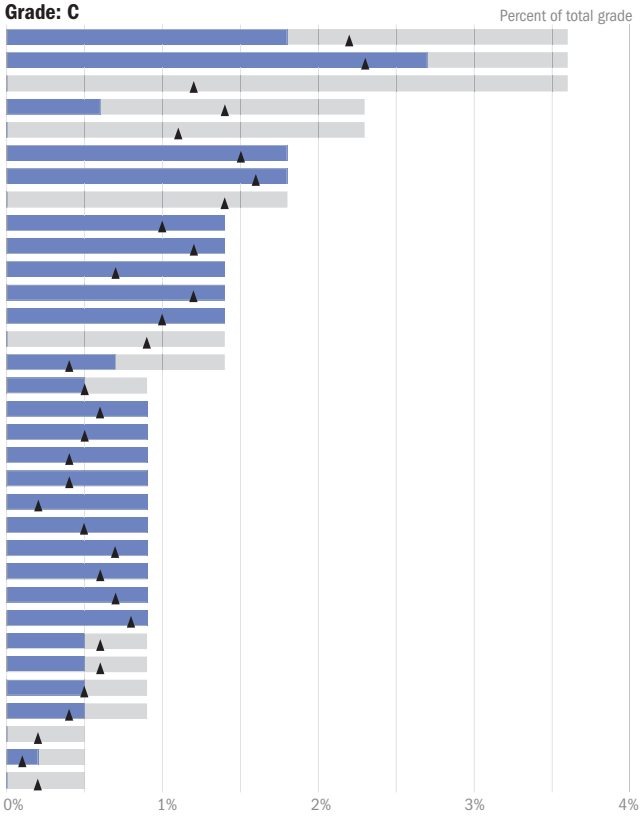
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

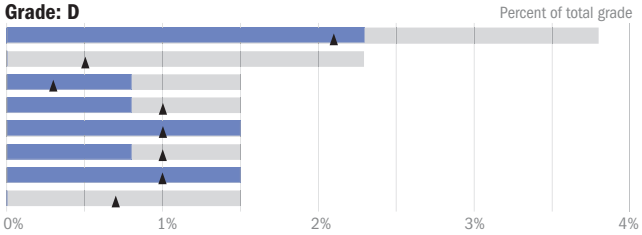
- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

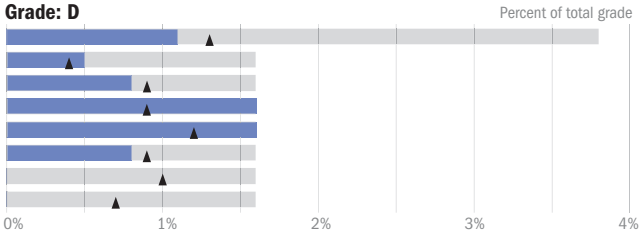
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Kansas

Innovations

- Peer-run and peer-provided supports
- Collaboration to develop housing
- Consumer/family partnership in policy development

Urgent Needs

- Community-based inpatient care
- Supportive housing
- Alternatives to incarceration
- Comprehensive parity legislation

Consumer and Family Comments

- *"I worked on an ACT Team in [another state] for over six years. I witnessed its value in keeping people out of the hospital and receiving the varying amount of support they needed over time. In my experience, no one I have dealt with in Kansas knows anything about it!"*
- *"My peer services are great. One of the things that has been most helpful is the Pathways to Recovery group at my CRO."*
- *"There has to be more funding available to provide the services. There are not enough beds or service providers and so we have a major problem. My son ends up being placed in jail to keep him and others safe. He does not belong in jail, but the services he needs are not available!"*

The nation's Heartland can be proud of Kansas' plucky spirit. In 2006, Kansas' mental health system received an F grade. Since then, the state seems to have acknowledged its challenges and begun building on its strengths, working to identify a clear path for the future. Three years later, however, much work still needs to be done. The state has achieved a D.

The Division of Disability and Behavioral Health Services (DDBHS) of the Kansas Department of Social and Rehabilitative Services (SRS) provides oversight of the community mental health system, including Kansas Health Solutions (the Medicaid-managed care program) and three state hospitals. Kansas contracts with 27 state- and county-funded and locally administered community mental health centers that serve 105 counties, many of which are rural or frontier.

SRS is to be commended for its collaborative Hospital and Home Initiative, which has brought diverse stakeholders to the table to identify best practices, needs, and barriers to care. It also makes recommendations for a comprehensive array of hospital and community services that promote wellness and recovery.

Kansas deserves praise for emphasizing development of safe and affordable housing options for people living with serious mental illnesses or co-occurring disorders. The state has expanded evidence-based practices (EBPs) and now has 16 supported employment programs—six more than in 2006—and a number of integrated dual diagnosis treatment programs. Further, Kansas is building on its support of consumer-run organizations by establishing certified peer specialists within community mental health centers and consumer liaisons to assist with state hospital discharge planning.

Kansas has historically provided excellent access to psychiatric medications—an important tool in the recovery of many people who live with serious mental illness. The state is also noted for nurturing a culture in which consumers and families feel valued and included as key partners in policy development.

Although Kansas is making important efforts to improve mental health services and supports, a growing shortage of psychiatric inpatient beds and community alternatives challenge the state. The Hospital and Home Initiative's priority recommendation is to address this gap by investing in community-based inpatient care and crisis services throughout the state.

Kansas is challenged by a pressing need for permanent supportive housing. In addition, transportation and expansion of EBPs remain a concern. Kansas still lacks Assertive Community Treatment (ACT) for populations in need of highly intensive services. Although the state has taken steps to reduce criminalization of people living with mental illness through support of police Crisis Intervention Teams (CIT) in five communities, more action is needed to develop alternatives to incarceration.

Kansas is hampered by its lack of equitable coverage for mental health and substance use disorders in private insurance plans. In 2008, Congress passed a federal mental health insurance parity law that enjoyed wide support from the business, insurance, and mental health communities. Kansas should follow suit by extending parity to all residents covered by state-regulated health insurance plans.

Kansas' willingness to acknowledge weaknesses and work collaboratively to identify appropriate solutions is the kind of response to a report card grade that NAMI applauds. However, political will is needed to preserve the gains recently made and provide the funding necessary to implement the recommendations of the Hospital and Home Initiative.

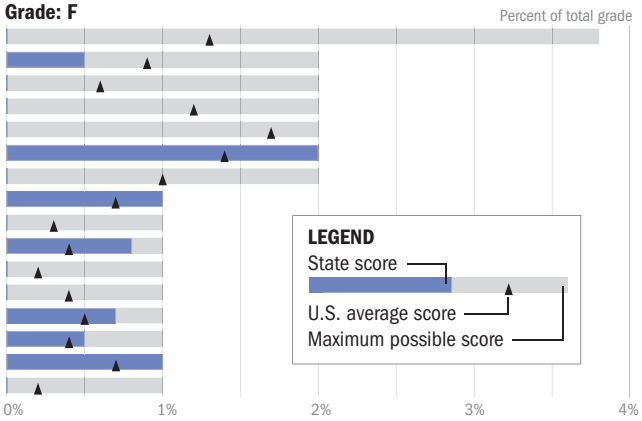
NAMI Score Card: KENTUCKY

Grade: F

Category I: Health Promotion & Measurement

Grade: F

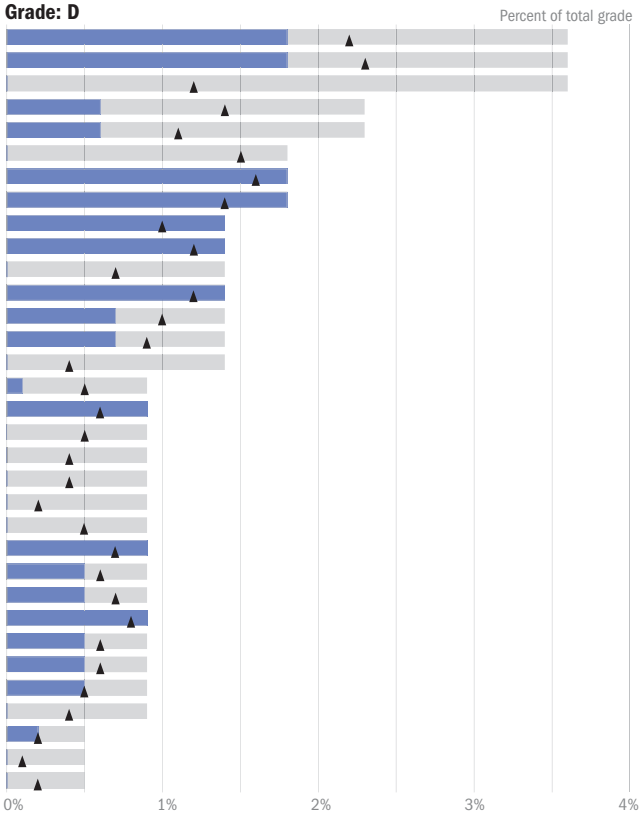
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

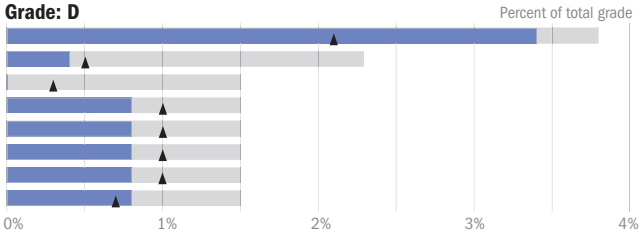
- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

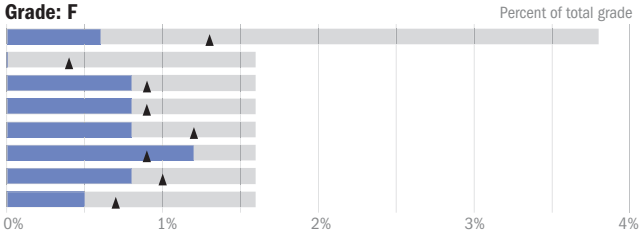
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: F

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Kentucky

In 2006, Kentucky's mental health care system received an F grade. Three years later, the grade remains the same. Little progress has occurred, although there is potential for improvement.

The Department for Mental Health, Developmental Disabilities and Addiction Services (DMHDDAS) is part of the Cabinet for Health and Family Services. It provides mental health services through 14 regional Mental Health Centers and four psychiatric hospitals.

The state has a long history of persistent rural poverty and limited funding of public mental health services. The community mental health centers haven't received a cost-of-living increase in their state contracts in 12 years. Due to lack of funding, mental health services are eroding, and centers have had to close programs and lay off staff.

Kentucky does have strengths, especially in the area of criminal justice. Building on a well-established program in Louisville, police Crisis Intervention Teams (CIT) are expanding throughout the state. Lauded in 2006, a statewide telephonic triage system continues to screen jail inmates and provide linkages to treatment; the department recently received a federal grant to strengthen the system. The department also received a grant to develop a strategic plan for pre- and post-booking programs. The department provides a peer support specialist training program and a Peer Leadership Academy.

Community mental health centers receive department funds for a new statewide program called Direct Intervention, Vital Early Response Treatment Systems (DIVERTS) to specifically help reduce the number of persons becoming homeless or going to jail—as well as the number of hospitalizations and suicides. Each of the 14 regions worked with the Department to tailor the flexible DIVERTS program to its particular needs.

A new psychiatric facility to replace Eastern State Hospital in Lexington is on track to begin construction in 2010. The new hospital will replace the second oldest state hospital in the nation (opened in 1824). Kentucky's state hospitals have reduced the use of seclusion and restraints.

In some areas of the state there are forms of evidence-based practices (EBPs), such as supported employment, Assertive Community Treatment (ACT), supported housing, and integrated dual diagnosis treatment (IDDT), but none meet the standards of national models. The lack of supported housing is severe. The state has a shortage of mental health professionals, especially psychiatrists, in rural areas.

In addition to inadequate funding, the state's problems are the result of an imbalance in investment of existing funds: 62 percent of the budget goes to facilities and only 38 percent to community mental health services. This imbalance substantially limits progress.

Budget cuts only undermine an already shaky and insufficient infrastructure of community services. On a positive note, Governor Steve Beshear is aware of problems in the mental health care system and is expected to recommend to the legislature no further cuts to mental health services after a three percent reduction in 2009.

If Kentucky is to improve the quality of mental health services that it provides, greater political leadership and will is needed. Progress depends on sustained investment, with a greater proportion of funds dedicated to community programs.

Innovations

- DIVERTS program
- Collaboration with consumer and family organizations
- Strengthened statewide jail triage system and criminal justice planning grants
- Reduction in restraints and seclusion

Urgent Needs

- Leadership and political will
- Invest in community services and evidence-based practices
- Workforce development, especially psychiatrists
- Supportive housing

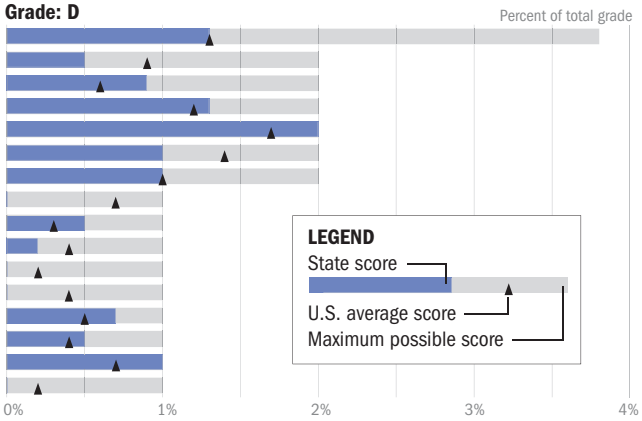
Consumer and Family Comments

- *"Eastern State Hospital is the most depressing place I have ever visited."*
- *"They care and they listen. Even with their heavy workload, they make time for me when I need it."*
- *"No services available in rural areas . . . Need more psychiatrists and psychologists in rural communities . . . Beds not available in emergencies."*
- *"Resources are too few and far between."*

NAMI Score Card: LOUISIANA — Grade: D

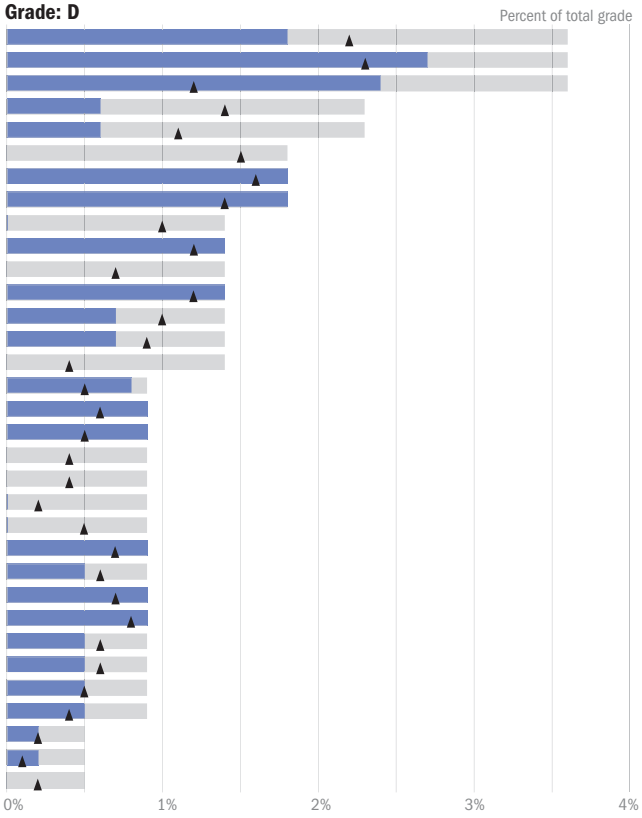
Category I: Health Promotion & Measurement — Grade: D

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



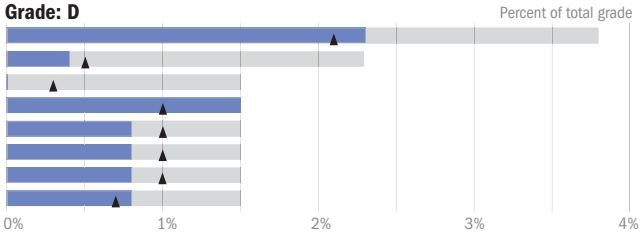
Category II: Financing & Core Treatment/Recovery Services — Grade: D

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



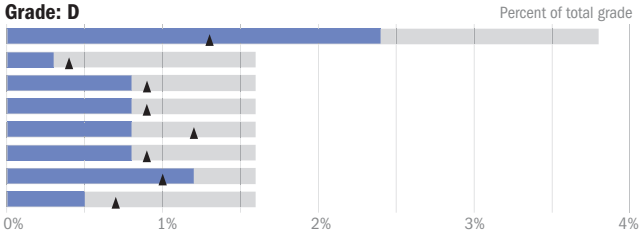
Category III: Consumer & Family Empowerment — Grade: D

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Louisiana

Innovations

- Capital Area Human Service District mobile health unit
- "Road Home" program housing allocation for people with serious mental illness
- Co-occurring disorders provider training and service access

Urgent Needs

- Expand crisis, inpatient, and community services
- Finance mental health services under Medicaid
- Address mental health workforce shortage

Consumer and Family Comments

- *"A great deal of money and human suffering could be spared if ADEQUATE resources were put into prevention and management of mental illness rather than waiting until the person needs to be hospitalized."*
- *"No beds available, no psychiatrists available, no community support available."*
- *"Those in the field are generally caring—just overloaded. Hospital stays for my daughter have been too short to assure stability, resulting in a subsequent hospitalization soon after discharge. Housing remains one of the area's greatest needs."*

In 2006, Louisiana's mental health care system received a grade of D. Three years later, the grade has not changed.

Louisiana's mental health system must be viewed in the context of Hurricane Katrina in 2005 and subsequent storms, which affected inpatient beds, workforce availability, and access to services throughout the Gulf region—including those areas that received evacuees. While people with serious mental illnesses continue to lack access to treatment, leading to overflowing emergency rooms and jails, the state has taken steps to improve the system.

Louisiana's administrative structure for the delivery of care is still evolving. The Office of Mental Health (OMH) operates within the Department of Health and Hospitals, and the community mental health system is moving toward independent health care authorities or districts under OMH direction.

In 2008, Governor Bobby Jindal proposed several mental health care reforms that the legislature enacted. They included a 24/7 telephonic crisis screening and referral system, additional support for police Crisis Intervention Teams (CIT), more mental health staff for the New Orleans parish prison, staff to serve consumers affected by Hurricane Gustav, and crisis receiving centers to be implemented on a statewide basis.

Signs of other progress are visible. In the New Orleans metropolitan area, new services—such as Assertive Community Treatment (ACT) and rental subsidies to increase access to housing—are becoming available. Elsewhere, some human services districts are doing exemplary jobs, including using evidence-based practices and communicating well with consumers and families. Louisiana also has worked to improve provider training and policies to support individuals with co-occurring disorders.

In 2007, the state expanded its outpatient commitment law and increased access to telemedicine for commitment procedures.

Louisiana faces significant challenges in retaining an adequate workforce in mental health services. In some cases, there are no psychiatrists at all in the public mental health centers. Out-migration of mental health workers is a serious problem and contributes to decreased access to services.

The state has moved very slowly in using Medicaid to finance mental health services and supports. As Louisiana moves forward with Medicaid reform in general, it is important that mental health services are not left behind and that provider reimbursement is adequate to sustain them. Unfortunately, the state restricts access to psychiatric medications in the Medicaid program—which in the long run can cost more as people experience poor outcomes.

Turmoil and change characterize Louisiana's overall challenges in recent years, as hurricanes have wracked havoc in the state, and a new governor has been elected. The state needs stability and progress to build a mental health system that will meet the needs of its citizens.

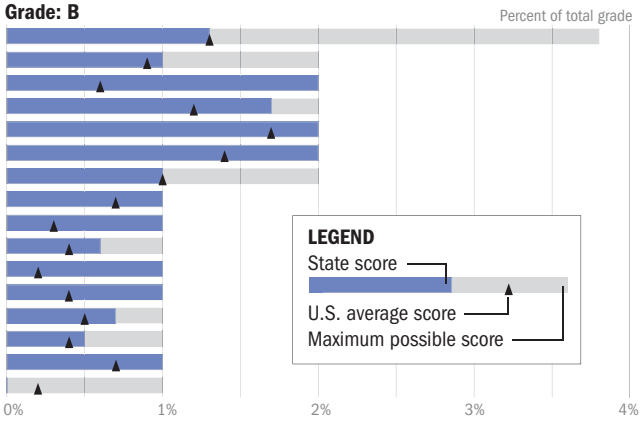
NAMI Score Card: MAINE

Grade: B

Category I: Health Promotion & Measurement

Grade: B

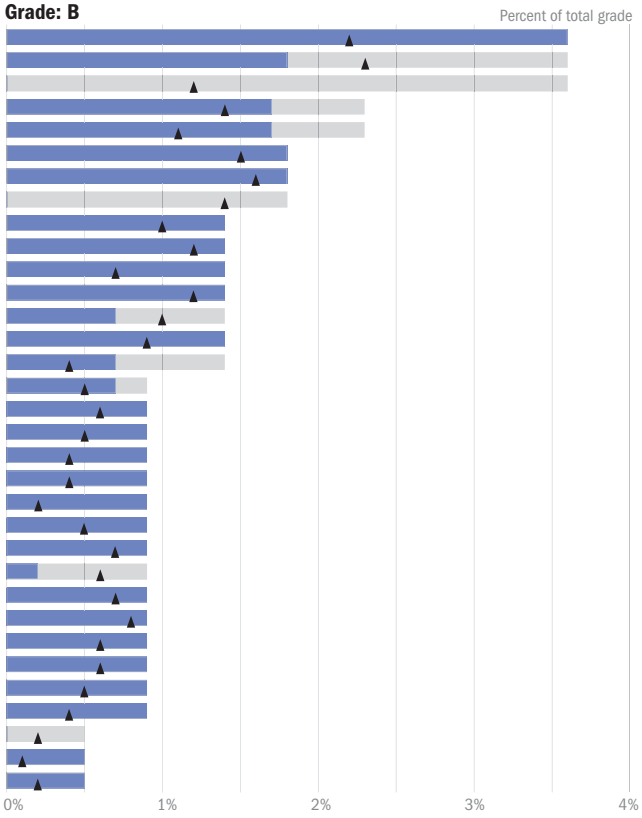
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: B

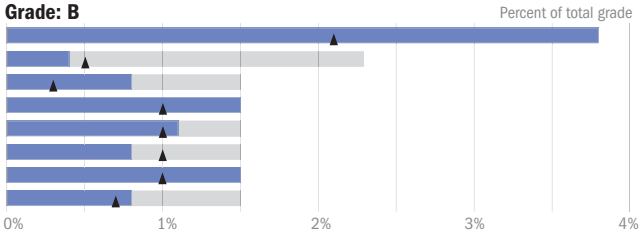
- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: B

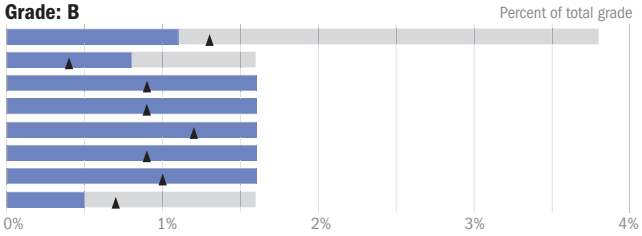
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: B

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Maine

In 2006, Maine's mental health system received a grade of B. Three years later, the grade remains the same. Even so, during the past three years, Maine has responded to budget shortfalls by cutting Medicaid and services for people with serious mental illnesses.

The state is still subject to a consent decree from a 1990 class action lawsuit, which provides some protection to consumers. Despite the state's motto, "Dirigo," meaning "I lead," Governor John Baldacci and the Department of Health and Human Services (DHHS) have shown little leadership in the face of the mental health care crisis.

Maine deserves praise in some areas. The state has one of the lowest rates of uninsured persons in the nation, and the state's Dirigo health plan provides full parity for mental illness and substance use disorders for some uninsured residents. Evidence-based practices are in use, and multiple efforts are underway to integrate mental health and substance abuse treatment with primary care. The Maine Health Access Foundation, the state's largest private healthcare foundation, has distributed 17 grants totaling $3 million to providers and collaborative groups to improve integrated care.

In 2008, the state was in year three of a five-year grant to promote wellness through the use of "medical homes," which serve as "one-stop shops" for consumers with complex mental health, substance abuse, and other medical needs.

Through a federal grant, Maine has worked to integrate mental health and substance abuse treatment by instituting a "no wrong door" policy and integrated billing, and offering co-occurring disorder competency training to providers. However, the state has a long way to go toward developing licensing standards for these providers.

Maine has long provided peer support services in a variety of treatment settings, and the state is proud of its Intentional Peer Support training and certification. Although consumer advocates express concern that Maine's training and certification requirements are poorly implemented and present a financial burden for peer programs, they are still important to ensuring quality services.

Fifty percent of persons incarcerated in Maine have mental illnesses; the state's mental health care system has made collaboration with the criminal justice system a priority. Police Crisis Intervention Teams (CIT) exist statewide, and the state's first co-occurring mental health and substance abuse court was established in 2005.

The Department of Corrections has created an award-winning young offender reentry program. Although some jails have made significant efforts to put mental health services in place, most people still do not get adequate care while incarcerated.

Innovations

- Co-occurring disorder initiatives
- Integration of mental health, substance abuse, and primary care
- Young offender reentry program
- Medical homes

Urgent Needs

- Leadership by governor and Department of Health and Human Services
- Services for aging population
- Cultural competence plan
- Increase mental health workforce in rural areas

Consumer and Family Comments

- *"The dedication of mental health workers in Maine is wonderful and incredible, given all the hassles and funding cutbacks they suffer from State of Maine legislature and at the federal level. If it wasn't for their dedication . . . my family member (who has schizophrenia) would be truly a lost soul."*
- *"The focus is on keeping the patients coming and going in 15-minute billable increments."*
- *"It took me six weeks to find someone who accepts Medicaid."*
- *"ACT has been my saving grace navigating me through the system. [In] voc rehab . . . I felt like I was respected, listened to, and supported to meet my work goals. I was asked, not told."*

Despite its positive elements, Maine's system of care is built on a shaky foundation. Cuts in the Medicaid program have decreased the federal government's matching dollars. In 2007, the program shifted to a managed care system. The state also added a $25 enrollment fee in 2008 for childless adults, putting Medicaid out of reach for some. Consumers and family advocates report that the cuts have led to providers closing their doors. It remains unclear how the new Medicaid managed care program has affected consumers—and whether it has resulted in any net savings. Anecdotal reports suggest that chaos has plagued the transition, with delays in provider registration and confusion about which private contractors provide case management. The new program also lacks transparency. Thus far, DHHS has failed to report on outcomes from the experiment.

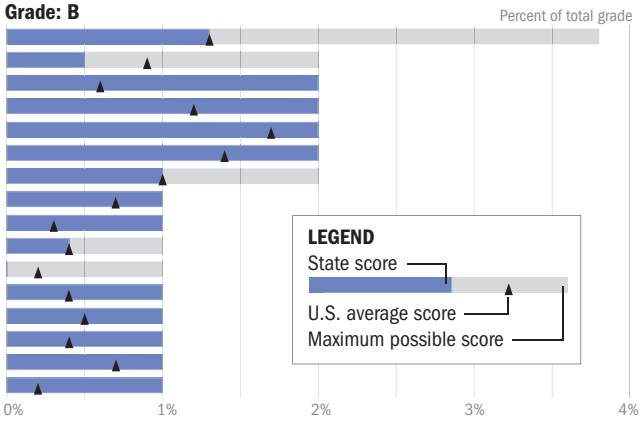
As part of its broader financial challenge, the state will increasingly need to provide specialized services for older adults living with mental illnesses.

Maine stands at a crossroads. It can seek to build on existing strengths, or it can fall into decline. Stronger leadership and political will are needed from the governor and legislature.

NAMI Score Card: MARYLAND — Grade: B

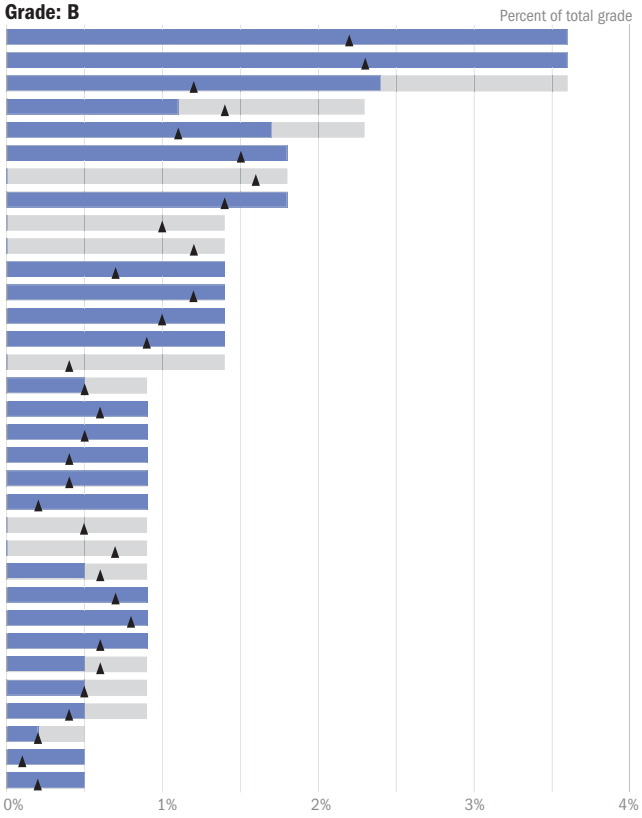
Category I: Health Promotion & Measurement — Grade: B

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



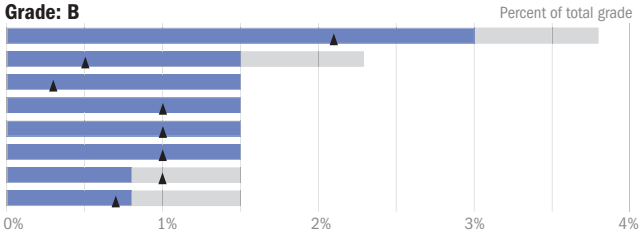
Category II: Financing & Core Treatment/Recovery Services — Grade: B

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



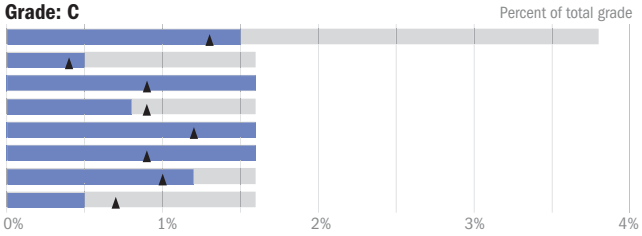
Category III: Consumer & Family Empowerment — Grade: B

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: C

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Maryland

Innovations

- Transformation planning
- Wellness and recovery promotion
- Collaboration with consumer and advocacy organizations

Urgent Needs

- Meet national standards for evidence-based practices
- Expand integrated mental health and substance abuse services
- Expand mobile crisis teams and community crisis beds
- Improve reentry programs and ensure Medicaid restoration

Consumer and Family Comments

- *"The variety of services available is under a lot of different departments and organizations, making it very difficult to even find out about them."*
- *"So many people do not 'fit' into the system and wind up homeless or in jail or prison. There are not enough services available, so getting a full set of services can be like playing musical chairs."*
- *"The best thing about the public mental health services is the mental health court."*
- *"Maryland needs decent, safe affordable housing for persons with mental illness who have no income . . . It is virtually impossible to find supported housing for the severely ill or dually diagnosed."*

In 2006, Maryland's mental health care system received a C. It was considered an underachiever with the potential to do much better. Three years later, it has improved to a B, reflecting the state's emergence as a national leader in promoting wellness and recovery.

But more still needs to be done. Evidence-based practices (EBPs) exist but are not statewide, and availability of services is uneven. Nonetheless, Maryland is making progress in many areas, including cultural competence, supportive housing, police Crisis Intervention Teams (CIT), and jail diversion.

The Maryland Department of Health and Mental Hygiene provides services through its Mental Hygiene Administration. At the local level, 20 Core Service Agencies (CSAs), both public and private, are responsible for services. Because of local control, programs and services differ from county to county. Some CSAs receive county funds that supplement state funds—resulting in more or better services in affluent areas, compared to rural ones.

Maryland offers many excellent, innovative programs and is a national leader in supporting consumer empowerment. The Maryland Transformation Project joins policymakers with consumers, families, advocates, service providers, and the academic community to build a system that supports recovery and resilience across the lifespan. The project is also engaged in planning in primary care and mental health integration, supportive housing, supported employment, workforce development, cultural competence, older adult needs, and reducing the use of restraints and seclusion.

Supported employment programs are widespread. Mobile crisis teams help evaluate consumers in community hospital emergency rooms in Montgomery and Anne Arundel Counties, enabling diversion to community services when appropriate. The state also provides services for National Guard veterans and their families.

The state operates mental health courts in Baltimore, Prince George's, and Harford Counties, and CIT in Baltimore and in several counties. Maryland is planning more of both approaches to link people to services while avoiding incarceration. The Mental Hygiene Administration also encourages mental health training of public safety officials and corrections officers. Innovatively, the Maryland Department of Public Safety and Correctional Services arranges for inmates to be issued personal identification—essential for life in the community—before release from prison.

The state is nationally recognized for collaboration with consumer and advocacy organizations, such as "On Our Own of Maryland," a statewide mental health consumer education and advocacy organization. Consumer Quality Teams, made up of consumers and family members, monitor both inpatient and outpatient care and are authorized to conduct *unannounced* visits to facilities.

Maryland is a national leader in the wellness and recovery approach to mental health services. Through smoking cessation and health promotion efforts, the state seeks to lower morbidity and mortality among people with serious mental illnesses.

The state also has its share of problems. Some Assertive Community Treatment (ACT) teams lack fidelity to the 24/7 evidence-based model. Greater funding is needed to fully implement and sustain ACT and other EBPs, but resources vary because funding depends on local decision making. Jail and prison reentry support programs need further development and expansion.

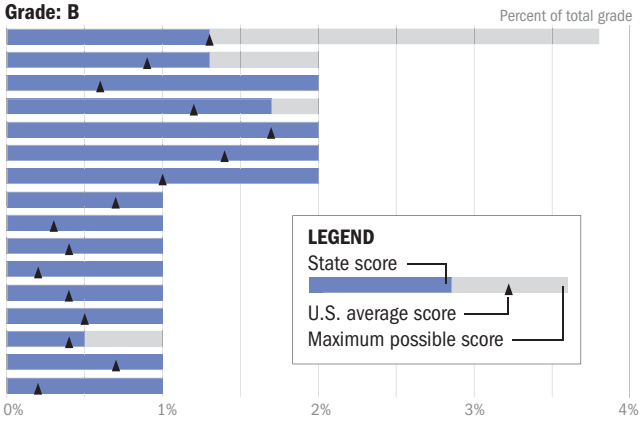
In 2005, the legislature voted to suspend, rather than terminate, Medicaid benefits for consumers who are incarcerated, with restoration upon release. This has not yet been fully implemented because of computer system problems.

The state's county-based, fragmented mental health care system requires planning and coordination of services across county lines and more extensive oversight to ensure equitable and consistent services. Maryland is using its federal transformation grant to plan for projects that can leverage additional funds. These innovative efforts will need to be sustained when the grant ends in 2010.

NAMI Score Card: MASSACHUSETTS — Grade: B

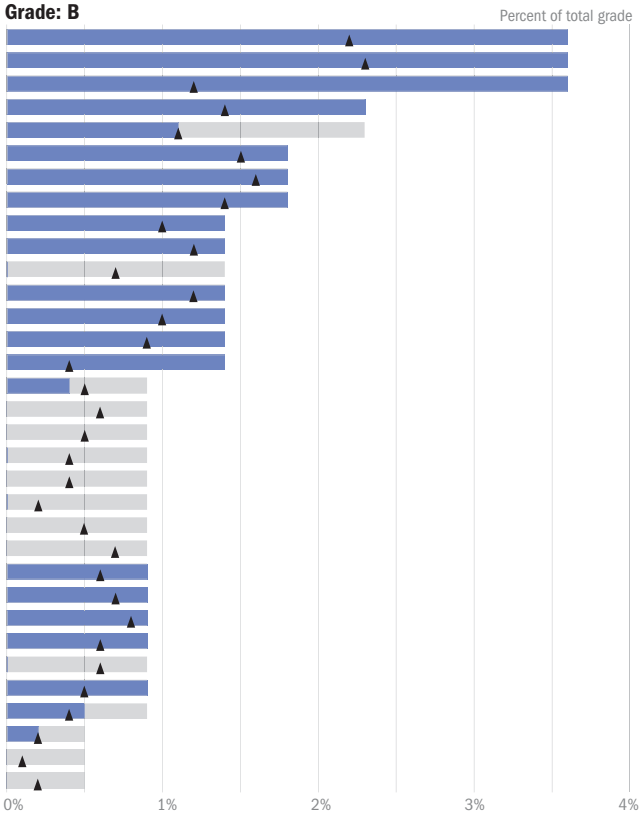
Category I: Health Promotion & Measurement — Grade: B

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



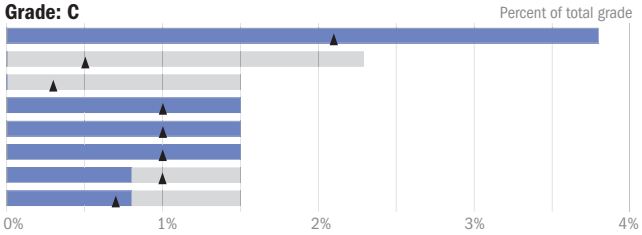
Category II: Financing & Core Treatment/Recovery Services — Grade: B

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



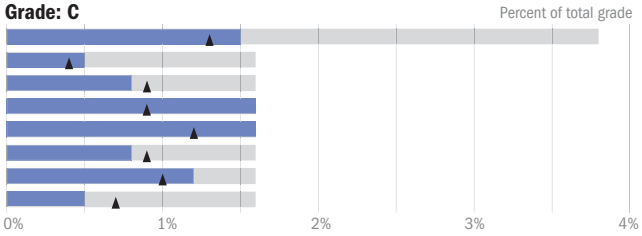
Category III: Consumer & Family Empowerment — Grade: C

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: C

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Massachusetts

Innovations

- Comprehensive health care reform efforts
- State parity law expansion
- National model for reduction of use of restraints and seclusion
- Clinical performance measures for Medicaid carve-out

Urgent Needs

- Restore funds for supported employment and day services
- Restore funding and expand jail diversion programs
- Address prison suicide crisis

Consumer and Family Comments

- *"I would not be alive if it were not for the help of services here."*
- *"The service system is stretched to the breaking point."*
- *"Lack of continuity of care . . . we go from crisis to crisis."*
- *"Services are inadequate, but ACT is the most help."*

In 2006, Massachusetts' mental health care system received a grade of C, barely above the national average. Three years later, its grade has risen to B. This improvement coincided with a relatively calm economy, but the Commonwealth has now hit turbulent times. The test of true progress will come in crisis management.

Massachusetts has a proud history of innovation in mental health services. The nation is watching to see whether the state's 2006 Health Care Reform Act can successfully mandate universal health care. This ambitious health care reform initiative has exceeded expectations for enrollment—and cost. Massachusetts now has the lowest rate—3.7 percent—of uninsured citizens of any state in the nation.

At the same time, Massachusetts came up short by more than a billion dollars in September 2008. Another $1 billion shortfall has been projected for the rest of the fiscal year. Resulting budget cuts have heavily impacted the state's Department of Mental Health (DMH). DMH received the deepest mid-year cuts of any of the state's human services agencies.

Since 2006, Massachusetts has made several noteworthy strides. An improved parity law will go into effect in July 2009, adding alcohol and substance use disorders, eating disorders, posttraumatic stress disorder (PTSD), and autism to private health insurance coverage. The state also continues to be a national leader in developing alternatives to the use of restraints and seclusion—in both public and private hospitals.

Emergency rooms overseen by the Department of Public Health (DPH) still routinely use restraints. Thus far, DPH has failed to disclose emergency room restraints data—which is critical to correct a significant problem, align the overall public health system, and reduce individual trauma.

The state has developed six peer recovery learning centers, which also represent a hopeful cultural change, but more are needed across the state.

The for-profit Massachusetts Behavioral Health Partnership (MBHP), which provides the behavioral health care carve-out for Medicaid, is a far-sighted model for providers to make money by meeting clinical standards rather than denying services. Connecting mental health care consumers to primary care and arranging follow-up appointments after hospitalizations makes good business sense—as well as common sense.

The cuts in DMH to date have eliminated supported employment, outpatient day treatment, and almost all jail diversion programs. Cutting day treatment will strain resources for consumer clubhouses, which are expected to absorb many people who lose other day programs. The impact on individuals and the pressures on inpatient and correctional facilities will be felt quickly.

Massachusetts' prison population has reached an all-time high, and prison suicides are at crisis levels—the state has one of the highest rates of inmate suicides in the nation. DMH needs to exert leadership in working with the Department of Corrections to attend to this crisis.

It is uncertain how the state's financial problems will impact two important DMH building projects in the planning stages: the rebuilding of Worcester State Hospital and a public-private collaboration to rebuild the Massachusetts Mental Health Center in Boston. Both facilities are sorely needed as a critical foundation for the state's mental health care system.

Given its resources and commitment to universal health care, Massachusetts has the potential to be a leader in the transformation of the nation's health and mental health care system. Whether it can meet that challenge will depend on choices made by the governor and legislature over the next three years.

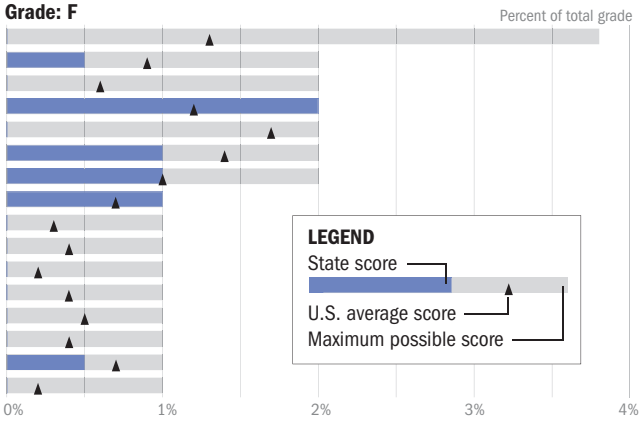
NAMI Score Card: MICHIGAN

Grade: D

Category I: Health Promotion & Measurement

Grade: F

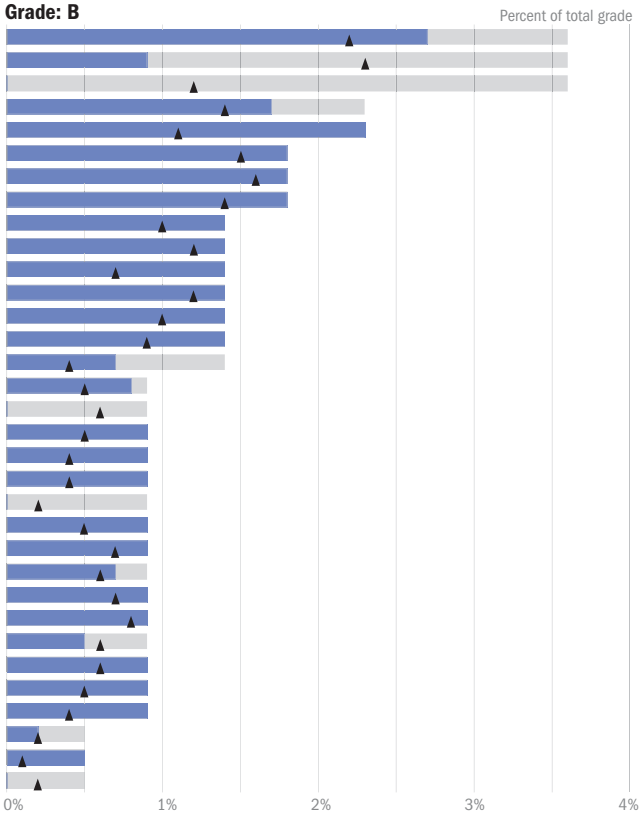
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: B

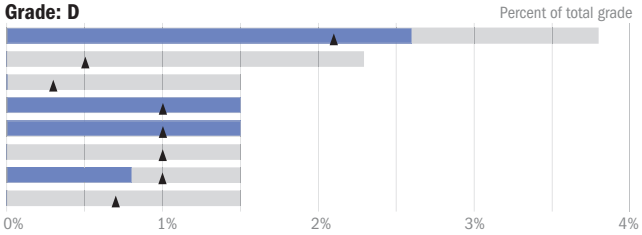
- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

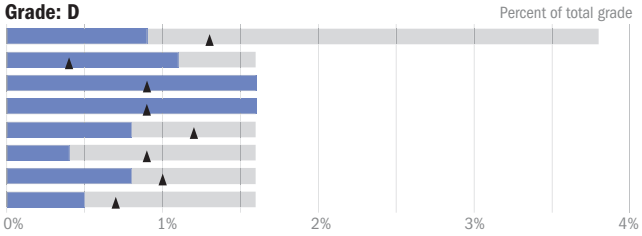
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Michigan

Innovations

- Evidence-based practices
- Person-centered planning and recovery focus
- IDDT for co-occurring mental health and substance use disorders

Urgent Needs

- Non-Medicaid mental health services
- Mental health courts and jail diversion programs
- Comprehensive insurance parity

Consumer and Family Comments

- *"Michigan is WAY ahead of other states with regards to the recovery movement. Folks come into our public mental health services automatically hearing that recovery is possible."*
- *"Emergency services said [my son] was not suicidal or threatening, so they released him in slippers, scrub pants, and a hospital gown. I found my very psychotic, delusional son wandering around in the parking lot in below-zero temperature. . . No person with ANY OTHER ILLNESS would be treated so poorly!"*
- *"In Michigan, jails and prisons are becoming the de facto institutions of care. And they don't care about mental health in jail or prison. We are punishing the victims of untreated mental illness for not having treatment. That is a damned shame."*

In 2006, Michigan's mental health care system received a grade of C. Three years later, it has dropped to a D. As a result of the foundering economy, the need for mental health services is increasing, but the community mental health system is greatly challenged.

Michigan has a Medicaid program that provides an array of evidence-based practices (EBPs) and reflects a person-centered, recovery-focused approach to care. But for those who are not eligible for Medicaid, mental health services are often very limited, difficult to access, and crisis-driven.

The Mental Health and Substance Abuse Administration in the Michigan Department of Community Health (MDCH) contracts with 18 regional prepaid inpatient health plans (PIHPs) that deliver Medicaid mental health services through community mental health service programs (CMHSPs). The state contracts directly with 46 CMHSPs to provide non-Medicaid community mental health services in 83 counties.

Consumers and families note that MDCH is open, accessible, and committed to providing EBPs and to expanding the state's groundbreaking work in person-centered planning. The state has close to 400 peer support specialists who work in a variety of settings. Every CMHSP has at least one consumer-run drop-in center or clubhouse.

Michigan has steadily implemented EBPs, which include 88 Assertive Community Treatment (ACT) teams, statewide family psychoeducation, and both cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT). Significant efforts have been made to provide integrated dual diagnosis treatment (IDDT) for co-occurring mental health and substance use disorders in every region, with an important focus on building capacity through training and technical assistance. As acute psychiatric inpatient beds dwindle, the state plans to increase intensive crisis stabilization and crisis residential services to provide needed alternatives to hospitalization.

Despite the state's economic turmoil, Governor Jennifer Granholm, state lawmakers, and MDCH have worked hard to mitigate impacts by maximizing federal reimbursements available through Medicaid. Unfortunately, limited non-Medicaid community mental health funding leaves too many individuals who are not eligible for Medicaid without the services they need to manage their mental illnesses successfully. Nowhere is the impact felt more keenly than in Michigan's jails and prisons, where many individuals with mental illness end up incarcerated.

Michigan's shame is the heartbreaking case of Timothy Souders, who died of thirst while pleading, chained in his prison cell, for water. This neglect and abuse of a person with serious mental illness, as well as previous cases, sparked extensive media exposés and multimillion dollar lawsuits. To its credit, the Michigan Prisoner Reentry Initiative, a cooperative effort led by the Department of Corrections, is now making inroads in providing care in custody and connecting individuals to appropriate treatment and supports upon release. However, greater efforts are needed, particularly in local communities, where consumers frequently languish in jails that fail to provide critical care.

Given the high costs of maintaining jails and prisons, the current fiscal environment is an opportune time for the state to move to treatment in lieu of incarceration. Expansion of mental health courts and jail diversion programs for persons with mental illnesses and co-occurring disorders are crucial.

The legislature also needs to enact long-delayed mental health and substance abuse insurance parity and increase funding for non-Medicaid mental health services—both of which are needed to help provide timely access to care.

The state's citizens deserve better than a D.

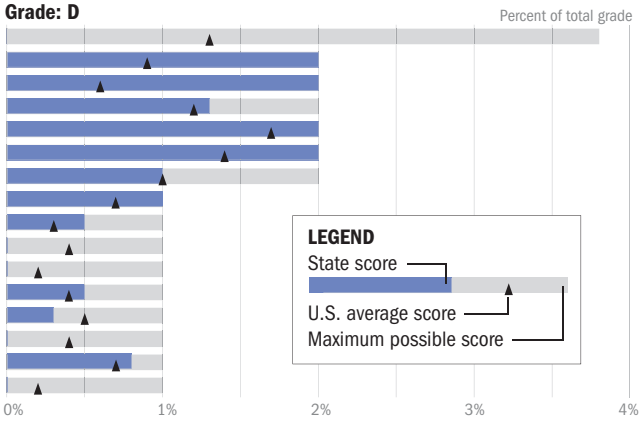
NAMI Score Card: MINNESOTA

Grade: C

Category I: Health Promotion & Measurement

Grade: D

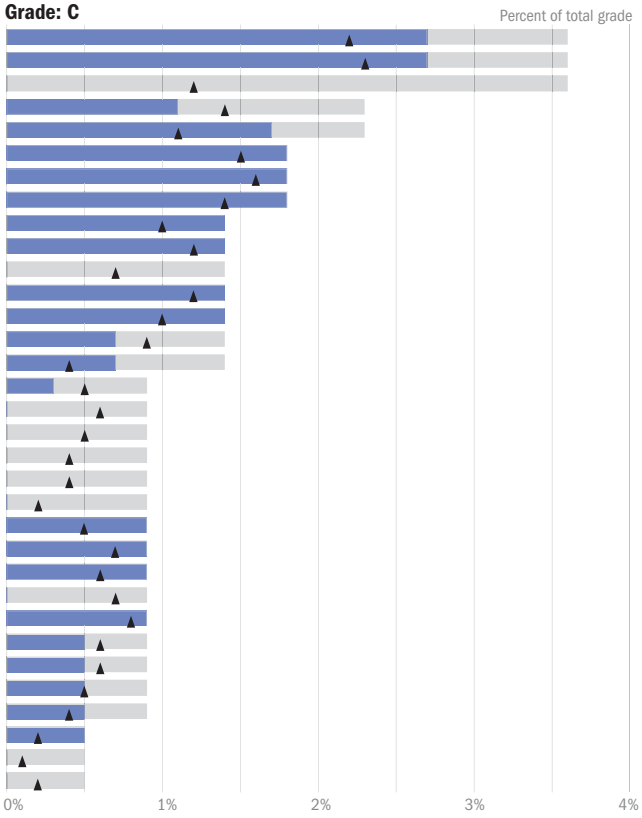
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

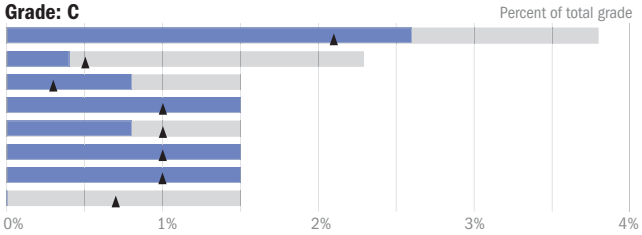
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: C

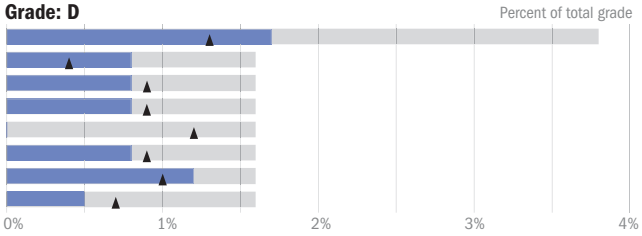
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Minnesota

Innovations

- Investment in infrastructure
- Strong vision for the state mental health system
- Uniform benefits for mental health in all state programs

Urgent Needs

- Reduce workforce shortages, particularly in rural areas
- Ensure access to treatment for diverse communities
- Housing and employment programs

Consumer and Family Comments

- *"There are a wide variety of services available and that Minnesota is committed to taking care of its citizens. I hope they continue to do so."*
- *"Need more providers especially in rural areas. We often have to wait two months for an appointment and many people are driving a long way."*
- *"It is difficult to find employment that allows reasonable accommodations for psychiatric disabilities."*

In 2006, Minnesota's mental health care system received a grade of C. Three years later, it remains a C. The state is working hard to chart a course for reform. Recent investments in the system have not yet produced results that might have helped improve its standing.

Minnesota has made significant recent investments in infrastructure for its mental health care system. In 2007, the state increased the mental health budget for adult services by about $21 million to increase access to providers. Minnesota is also piloting an integrated approach to mental and physical health care that consumers and families hope will lower mortality rates.

Minnesota also has enjoyed bipartisan support for mental health services. Governor Tim Pawlenty and the Department of Human Services Chemical and Mental Health Services Administration (CMHSA) established a Mental Health Initiative, and leaders of the state legislature created a mental health subcommittee in the Health and Human Services Policy Committee specifically to advance mental health policy.

CMHSA administers the mental health care system. Local mental health authorities—county boards and their agencies or multi-county authorities—ensure delivery of services through case management or contracts with providers.

Minnesota's strengths include the creation of a uniform benefit package for mental illness for all state-funded insurance plans. Notably, MinnesotaCare, the state's program for the uninsured, has the most expansive outpatient benefits of any state uninsured plan. Individuals who lose Medicaid coverage and come under MinnesotaCare retain the same benefits. These include Assertive Community Treatment (ACT), adult rehabilitative services, intensive residential treatment, and crisis services. The state requires Medicaid health care plans to provide unrestricted access to all psychiatric medications.

Minnesota could do more to address workforce shortages and transportation needs in rural areas, as well as disparities in access to services. Despite progress in providing housing and employment supports, demand for these critical services continues to exceed availability. Criminalization of mental illnesses also is a concern. There are only two mental health courts and a few police Crisis Intervention Team (CIT) programs in the state. The state's infrastructure investment addressed many of these needs, but the state will need to build on that effort.

In 2005, the Minnesota Mental Health Action Group, a broad coalition of state officials, advocates, providers, insurers, and others, mapped a strong vision for the future of mental health care in the state. Its report is aptly named the *Roadmap for Mental Health Reform in Minnesota.*

Minnesota has a foundation for progress. A broad coalition has mapped priorities for reform. The governor and legislature know the issues. The state's challenge now is to build momentum to meet the needs of its citizens living with mental illness.

NAMI Score Card: MISSISSIPPI — Grade: F

Category I: Health Promotion & Measurement — Grade: F

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
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State Studies Cause of Death
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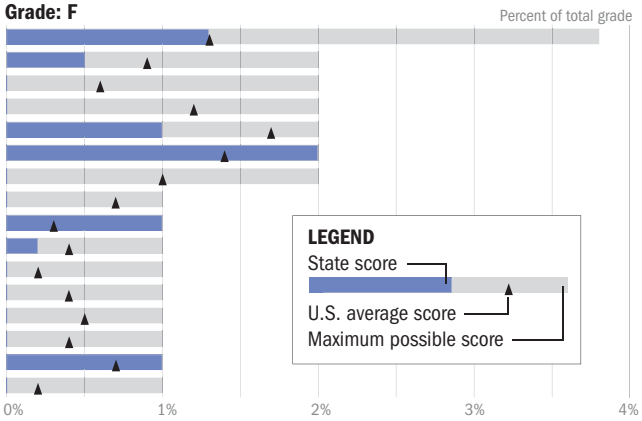
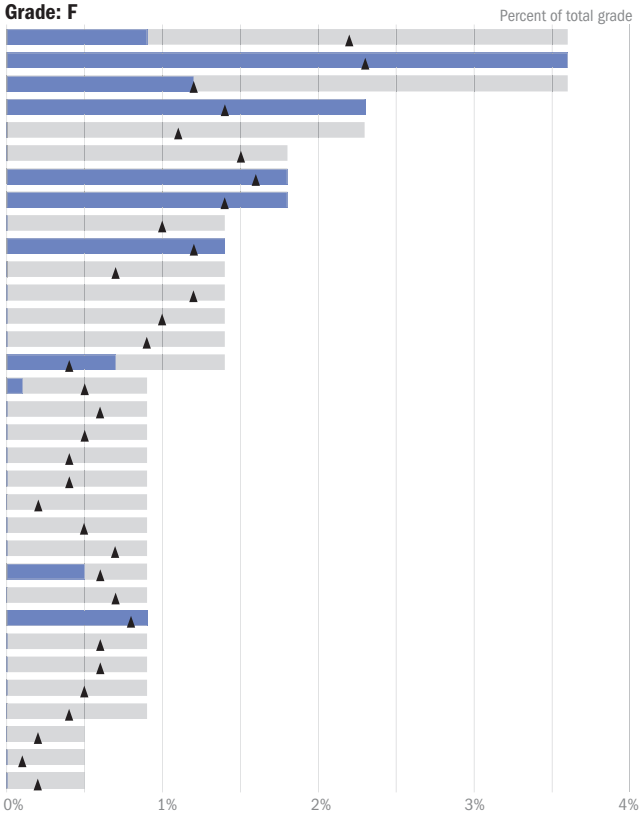
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



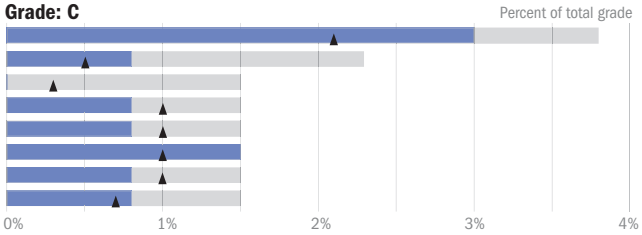
Category II: Financing & Core Treatment/Recovery Services — Grade: F

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



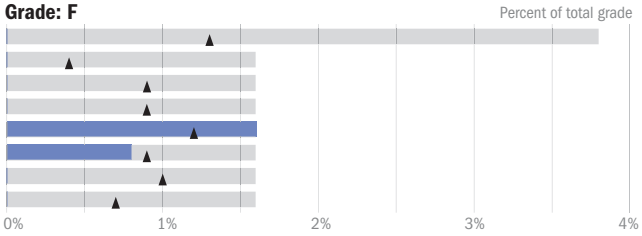
Category III: Consumer & Family Empowerment — Grade: C

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: F

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Mississippi

In 2006, Mississippi's mental health care system received a D grade. Three years later, it has dropped to an F.

Three years ago, NAMI criticized Mississippi for holding in jails individuals with serious mental illnesses who had been civilly committed for treatment, while waiting for available psychiatric hospital beds. Even so, the state was aware of the problem, and there were some slight signs of progress in addressing this deplorable situation.

However, the real problem is not lack of hospital beds. Mississippi has a higher per capita rate of state psychiatric beds than any other state. Mississippi's primary challenge is the continuing lack of appropriate community-based services and supports. There is too much reliance on a system of care that is not responsive to consumer and family needs. Services are not available until people reach a point of severe crisis. Then, individuals either become the responsibility of the state hospital system or the state correctional system. There is little mystery as to why Mississippi's psychiatric hospitals are filled to capacity and why jails and prisons contain disproportionate numbers of inmates with mental illnesses.

New leadership in the Department of Mental Health (DMH) seems to accept that system transformation is needed but is tentative and indecisive about how to accomplish it. After many years of delay, seven community mental health crisis centers are up and running but they are primarily being used for overflow beds for inpatient treatment, rather than crisis intervention services.

DMH has provided grants to 15 Community Mental Health Centers throughout the state to coordinate services for co-occurring disorders. DMH also provides support for family and peer education programs.

DMH is collaborating with the Jackson Police Department, the Hinds County Sheriff's Office, and local mental health agencies and facilities to implement a police Crisis Intervention Team (CIT) program. In collaboration with the University of Mississippi's Medical Center, DMH also has provided funding and technical assistance to two rural regions for tele-psychiatry.

Innovations

- Preliminary steps toward community-based services
- Regional crisis centers
- Support for CIT in Jackson

Urgent Needs

- ACT, integrated dual diagnosis treatment, and supportive housing
- Medicaid funding for evidence-based practices
- Eliminate use of jails for people under civil commitment orders

Consumer and Family Comments

- *"Clinics are run like mills. You wait long periods of time for appointments, and then they just drug you without adequate diagnosis. They don't care."*
- *"The facilities are archaic and add to the embarrassment of having to seek mental help."*
- *"Lack of housing and other community-based services . . . Services in general are too fragmented from region to region . . ."*

Modest signs of progress notwithstanding, Mississippi faces numerous problems. Evidence-based practices (EBPs) generally are not available. Currently no Assertive Community Treatment (ACT) teams exist. There has been no investment in integrated dual diagnosis treatment (IDDT), supported employment, supportive housing, or other EBPs. Mississippi's Medicaid program has a restrictive preferred drug list for psychiatric medications.

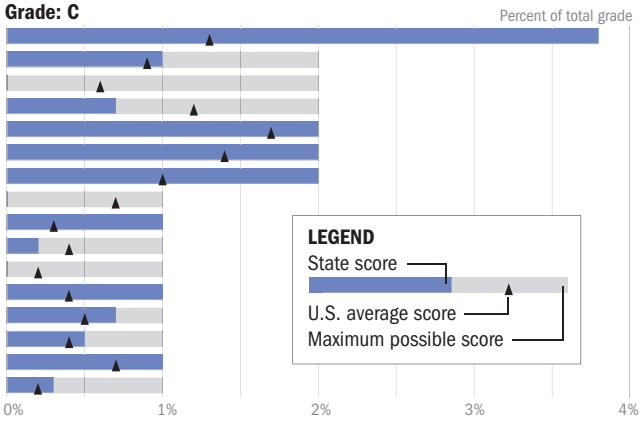
The mental health system in Mississippi is outdated and outmoded. Although services such as ACT, IDDT, and supportive housing may seem expensive, they are far less expensive than the cumulative cost of unnecessary hospitalizations, incarceration, or homeless services.

Dramatic change and tangible progress, rather than plans and promises, are needed in Mississippi. Acknowledging that problems exist and identifying solutions are the first step towards fixing a non-existent or badly broken mental health system, and Mississippi's new DMH leadership appears genuinely committed to taking the right steps. However, leadership from the governor and legislature, political will, and adequate investment will be vital to any possible future success in Mississippi.

NAMI Score Card: MISSOURI — Grade: C

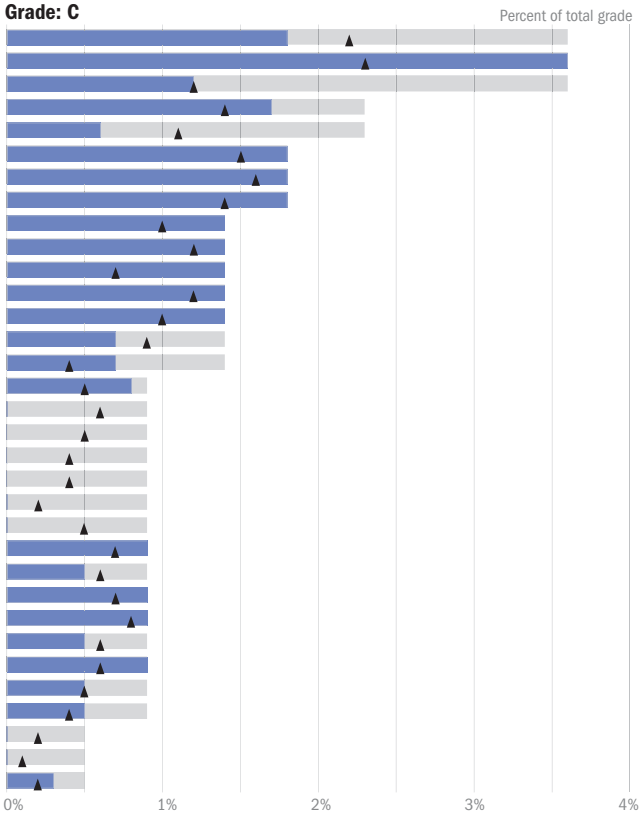
Category I: Health Promotion & Measurement — Grade: C

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



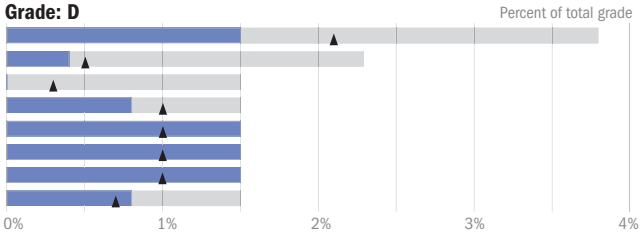
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



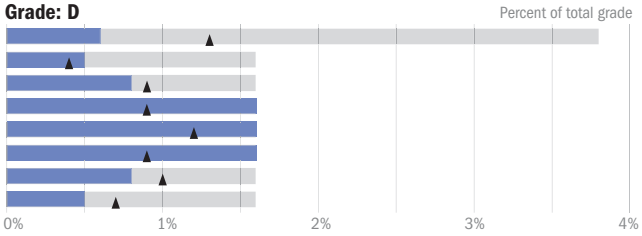
Category III: Consumer & Family Empowerment — Grade: D

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Missouri

Innovations

- ACT
- Clinically driven prescription feedback
- Telemedicine expansion
- Transformation grant for consumer and family involvement

Urgent Needs

- Address growing uninsured population
- Department of Mental Health management of state hospital beds
- Beds in hospitals, not jails
- Housing and community supports

Consumer and Family Comments

- *"The best thing is the doctors and the availability of medicines."*
- *"MidMo is vastly overcrowded."*
- *"I drive one and a half hours to see the doctor."*
- *"Peer support groups in my area would be extremely helpful."*

In 2006, Missouri received a grade of C. At the time, the state had cut its Medicaid program and mental health care systems to the bone. Three years later, the state also receives a C; but, in many respects, the overall situation seems worse.

Missouri eliminated more than 100,000 people from Medicaid rolls in 2005 and 2006. Since then, no adults have had their insurance restored, and early efforts in managed care have resulted in cuts to mental health provider rates. Governor Jay Nixon, elected in 2008, has been interested in reversing the 2005 cuts, but state budget pressures present a daunting challenge.

Nonetheless, since 2006, some important, positive developments have occurred. The state has established five Assertive Community Treatment (ACT) teams—making it one of the last states to implement an evidence-based practice developed more than 25 years ago. Obviously, five teams fall well short of the total need, but they do represent a step forward. A federal transformation grant has brought consumers and family members into the process of improving the system.

Access to mental health professionals—in particular, psychiatrists—is a major concern. The state's nascent efforts to develop telemedicine are also welcome. The Medicaid pharmacy program continues to offer sensible, clinical data that are driving efforts to improve prescription practices.

Police Crisis Intervention Teams (CIT) and jail diversion are strong in Kansas City and St. Louis but sorely lacking across the rest of the state—although the state has started to invest in expanding CIT. Missouri also has shown leadership in reducing the use of restraints and seclusion, clinical approaches to reducing pharmacy expenses, and studying and addressing causes of premature death among consumers.

Access to care is a persistent and severe problem; in this regard, Missouri is the definition of a system under too much strain.

The Department of Mental Health (DMH) reports it does not have control over who is admitted and discharged from its public long-term beds. Obviously, the DMH needs such authority to allocate resources when the system is being stretched. Despite tremendous demand for beds, the state has announced plans to privatize a portion of Western Missouri Mental Health Center to Truman Medical Centers, a private institution. No new beds are planned as part of the change; 25 existing beds will simply move to the private ledger beyond state control. Privatization removes a level of protection for a vulnerable population in two ways: reducing beds for involuntary commitments and potentially losing an important, long-term resource. Private hospitals have eliminated psychiatric beds in Missouri in the past, and this could certainly happen again.

The access crisis also extends to Middle Missouri Mental Health (MidMo) Center, the state facility in Columbia, which is frequently full. People in need of admission are frequently put on "diversion" to St. Joseph Health Center, a hospital that is several hundred miles away. This results in either long, excruciating waits for individuals needing hospitalization or long rides— often in handcuffs—making family visits a challenge. Overuse of nursing home beds is another symptom of the problem. The bed pressure is related directly to the lack of community resources, housing, providers, and residential supports in the state.

Missouri is the recipient of a federal transformation grant and can be commended for its desire to transform its mental health care system and openness to new ideas. Unfortunately, the state's delivery is not matching its vision, and in some cases, it is creating its own problems.

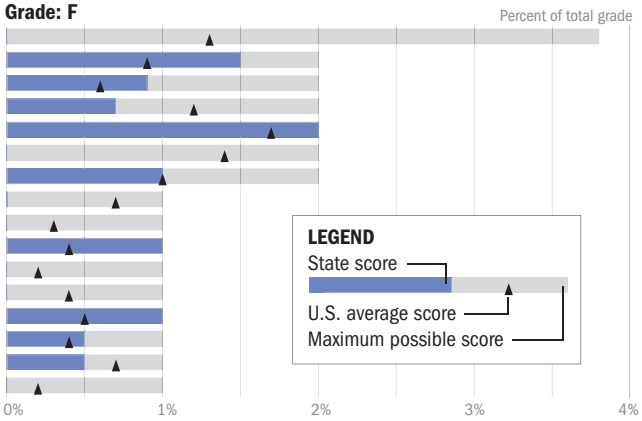
NAMI Score Card: MONTANA

Grade: D

Category I: Health Promotion & Measurement

Grade: F

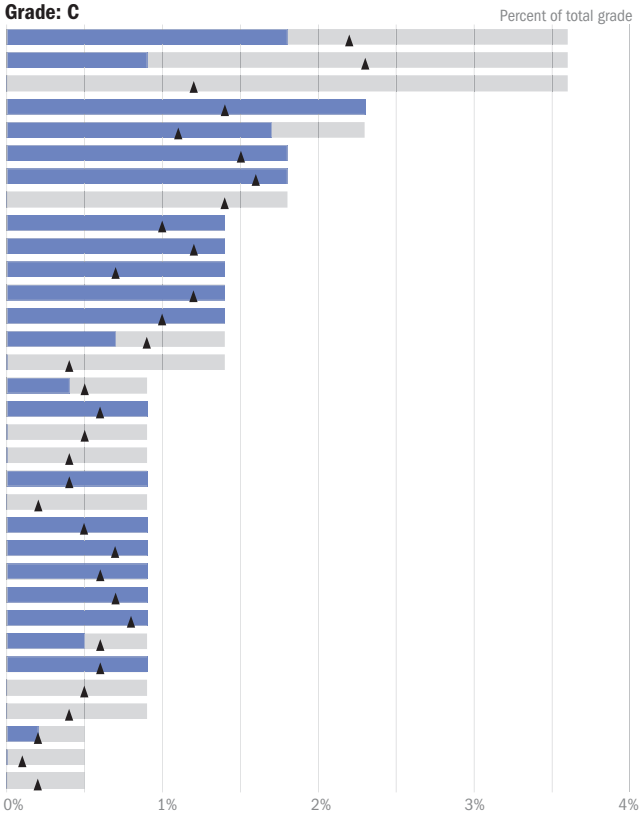
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

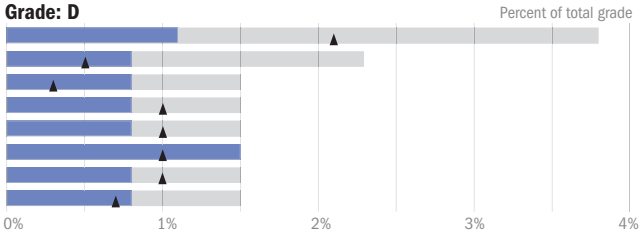
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

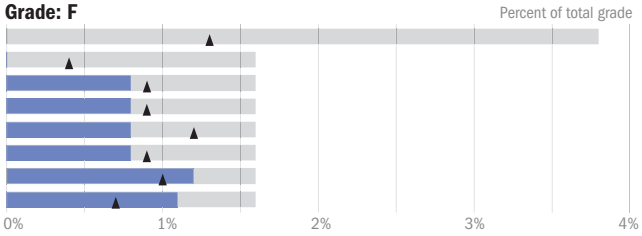
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: F

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Montana

In 2006, Montana received an F grade. Three years later, it has advanced to a D. For a rural state with a low population and relatively low per capita income, it demonstrates that progress is possible. In fact, Montana has the distinction of providing the highest degree of Assertive Community Treatment (ACT) among frontier states.

But difficult challenges remain. Montana has the highest suicide rate in the nation, and lack of an adequate professional workforce remains a limiting factor in the state's ability to strengthen mental health services.

The addition of 24 private inpatient beds at St. Peter's Hospital will help address the overall bed shortage that has plagued the state for years. The state also guarantees up to 72 hours of care to every person who needs it, regardless of insurance status.

Montana fosters collaboration among providers, consumers, and family members within its mental health system. The culture of collaboration is expanding to mental health care in the criminal justice system and represents an acknowledgement that criminalization of mental illness is a major problem.

Availability of ACT continues to be exemplary—six teams in a sparsely populated state are, proportionally, a national model.

The Montana National Guard developed a pilot program to check soldiers for signs of posttraumatic stress disorder (PTSD) every six months for the first two years after return from combat, then once a year thereafter. During the 2008 election campaign, after meeting with Montana advocates, then presidential candidate Barack Obama promised a national expansion of the program.

The state also is working to develop an electronic records system—an indication of vision, as well as progress.

The system still has a long way to go. The state moved to address overcrowding at Montana State Hospital in 2008, but the census indicates it is at full capacity. This speaks to the need for greater community-based mental health services.

Cultural competence and lack of inclusion in the system are a weakness. In 2006, Montana enacted a law to protect tribes from Medicaid changes, but it is too early to assess the impact.

Innovations

- Expansion of ACT
- Increase in inpatient psychiatric beds in Helena
- Access to short-term inpatient care, regardless of insurance

Urgent Needs

- Address workforce shortage
- Solutions to overcrowding at Montana State Hospital
- Community housing and crisis services

Consumer and Family Comments

- *"Doctors are good . . . but don't last very long."*
- *"The development of ACT teams is the best thing that has happened in Montana."*
- *"There is a lack of culturally competent therapists."*
- *"At present, when there is a need for transport, the patient is handcuffed and taken to the hospital in a sheriff's squad car, like a criminal."*

The Montana Law Enforcement Academy has worked to expand police Crisis Intervention Teams (CIT) throughout the state. Jail diversion also is needed.

The state supports a comprehensive suicide prevention plan backed by funding, but prevention efforts will need to be sustained over time. The urgent need for a professional workforce is illustrated by the recent retirement of one psychiatrist in Missoula—there was no other doctor to whom he could refer 600 patients. The federal government recently designated Missoula a health professional shortage area. The state still needs a comprehensive plan to recruit, train, and retain mental health professionals.

Consumer-run programs are in their infancy, but provide an opportunity for workforce development through which the state could position itself as a leader. Six programs are currently in development.

Having elevated its grade from an F to a D, Montana's key challenge is to keep moving forward. Unfortunately, moving into 2009, Governor Brian Schweitzer proposed cuts to community services, correctional mental health care, and Montana State Hospital. Such cuts are ill-timed and ill-considered.

Leadership, political will, and investment are needed. Now is not the time to retreat.

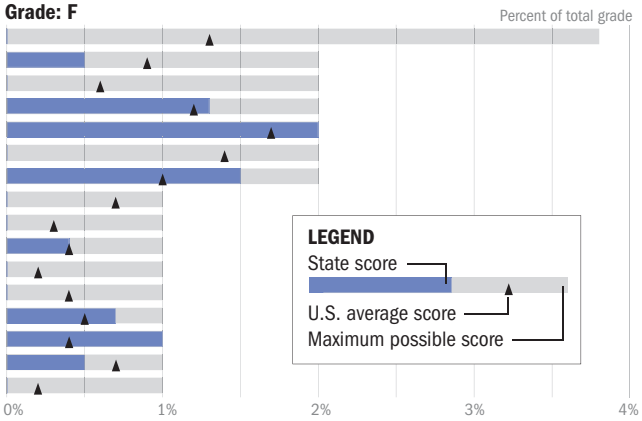
NAMI Score Card: NEBRASKA

Grade: D

Category I: Health Promotion & Measurement

Grade: F

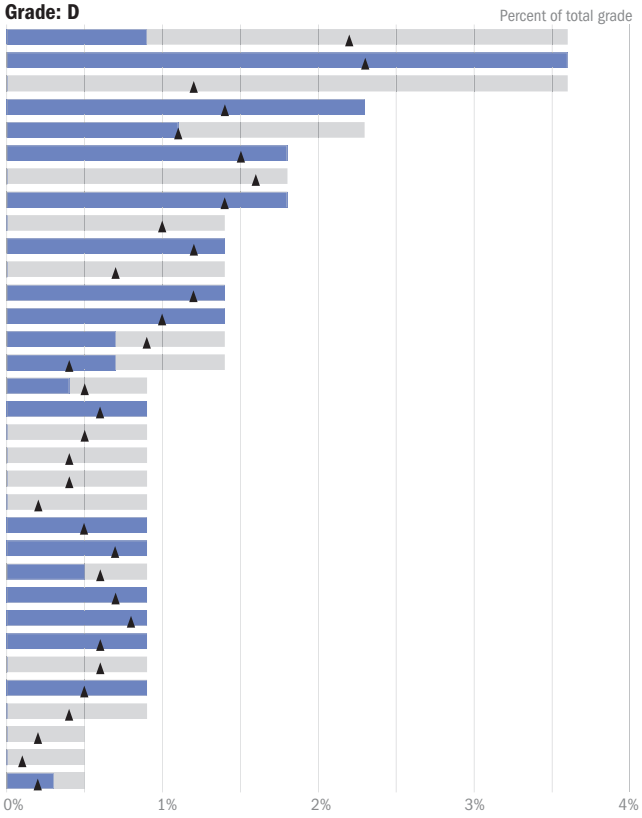
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

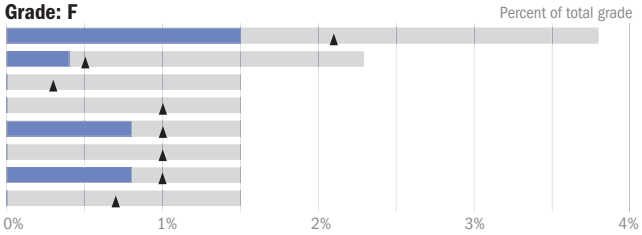
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: F

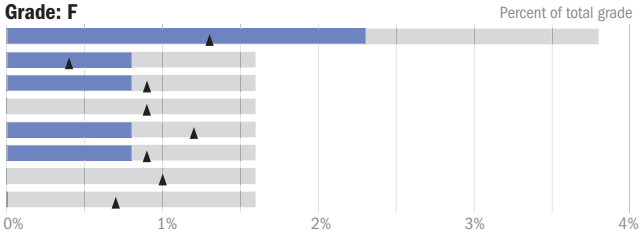
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: F

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Nebraska

Innovations

- Behavioral Health Reform oversight committee
- "Coercion Free Nebraska" restraint and seclusion reduction initiative
- Supported housing
- Promotion of consumers as peer specialists

Urgent Needs

- Integrated dual diagnosis treatment
- Cultural competence
- Jail diversion
- Workforce development

Consumer and Family Comments

- *"Nebraska is slow at making changes in the mental health system."*
- *"It takes a long time to start seeing a doctor or a therapist. The wait list is very long."*
- *"There is an extreme lack of available services in our rural area, which is the Panhandle of Nebraska. People must travel long distances for services up to 100 miles one way."*
- *"More cultural competency workshops and trainings need to be provided so workers can be more effective."*

In 2006, Nebraska's mental health care system received a D grade. Three years later, it again receives a D. There is progress, but not enough to raise the state's grade.

The Department of Health's Division of Behavioral Health (DBH) oversees mental health, substance abuse, and gambling services. It provides funding, oversight, and technical assistance to six local Behavioral Health Regions, which contract with local programs to provide services.

In 2004, the state set out to redesign its mental health care system from one centered on institutional care to community-based services with evidence-based practices (EBPs). The Behavioral Health Reform initiative is an ambitious and positive undertaking. Changes are underway and progress is evident, but substantial challenges and gaps in services remain.

Three Assertive Community Treatment (ACT) teams and a "clubhouse" certified by the International Center for Clubhouse Development exist in the state. Since 2006, supported housing has increased annually, and supported employment is available in much of the state. The state provides mental health services to National Guard members and their families.

Another positive effort is the statewide development of mobile crisis teams.

Consumer involvement and leadership is increasing. Each region employs a regional consumer specialist to implement consumer initiatives. Trained peer facilitators serve as staff members in a variety of treatment programs, including assistance to consumers in developing Wellness Recovery Action Plans (WRAP). Consumer and family teams monitor conditions at the two state hospitals—and the hospitals are reducing use of restraints and seclusion.

DBH is also collaborating with the Nebraska Coalition for Women's Treatment on a "Trauma Informed Nebraska" to oversee the development and implementation of statewide, consumer-driven, recovery-oriented, trauma-informed mental health services.

As a large, predominantly rural state, Nebraska has great variations in access to community mental health services. EBPs are becoming available in the most populated areas but are largely absent elsewhere. No evidence-based, integrated dual diagnosis treatment programs exist. The state has received federal grants to plan and implement a Crisis Intervention Team (CIT) program and in the future expects to make CIT more widely available, including in rural areas. However, it has only two jail diversion programs and no mental health courts.

Workforce development challenges exist. DBH recognizes the need for workforce planning and expects to develop a statewide workforce plan that will address shortages in the rural areas. However, DBH lacks a strategy to address cultural competence issues, although some regional efforts exist.

The Behavioral Health Reform initiative is starting to make progress toward creation of a community-focused, recovery-oriented, evidence-based system, but needs to address co-occurring disorders, workforce development, criminal justice issues, and cultural competence. Nebraska still has a long way to go. Nonetheless, the initiative is commendable. Continued leadership, political will, and investment will be essential to fulfill its promise.

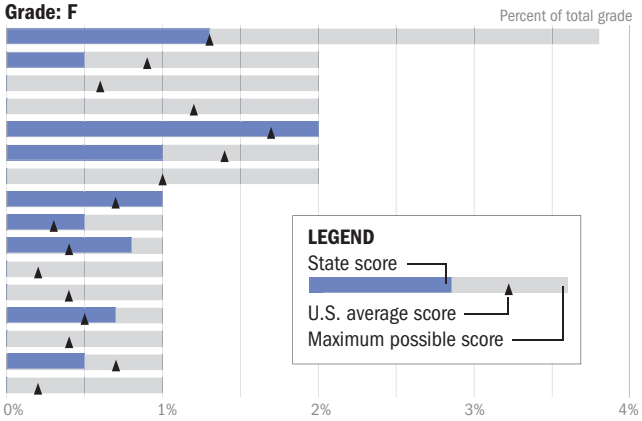
NAMI Score Card: NEVADA

Grade: D

Category I: Health Promotion & Measurement

Grade: F

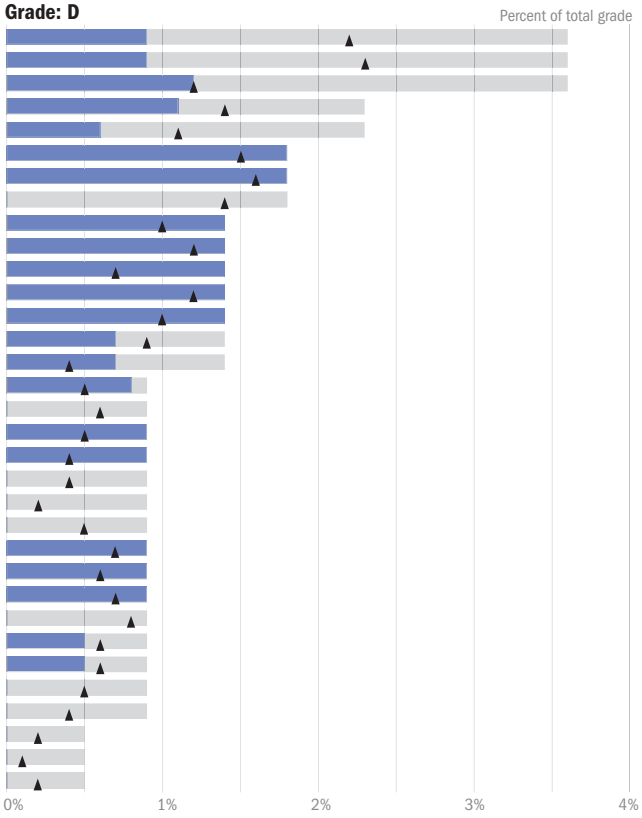
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

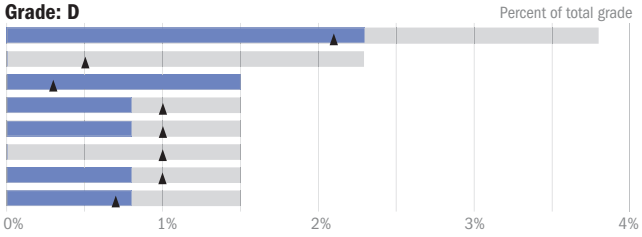
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

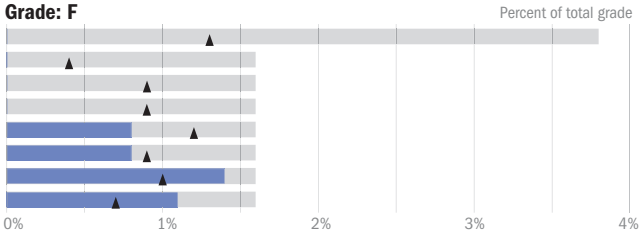
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: F

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Nevada

Innovations

- Transparency
- Urgent walk-in clinics and medication clinics
- Mental health courts

Urgent Needs

- Restore inpatient staffing
- Increased capacity for case management, medications, and therapy
- Supportive housing options

Consumer and Family Comments

- *"Southern Nevada Adult Mental Health Services is the Mental Health Agency that serves my family member. . . The wait can be as long as five hours in a tiny lobby."*
- *"The lack of mental health care in rural areas of the state . . . It is simply inaccessible."*
- *"The best thing is that Las Vegas has mental health courts. The illness is treated through the probation officer, the therapist, the mental health case worker, and the psychiatrist all working together."*

In 2006, Nevada's mental health care system received a D grade. Three years later, the grade remains the same. The state's citizens deserve far better.

Nevada has struggled to keep pace with population growth and demand for mental health services. Demand has grown most rapidly in the Las Vegas area. Tourism drives the state economy, and economic distress hits earlier and harder than in other states.

Although the state legislature increased mental health funding in previous years, over $20 million in cuts in 2008 and an $11 million cut in 2009 have resulted in closures of clinics, reduced services, and staff cuts in state hospitals and outpatient care. Deeper cuts are anticipated. The governor's biennial budget for 2010-2011 has proposed additional cuts of 10 percent or more.

Three state agencies, Rural Clinics (RC), Northern Nevada Adult Mental Health Services (NNAMHS), and Southern Nevada Adult Mental Health Services (SNAMHS) provide most of the state's non-Medicaid community mental health services. They are part of the Division of Mental Health and Developmental Services in the Department of Health and Human Services (DHHS). RC serves 15 counties through a series of satellite clinics, while SNAMHS, which has a number of clinics and a centralized hospital, serves the state's major urban areas. NNAMHS, which evolved from a state hospital, provides an array of inpatient and outpatient mental health services. Medicaid-funded services are largely delivered by providers under contract with the Division of Health Care Financing and Policy (DHCFP) in DHHS.

Nevada's efforts to increase investment in the system prior to 2008 deserve some degree of praise, as does the transparency of its system in identifying serious needs. Its biennial needs assessment, for example, provides helpful information on the mental health care system, including spending comparisons and unmet community needs. This transparency is important, as Nevada's growth has led to significant stresses on the system, which is particularly evident in the large number of people with mental illness seeking help in emergency rooms. In response, the legislature funded the new Rawson-Neal Psychiatric Hospital in Las Vegas, which opened in 2006. This acute care facility, coupled with a new urgent walk-in clinic model, provided needed relief for local emergency departments.

Nevada has also established Assertive Community Treatment (ACT) teams, medication clinics, and recovery-focused clubhouses and certified peer specialists. These and other positive developments, such as mental health courts, where preliminary outcomes data show remarkable success in reducing jail days, need to be sustained.

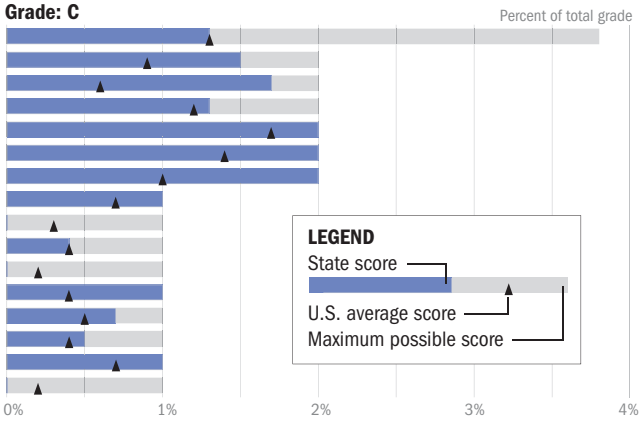
Nevada's greatest challenge is to adequately fund mental health services, including supportive housing. It also needs to develop culturally competent services. Nearly 40 percent of Nevada's population is ethnically or racially diverse, yet Nevada's cultural competence plan lacks evidence of implementation or progress.

In a state with high rates of severe depression and other serious mental illnesses—as well as suicides—a strong commitment is needed to restore and expand the mental health safety net. Without one, Nevada will find its emergency rooms and criminal justice system overwhelmed—and costs being shifted to other sectors of state and local government.

NAMI Score Card: NEW HAMPSHIRE — Grade: C

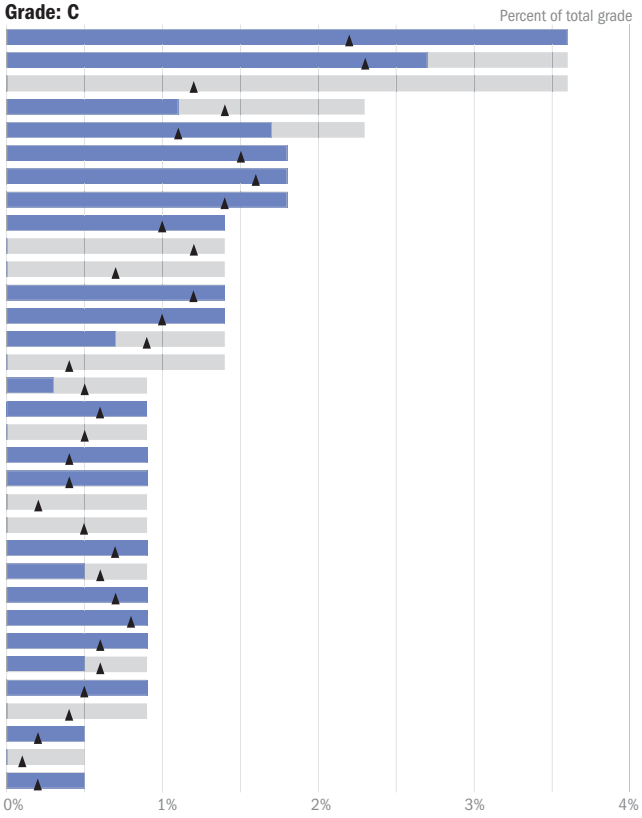
Category I: Health Promotion & Measurement — Grade: C

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



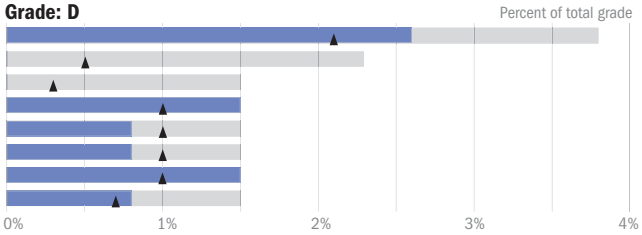
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



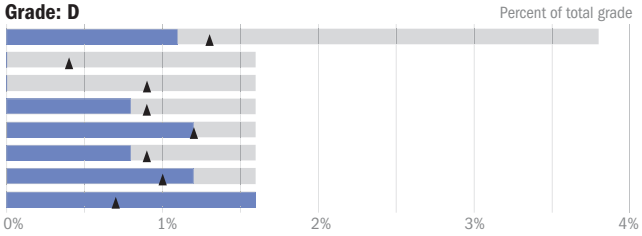
Category III: Consumer & Family Empowerment — Grade: D

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



New Hampshire

In 2006, New Hampshire's mental health care system received a grade of D. This came as a surprise to many, who had long considered the state a frontrunner nationally. Three years later, the state receives a C, but budget shortfalls threaten to undo this modest advance.

In 2005, New Hampshire's legislature created a commission that brought together the Bureau of Behavioral Health (BBH), legislators, providers, consumers, and families. The BBH and Commission's process restored lines of communication between stakeholders and advocates, who now feel they are included in addressing concerns. This sense of renewal, combined with BBH's commitment to gathering and using data to drive decision-making, are hopeful signs.

New Hampshire also is doing well with involving consumers in its mental health service system. There are peer support sites located in each of the 10 mental health regions in the state. In December 2008, the University of New Hampshire published results from a Public Mental Health Consumer Survey Project, which reflects the changing culture and consumer involvement (see www.iod.unh.edu/pmhs.html).

Overall, New Hampshire is aligning its Medicaid system to support evidence-based practices. Access to modern services has improved since 2006, but much more is needed. For example, illness management and recovery programs developed locally at Dartmouth University served 591 individuals in 2007 and 1,416 in 2008—an improvement to be sure, but a long way from universal access. Supported employment, also developed at Dartmouth, reached only 697 people. Such cost-effective models deserve better funding.

Hospital beds are a central concern in New Hampshire. The state population is increasing, and the number of psychiatric beds is decreasing. The state hospital in Concord is overtaxed. Admissions have increased 69 percent since 2000. Shortages of community resources add to the pressure—from 1990 to 2008, the state reports that the number of community voluntary beds declined from 236 to 186 (21 percent). For involuntary admissions, the number of available community beds declined from over 100 to just eight during the same period. In spite of this pressure, the state hospital has been successful in reducing use of restraints and seclusion.

Ten non-profit community mental health agencies funded by the state provide treatment and services and are facing the same demographic and financial pressures. They will not receive rate increases in 2009. All aspects of the system face chronic workforce shortages.

Rising housing costs make affordable housing difficult for consumers to find. As people go without adequate shelter or treatment, criminalization of mental illness becomes more of a concern. To address this, jail diversion requires more attention. But to succeed, community mental health services must be available.

New Hampshire is fostering a culture of consumer- and family-centered services. It is using a federal grant to implement a person-centered treatment planning approach in delivery of services that increases consumer and family involvement in preparing treatment plans. Wellness also is emerging as part of the culture. Monadnock Family Services in Keene has pioneered "In Shape," a proactive, preventive self-care model that could significantly address the mortality and morbidity crisis among people with serious mental illnesses. Another federal grant is allowing the state to add physical health to illness management and recovery. New Hampshire is poised to become a leader on preventable cardiac deaths but is not there yet.

New Hampshire's grade C this year could be a new beginning, but it depends on whether state leaders have the political resolve to invest in building a modern, cost-effective system. If not, then recent progress may be no more than a brief respite from a much longer fall in status.

Innovations

- Telemedicine
- Statewide planning process based on collaboration and inclusion
- "In Shape" proactive, preventative self-care model

Urgent Needs

- Inpatient beds
- Housing
- Reduce mental health workforce shortage
- Jail diversion programs

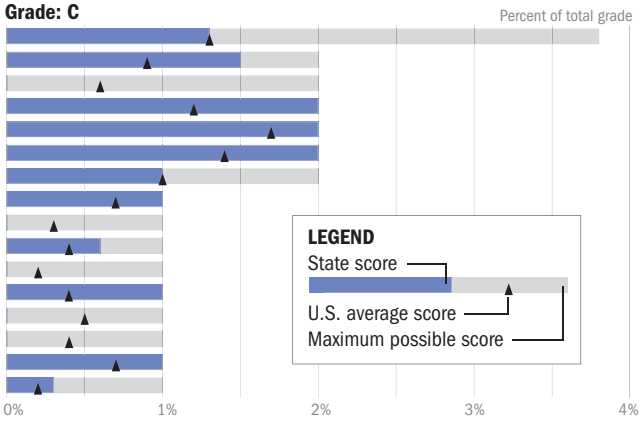
Consumer and Family Comments

- *"My daughter was released from a psychiatric hospital—it was six weeks before she could begin her community-based appointments with psychiatrists and talk therapists. A lot of ground was lost."*
- *"We don't feel that a person should have to become 'homeless' to receive a higher level of care."*
- *"Peer Support Agencies have 'warm lines' that you can use to keep a situation from becoming a crisis, and I use it all the time."*

NAMI Score Card: NEW JERSEY — Grade: C

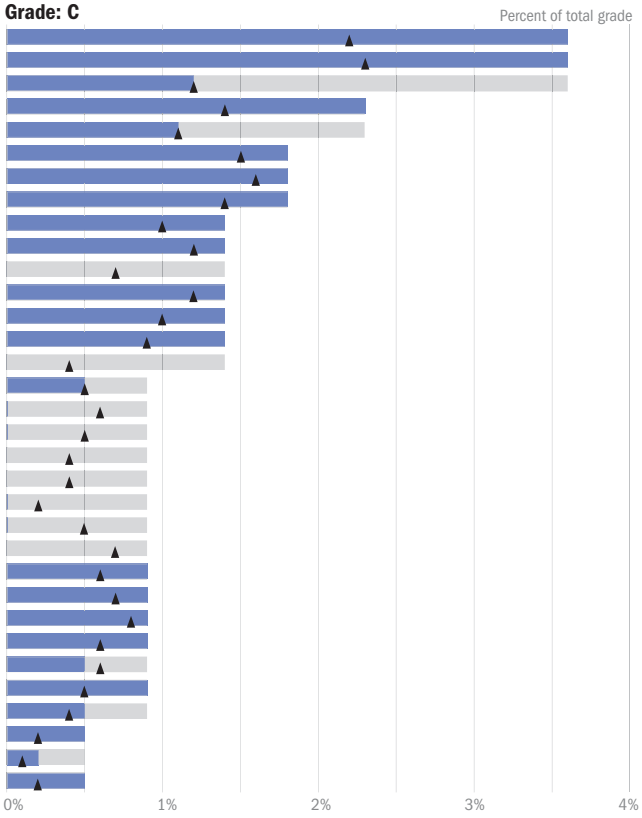
Category I: Health Promotion & Measurement — Grade: C

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



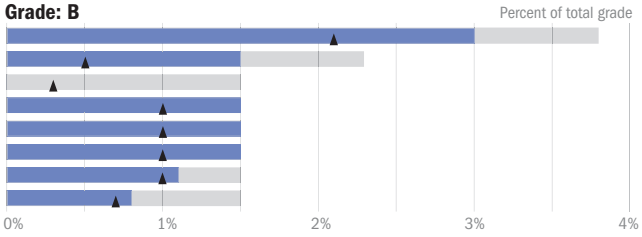
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



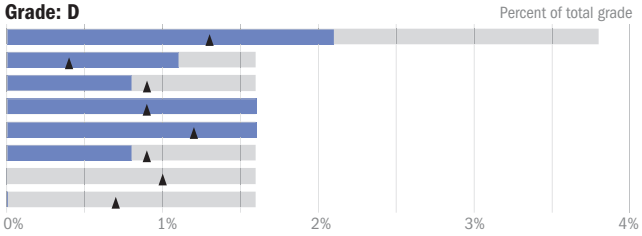
Category III: Consumer & Family Empowerment — Grade: B

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



New Jersey

Innovations

- Strong executive and legislative commitment
- Evidence-based practices such as ACT and supportive housing
- Peer-run services and peer supports

Urgent Needs

- Resolve civil rights and safety issues in state hospitals
- Invest in services for people with co-occurring disorders
- Statewide implementation of jail diversion and community reentry programs

Consumer and Family Comments

- *"The worst thing is that there is no relief for those who get criminal charges because of their mental illness."*
- *"The system is trying to change to a wellness approach, and it is very open to consumers' opinions."*
- *"The hospital system can be somewhat brutal and is in desperate need of overhaul. The Ancora model may be a big waste of resources and is not serving the consumers. [It is a] giant unmanageable warehouse."*

In 2006, NAMI credited former Acting Governor Richard Codey for leadership in improving services for people with serious mental illnesses. Improvements have continued under Governor Jon Corzine; however, all is not rosy in the Garden State. Its mental health care system is still inadequate, and its C grade has not changed from three years ago.

Inpatient psychiatric hospitals are overcrowded and unsafe, and there are not enough community-based services. Although the state legislature has increased funding for the public mental health system in recent years, it has not been enough to meet service needs in a state where housing and cost-of-living are among the highest in the nation.

New Jersey is committed to implementing evidence-based practices in its community mental health system. Assertive Community Treatment (ACT) is available in all of the state's 21 counties. Progress on expanding supported housing has continued under the leadership of Kevin Martone, the new Assistant Commissioner of the Division of Mental Health Services (DMHS).

New Jersey also supports peer-run services. Self-help centers have been established in all 21 counties, and a new center at Ancora Psychiatric Hospital is one of the first programs of its kind nationwide in a state hospital.

DMHS supports 12 small jail diversion programs throughout the state and awarded a $250,000 grant to Camden County to help launch the state's first Crisis Intervention Team (CIT). The program has proven so successful that the division is providing "knowledge dissemination" and programmatic support to create similar programs elsewhere.

Notwithstanding this progress, serious problems exist, particularly in Ancora, the state's largest psychiatric hospital. It is the focal point of concerns about safety and civil rights violations.

According to news media, six deaths have occurred at Ancora since 2006. Nearly 1,500 assaults on patients by staff or other patients occurred in 2007 alone. Nine of 11 psychiatrists have been beaten on one unit at the hospital. Smuggling and sale of drugs and contraband by staff to patients also is common. The U.S. Department of Justice is considering conducting an investigation of treatment and conditions at the hospital. The state has taken preliminary steps to address the problems, including negotiating contracts with other hospitals to reduce the patient census, along with improvement of security and safety measures.

To his credit, Governor Corzine has expressed personal concern about Ancora's severe problems and made unannounced visits on several occasions. However, the ultimate answer lies in increasing staff training at state hospitals and developing community-based alternatives for those persons ready for placement in less restrictive settings.

In 2005, the advocacy group "Disability Rights New Jersey" filed a lawsuit alleging that hundreds of people remain in state psychiatric hospitals because suitable community residential and service programs are not available. The lawsuit is still pending.

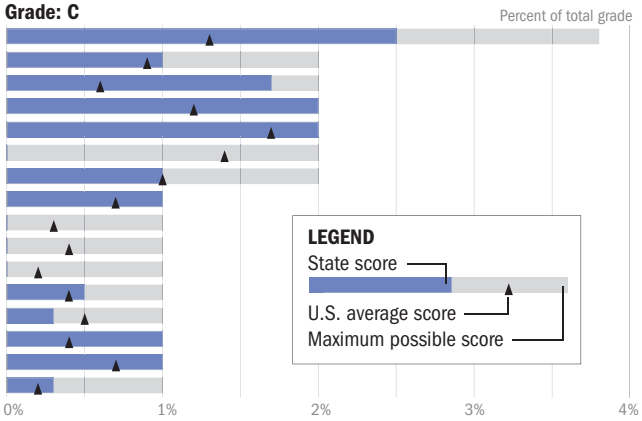
New Jersey must solve the problems in its hospitals in order to provide truly therapeutic environments. The state's success in closing the antiquated Greystone Psychiatric Hospital in Morris County, and replacing it with a new state-of-the art facility, shows that progress is possible. At the same time, the state must continue to develop community-based housing and services, particularly co-occurring disorders services. New Jersey has struggled to maintain adequate numbers of acute care psychiatric beds in recent years, as many community hospitals have eliminated their psychiatric inpatient units. Investing in these services sooner, rather than later, ultimately leads to cost-savings, and most importantly, saves lives.

New Jersey has much promise. Political leaders who care, educated and often affluent residents, and innovative DMHS stewardship provide the potential for a state-of-the-art public mental health system. However, daunting challenges must be overcome before promise can become reality.

NAMI Score Card: NEW MEXICO — Grade: C

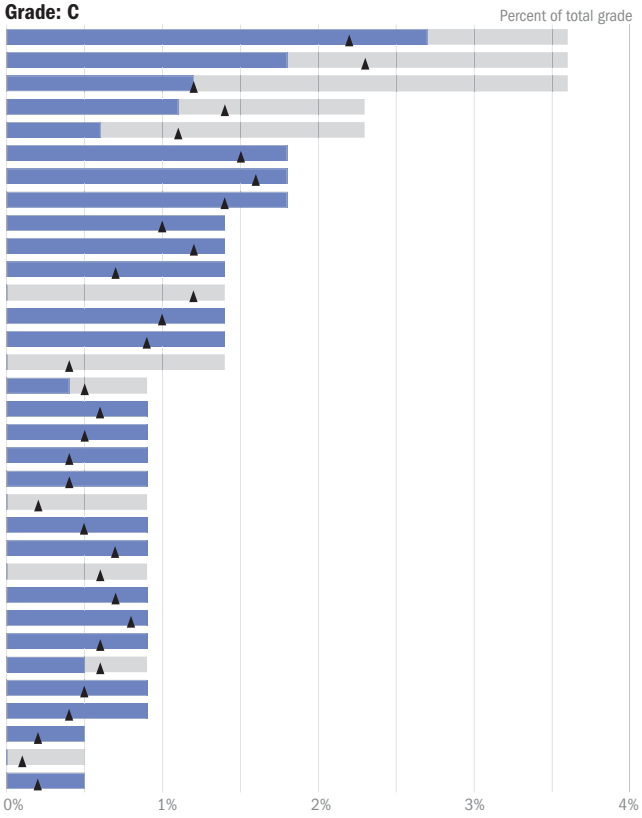
Category I: Health Promotion & Measurement — Grade: C

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



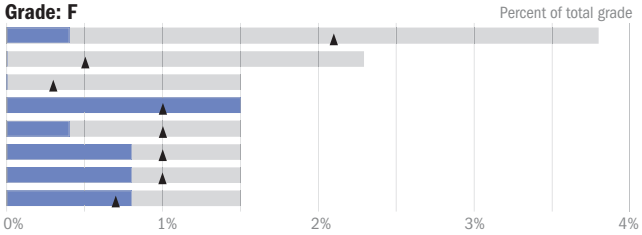
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



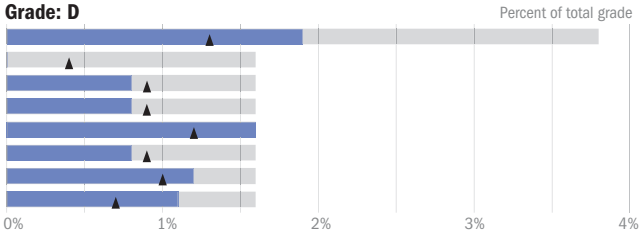
Category III: Consumer & Family Empowerment — Grade: F

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



New Mexico

In 2006, New Mexico's mental health care system received a C. Three years later, its grade has not changed.

In 2005, New Mexico embarked on a five-year effort to restructure its mental health system. Seventeen state agencies involved in financing mental health and substance abuse services were combined into a Behavioral Health Purchasing Collaborative, which then contracted with ValueOptions to provide them. The goals of this sweeping reorganization were to simplify and streamline services, reduce bureaucracy, and facilitate oversight and accountability, while at the same time promoting recovery.

The Collaborative has the potential to become a national model, but so far, it is potential only.

Some progress has been made. For example, 22 programs in the state have provided integrated dual diagnosis treatment for people with co-occurring disorders, and the state is working to promote co-occurring competency with a variety of providers. These efforts extend to the state's drug courts, which historically have not been sympathetic to people with co-occurring disorders. A federal grant has financed expansion of these services, but the grant will soon end. State funding will be necessary to sustain these gains.

Efforts are also underway to expand evidence-based practices such as Assertive Community Treatment (ACT), supported employment, and illness management and recovery.

New Mexico has approximately 30 consumer-run programs, an impressive number for a relatively sparsely populated state. It also is commended for efforts to provide an array of mental health services and supports for veterans of the wars in Iraq and Afghanistan, and their families.

Still, major problems and gaps in services exist. In many parts of the state, particularly rural regions, services are not available at all. Consumer- and family-friendly, comprehensive mental health services and supports exist more in principle than reality.

Good data collection and outcomes measurement are essential for states to identify service gaps and meet consumer needs. Unfortunately, New Mexico lacks that kind of information. The state was unable to provide any information about the number and types of inpatient psychiatric beds in response to the survey for this report. Additionally, New Mexico has no Olmstead plan, stating that "all was done to meet Olmstead requirements." Given statewide gaps in services, the lack of a written Olmstead plan, with measured outcomes, suggests that New Mexico has not done all it can to meet the spirit, if not the actual requirements, of the U.S. Supreme Court's 1999 Olmstead decision.

New Mexico has stated that services for individuals with mental illnesses who reenter communities after incarceration are a priority but has not modified policies to suspend, rather than terminate, Medicaid benefits while incarcerated. As a result, individuals must reapply for Medicaid benefits upon release, which can lead to long delays in getting needed treatment and services. In addition, the state also restricts access to antipsychotic medications through a preferred drug list under the Medicaid program.

Last, but certainly not least, in a state with such a culturally diverse population, New Mexico is progressing slower on developing culturally competent services than many other states.

Overall, New Mexico is trying to move in the right direction. The Collaborative's leaders are working hard to engage as many consumers and families as possible throughout the state to design a mental health care system that works. But the current system has many holes in it. Lack of funding, major shortages in services, and difficulties in serving people in isolated, rural regions are significant problems. Today, three years into the Collaborative experiment, the jury is still out whether it will lead to real improvements and expansion of services oriented toward recovery.

Innovations

- Services for co-occurring disorders
- Funding mental health services for returning veterans and their families
- Consumer-run services and peer supports

Urgent Needs

- Close gaps in services, particularly in rural regions
- Culturally competent services and providers
- Develop good data and outcomes measurement
- Provide unrestricted access to psychiatric medications

Consumer and Family Comments

- *"The worst thing about the public mental health system is the lack of funding for community-based services."*
- *"Even though it may not be a perfect outcome, the state is trying to transform our mental health system. They are doing something instead of doing nothing and letting the status quo remain the same."*
- *"There simply are not enough qualified caring providers to treat patients that only have Medicare/Medicaid or no insurance at all."*

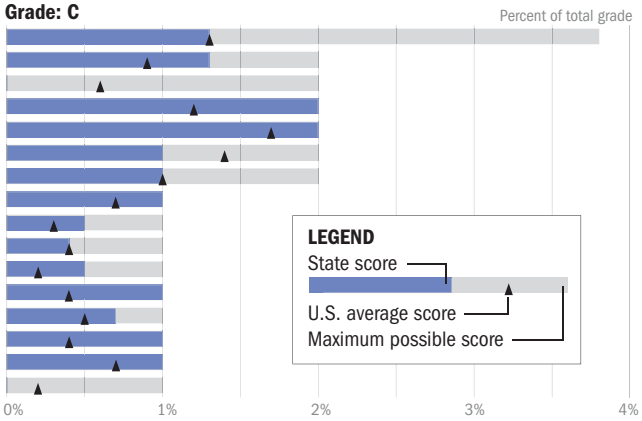
NAMI Score Card: NEW YORK

Grade: B

Category I: Health Promotion & Measurement

Grade: C

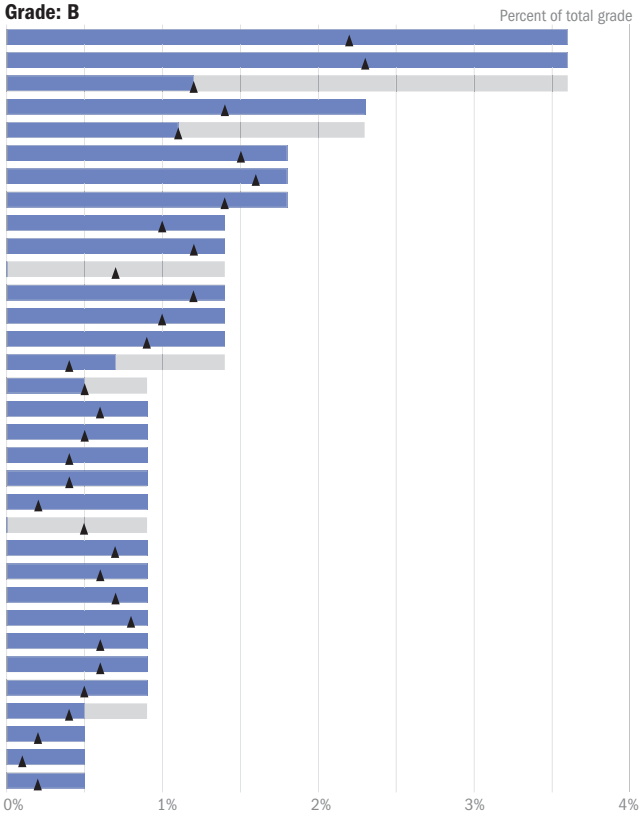
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: B

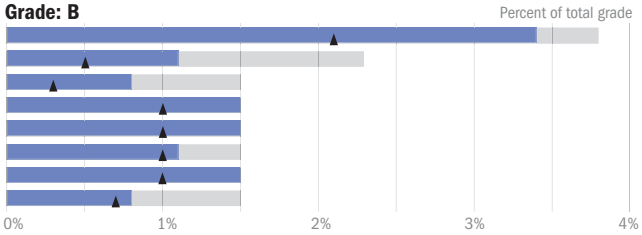
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: B

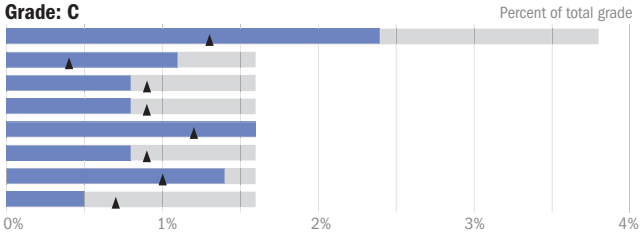
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: C

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



New York

Innovations

- Progress on evidence-based practices
- Mental health parity
- "Housing First" model

Urgent Needs

- Acute care and crisis beds
- Housing
- CIT programs

Consumer and Family Comments

- *"Emergency rooms at hospitals . . . It's like a nightmare and ignorance prevails with staff . . . "*
- *"No help from law enforcement agency or mental health system unless something bad happens."*
- *"Most of the providers are dedicated and very caring."*
- *"We need more housing that is safe and where they dispense the medication."*

In 2006, New York chose not to provide survey information on its mental health system, receiving a "U" grade for "unresponsive."

Three years later, the state receives a B. Despite this high grade, all is not perfect. New York has many strengths, but it also has many problems.

In recent years, the Office of Mental Health (OMH) has emphasized support for evidence-based practices. Seventy-seven Assertive Community Treatment (ACT) teams exist throughout the state. OMH also funds supported employment, peer counseling, peer education, and consumer-run programs.

Placement of large numbers of consumers in substandard adult care homes has been the subject of ongoing litigation. OMH is working to assist adult home residents to move into community-based housing linked with supportive services.

New York is also investing in housing. A recently signed agreement between New York City and the state, "New York/New York III," commits combined state and city resources to develop 9,000 housing units over 10 years. The Pathways to Housing "Housing First" model has become internationally recognized. Despite these initiatives, lack of housing is still a very serious problem.

In 2007, New York finally enacted "Timothy's Law," after a hard fought battle to achieve mental health insurance parity. Efforts are underway to expand it to include coverage of posttraumatic stress disorder (PTSD). Ironically, the state's program for the uninsured called "Healthy New York" excludes mental health services.

In 2008, another important development was the enactment of a law to limit segregation of prisoners with serious mental illnesses and instead provide them with treatment. The law should be replicated in every state.

Although still controversial among some advocates, "Kendra's Law," which authorizes involuntary assisted outpatient treatment, has resulted in fewer hospitalizations and arrests, as well as new investments in mental health services and supports.

Deficiencies exist, including severe shortages of acute care psychiatric beds and crisis stabilization programs. Confronted with dual problems of inadequate reimbursement rates and staff shortages, a number of community hospitals have recently downsized or closed psychiatric treatment units. Predictably, emergency rooms are overwhelmed with individuals in crisis with no available treatment beds.

In 2008, New York's bed crisis rose to national notoriety through a shocking video showing the death of a woman in a waiting room in Brooklyn's Kings County Hospital after waiting 24 hours for emergency psychiatric care. While lack of monitoring, failure to train staff, and lack of compassion contributed to her death, so did the lack of available psychiatric beds.

New York is surprisingly far behind many other states in developing partnerships between law enforcement and the mental health system. Only two police Crisis Intervention Team (CIT) programs currently exist.

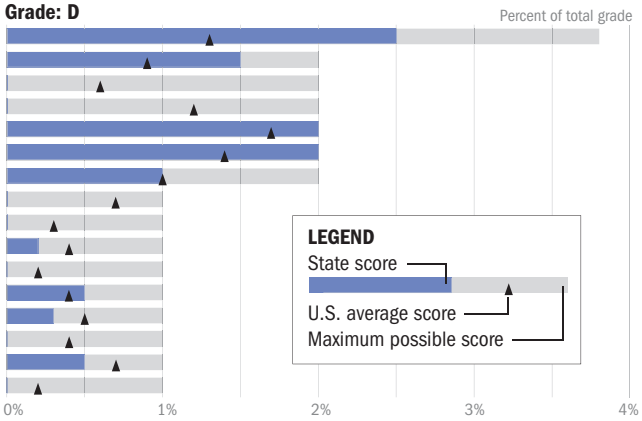
In 2009, New York's economic challenges cloud the horizon. Financial collapse on Wall Street and the recession have resulted in a $15.4 billion deficit, the largest in the state's history. Many consumers and families fear the economic squeeze could negate progress made in recent years.

New York has potential to become one of the national leaders in public mental health care. However, budget cuts, retreats, or delays in improving services will signal a faltering commitment to evidence-based, cost-effective transformation, and recovery. The next few years will be vital in setting the state's course for the future.

NAMI Score Card: NORTH CAROLINA — Grade: D

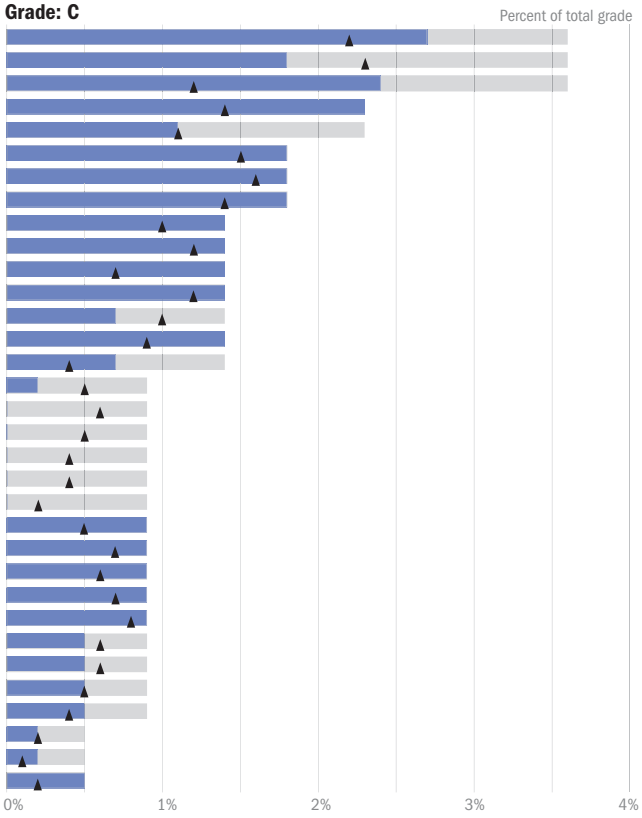
Category I: Health Promotion & Measurement — Grade: D

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



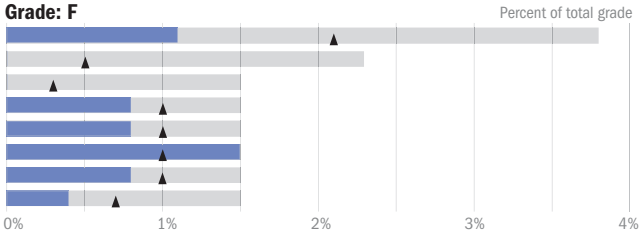
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



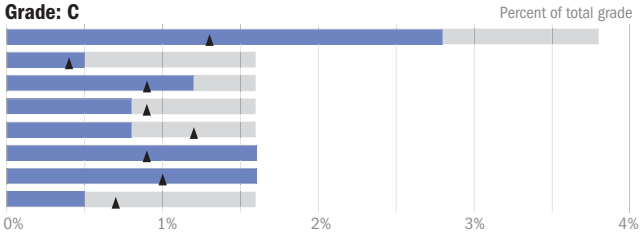
Category III: Consumer & Family Empowerment — Grade: F

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: C

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



North Carolina

Innovations

- Integrated physical and medical care pilot program
- Prescription pattern feedback
- Post-incarceration Medicaid reinstatement

Urgent Needs

- Restore confidence and order to overall system
- Improve state hospitals to enable transition to newer facility
- Restore ACT funding cuts

Consumer and Family Comments

- *"The state reorganized services several years ago . . . the psychiatrists all left the area."*
- *"The implementation of the peer support program has been the best thing since sliced bread."*
- *"It takes 24-48 hours to get a hospital bed if I need to be admitted."*
- *"Wake County has a crisis intervention program which I am grateful for."*

In 2006, North Carolina's mental health system received a grade of D. Three years later, the grade remains the same, but does not even begin to convey the chaos that now pervades the state's mental health care system.

NAMI warned three years ago that the state's reform initiatives were changing too much, too fast, resulting in an increasingly disorganized environment. This prediction was accurate. Fortunately, a change in governors in 2009 provides broader hope for the future.

Some bright spots exist. North Carolina enacted a mental health insurance parity law in 2007, a major step towards improving access to care. The state has taken jail diversion training seriously and has worked to build evidence-based practices. Assertive Community Treatment (ACT) is an acknowledged interest, although the state recently announced a seven percent cut in the program.

North Carolina has piloted granting resources to Local Management Entities (LMEs) to build local capacity, thereby reducing reliance on overcrowded state hospitals. It also has a promising pilot program that integrates mental and physical health care at four LMEs, including shared data systems and common measures to track results.

The state also gives feedback to doctors about their prescribing patterns, which is a positive development.

North Carolina certifies peer specialists and anticipates growing this area of its mental health workforce, if funding can be sustained.

Another strength is improvement in access to Medicaid for consumers who are incarcerated by suspending, rather than terminating, benefits.

North Carolina faces multiple challenges. One of the most complex changes that the state attempted was privatization of community mental health services, creating LMEs for geographic regions. After two years of billing, an auditor found that over $400 million had been wasted; another level of review subsequently found that number was overstated. Billing issues contributed to both financial and clinical disarray and coincided with the resignation of the HHS secretary.

Currently, ValueOptions manages Medicaid funding, while other state dollars go to the LMEs, resulting in more complexity and fragmentation. Essentially, there is a dual system for outpatient care.

Additionally, in 2005, the U.S. Department of Justice (DOJ) documented numerous safety concerns in North Carolina's state hospitals. Efforts to remedy those issues have not been reassuring. DOJ monitors ongoing problems at Dix and Broughton Hospitals. Cherry and Broughton Hospital in Morganton have lost federal funding due to numerous concerns.

The newly-opened Central Regional Hospital (CRH) in Butner was put on notice in 2008 that it too was at risk of losing federal funds. The loss of federal funds for Cherry Hospital is estimated to cost the state $800,000 per month.

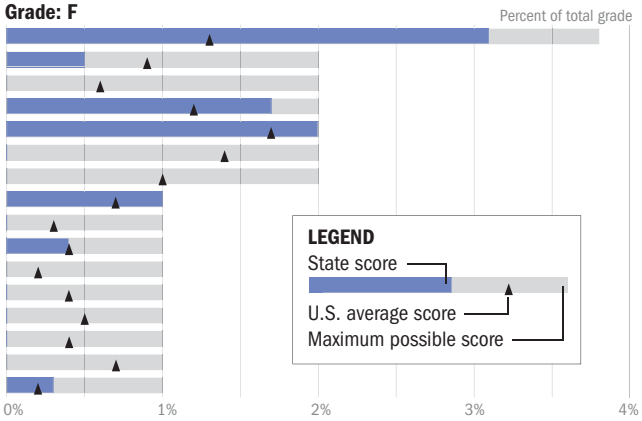
The state's plan to close Dix Hospital and transfer staff and patients to CRH has aroused numerous concerns about safety and staff training. The move has been delayed five times to date.

The new governor, Bev Purdue, inherits a complex, disorganized, and difficult legacy, but at least her charge is clear—to restore confidence and order to the system. Cleaning up the mess and improving care for the state's citizens will require leadership, political determination and involvement of the legislature, and sound investments.

NAMI Score Card: NORTH DAKOTA — Grade: D

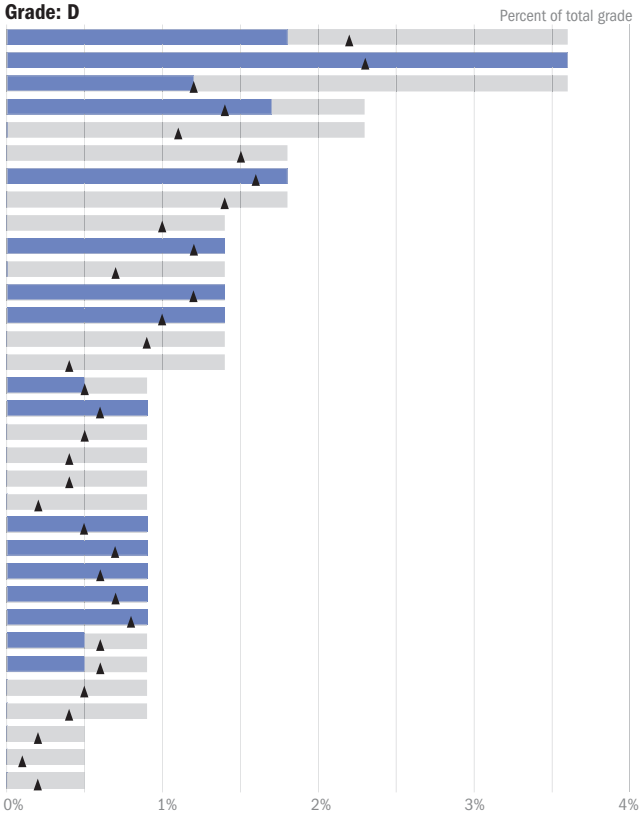
Category I: Health Promotion & Measurement — Grade: F

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



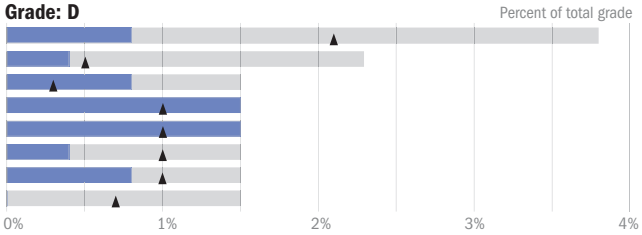
Category II: Financing & Core Treatment/Recovery Services — Grade: D

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



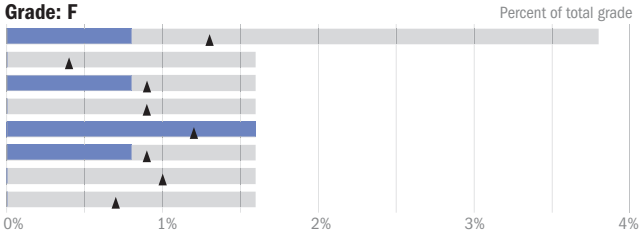
Category III: Consumer & Family Empowerment — Grade: D

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: F

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



North Dakota

In 2006, North Dakota's mental health care system received an F grade. Three years later, it has advanced to a D—a poor grade, but one that indicates the potential for steady advancement.

The Division of Mental Health and Substance Abuse (DMHSA) oversees mental health services, which are delivered through eight regional human service centers and one state hospital. North Dakota is among the nation's most rural states.

North Dakota is one of a minority of states with a budget surplus—amounting to $1.2 billion. The state is proceeding cautiously, but steadily, to adopt and adapt evidence-based practices (EBPs) in rural and frontier areas. The state's gradual approach to developing community-based services has involved extensive education and planning over the past three years.

The state has embraced evidence-based integrated dual diagnosis treatment (IDDT) based on national models. A pilot program is operating in Fargo, with plans to expand to other locations. DMHSA also expects to implement a statewide certified peer specialist initiative once it receives approval from the federal Center for Medicare and Medicaid Services (CMS).

DMHSA is implementing the North Dakota Consumer and Family Network, with peer staff in each of the eight regions, to enhance consumer involvement in policy development, education, and recovery promotion efforts. The Network will hold a statewide consumer conference in March 2009, a sign of the increased focus on recovery and consumer empowerment.

DMHSA has also obtained funds for police Crisis Intervention Team (CIT) training. CIT is being piloted in the Minot area, with expansion to other communities expected. The state is also studying the federal supported employment model.

North Dakota faces an extreme workforce challenge, but DMHSA is working with the Western Interstate Commission for Higher Education (WICHE) and the University of North Dakota to develop and support professional capacity. The state is also engaged in public education and efforts to reduce stigma, including a statewide billboard campaign as part of the federal Campaign for Mental Health Recovery.

The North Dakota Department of Human Services, the parent organization of DMHSA, employs a tribal liaison between the agency and tribal social service programs.

Innovations

- CIT and IDDT pilot programs
- Consumer and Family Network
- Peer specialists proposal program

Urgent Needs

- Implement ACT pilot programs
- Housing options
- Expand evidence-based practices

Consumer and Family Comments

- *"Desperately need more services . . . The programs are not operating appropriately due to low salaries of staff to provide the services . . . so frequent turnover and lack of support. The programs appear to be in name only."*
- *"The best thing is that services are available, and costs are prorated according to income. However, you have to be able to get to them (driving many miles), and follow-up appointments with medical personnel may be infrequent."*
- *"The state has such a small population that everyone knows someone who knows the patient . . . People here are proud and stoic and don't always seek help because of the loss of privacy involved along with the stigma of mental illness."*

There are significant concerns. A major disappointment—and mistake—is DMHSA's failure to implement Assertive Community Treatment (ACT), even in population centers such as Fargo, Minot, and Bismarck.

Lack of affordable, supportive housing remains a problem. Promising practices are being implemented in only a few sites. A serious lack of community services exists, and those that are available are spread thin, exacerbating the gap between hospitalization and office visits.

North Dakota is headed in the right direction at a deliberate, measured pace, but it is at the beginning of a long road.

Current DMHSA leadership has taken significant steps in the areas of planning, pilot programs, workforce development, and consumer involvement. The budget surplus provides an opportunity to expand EBPs from pilot projects to routine availability. ACT pilots should be implemented, at least in larger communities.

Moving from an F to a D represents progress and a foundation for further improvement. North Dakota's challenge now is to keep building.

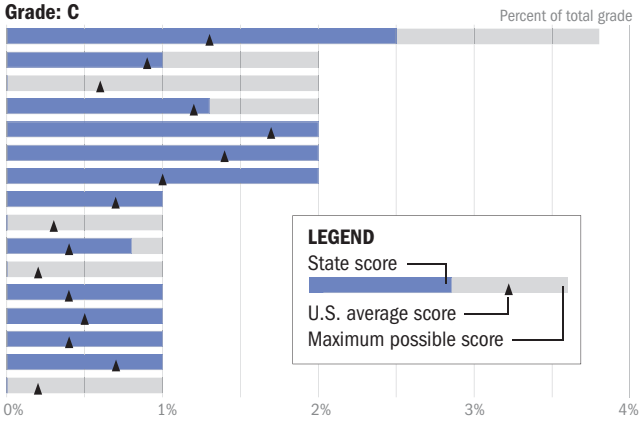
NAMI Score Card: OHIO

Grade: C

Category I: Health Promotion & Measurement

Grade: C

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
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ACT (availability)
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State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
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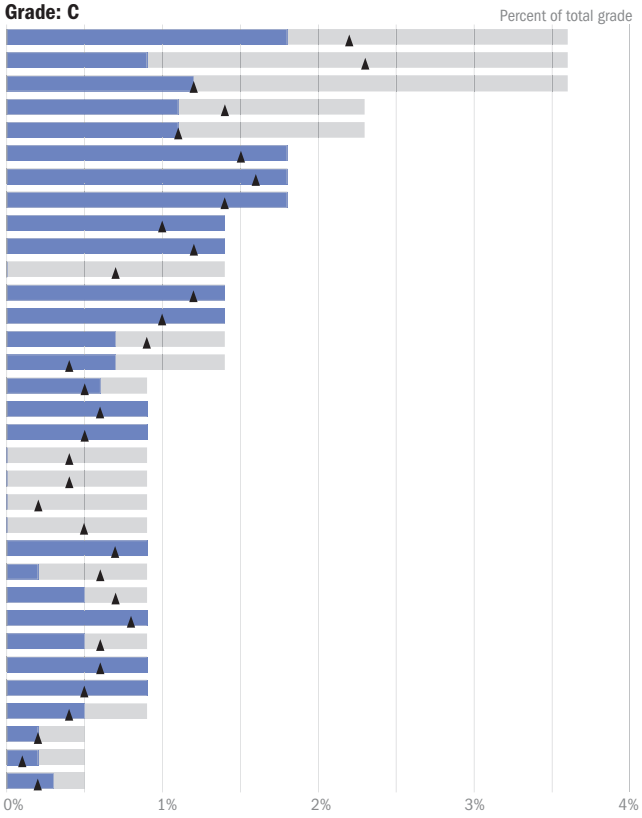
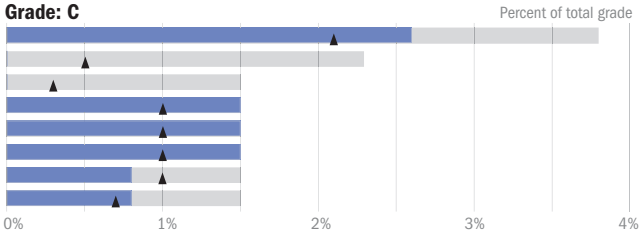


Category III: Consumer & Family Empowerment

Grade: C

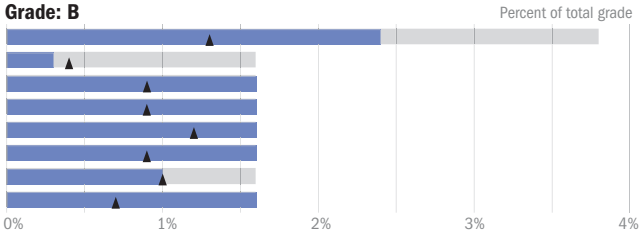
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: B

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Ohio

Innovations

- Evidence-based practices, such as ACT, IDDT, and supported employment
- National leadership on jail diversion and community reentry services
- Consumer and family involvement in design and delivery of services

Urgent Needs

- Restore and increase funding
- Improve coverage of uninsured persons and non-Medicaid services
- Increase acute care beds

Consumer and Family Comments

- *"Many people rely upon the services provided by the local levy and other general state funds. Medicaid appears to be eating up those valuable non-Medicaid services and little is being done about it."*
- *"For the most part, professionals are working to make the system better even when they feel overwhelmed by the need."*
- *"Lots of people fall through the cracks and in a crisis end up in jail . . . Why don't the taxpayers understand that jail costs five times more than treatment and medications?"*

In 2006, Ohio's mental health system received a B. Three years later, the state's status as a leader on mental health has slipped to a C. It's disappointing for a state that seemed in striking range of an A.

In Ohio, budget cuts and policy decisions threaten mental health services; burdens on criminal justice and emergency response systems are significant.

The Ohio Department of Mental Health (ODMH) helps coordinate county Alcoholism, Drug Addiction and Mental Health Services (ADM) boards, and distributes state funds. In turn, the boards contract with local programs to provide services.

Shared responsibility between ODMH and local boards has proven successful in many respects. The 11 Coordinating Centers of Excellence (CCOE) are a unique collaboration between universities, advocates, local mental health boards, private research entities, provider trade associations, and ODMH, among others. These centers, funded by ODMH, provide expertise and technical consultation on Assertive Community Treatment (ACT), integrated dual diagnosis treatment (IDDT), jail diversion, and supported employment.

A particularly strong ODMH-CCOE effort is reducing criminalization of people with serious mental illnesses. Ohio Supreme Court Justice Evelyn Lundberg Stratton and others have made the state a national leader in this area. Fifty-six of Ohio's 88 counties have pre- or post-booking jail diversion programs, and more than 3,000 law enforcement officers, including campus police, received Crisis Intervention Team (CIT) training in 2008. Ohio may also be the only state whose Department of Corrections funds forensic ACT and transitional housing for inmates with serious mental illnesses who reenter the community.

Ohio has made great strides in incorporating consumers and families into service design and delivery. For example, ODMH has an innovative, consumer-staffed, toll-free phone system, *Toll Free Bridges,* which provides information and resources.

Still, many existing problems threaten to get worse. Ohio admits its mental health system is "grossly underfunded." In 2008, the ODMH budget was cut by $31 million; an additional cut of 5.7 percent is expected in the first six months of 2009. This will reduce already inadequate community services funding by $30 million.

Ohio sorely needs more acute inpatient psychiatric beds. State hospitals in Dayton and Cambridge closed in 2008, and many private psychiatric hospital beds have been eliminated. As a result, people are hospitalized further from home, negatively impacting family visits and reintegration into the community.

ADM boards have prioritized those mental health services reimbursable with federal Medicaid dollars. This can prevent consumers, particularly those who are non-Medicaid-eligible and uninsured, from getting the right services. Boards are responsible for matching federal Medicaid dollars, so little remains for non-Medicaid services.

Ohio's Medicaid program recently restricted access to psychiatric medications with a preferred drug list and prior authorization requirements. While the state "grandfathers-in" consumers whose prior medications were working, the changes are restrictive, confusing, and a barrier to access.

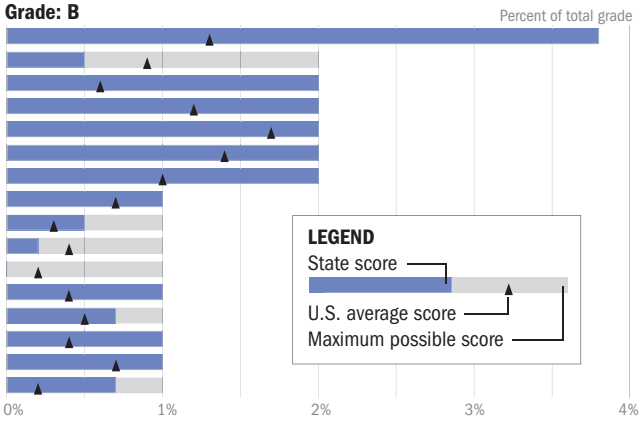
In 2006, former U.S. Representative Ted Strickland, a trained psychologist, became governor. In Congress, he was a leading advocate for people with serious mental illnesses, but as governor, he has been less receptive. Though likely due to the state's enormous financial challenges—not a lack of concern—this has nonetheless been a blow to the hopes of many consumers and families.

Ohio is at a crossroads. More budget cuts could cause it to slip further. Strong leadership is needed to regain its status as a national leader in mental health care.

NAMI Score Card: OKLAHOMA — Grade: B

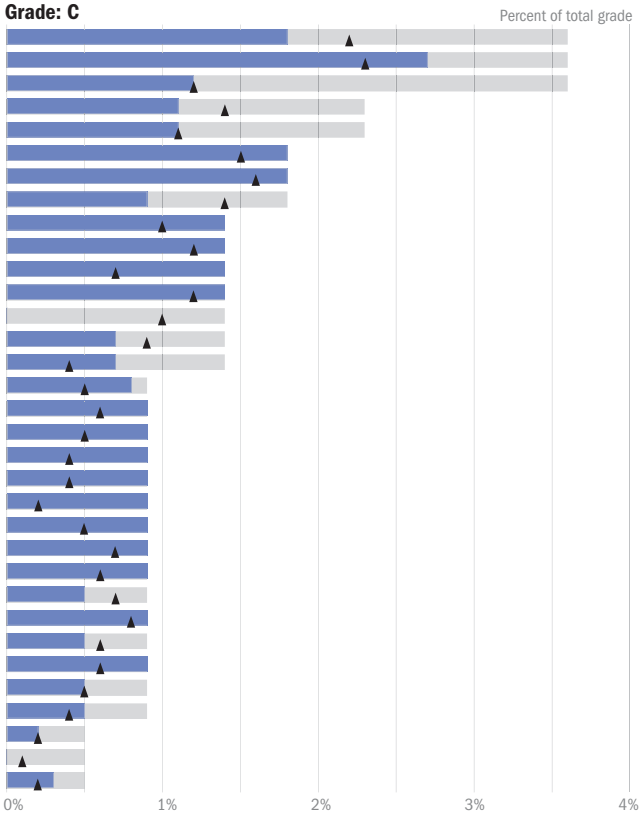
Category I: Health Promotion & Measurement — Grade: B

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



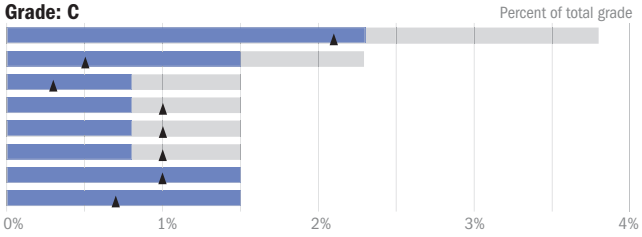
Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



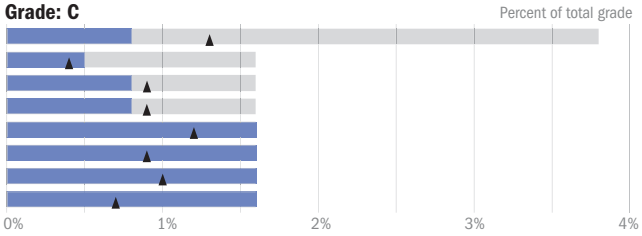
Category III: Consumer & Family Empowerment — Grade: C

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: C

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Oklahoma

In 2006, the state's mental health care system received a D grade. Three years later, the grade is a B, reflecting remarkable improvement and significant opportunities.

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), an independent agency, created an inclusive, collaborative process, effectively using planning funds. ODMHSAS convened consumers and family members, providers, and other human service organizations in six working groups to assess mental health needs. The process resulted in the "Oklahoma Comprehensive Plan for Substance and Mental Health Services," which is intended to guide the implementation of state-of-the-art, evidence-based, wellness-oriented services. The success of this initiative led to acknowledgement from the larger human services community that mental health is a critical component of overall health.

Over the past several years, Oklahoma has implemented several best practices, including jail diversion and reentry programs, Medicaid-funded peer specialists, and dual diagnosis mental health and substance abuse services at all 15 of the state's community mental health centers (CMHCs). Oklahoma is also known for its statistics division and innovative use of data. For example, the state uses data to provide an enhanced payment to CMHCs that include wellness activities, such as nutrition classes and smoking cessation, as an integral part of care.

ODMHSAS is partnering with the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, on an innovative project called "SoonerPsych" that tracks physician prescribing practices and notifies doctors if their prescribing pattern falls outside accepted guidelines. This voluntary program is beneficial not only to psychiatrists, but also general practitioners who prescribe psychiatric medications.

The state has very high rates of incarceration. Inmates include many people with mental illnesses. Together, ODMHSAS and the Oklahoma Department of Corrections are working to change this, but progress is hampered by lack of funding for community mental health services.

There is one state hospital, and with scarce funds it is difficult to build up community services to lessen dependence on inpatient care. The lack of a statewide, full range of community evidence-based practices increases the need for inpatient care, resulting in a shortage of inpatient beds—a vicious cycle that ultimately costs the state money.

In 2008, ODMHSAS reported 202 people served by the agency's rental subsidies and other housing support services. More supportive housing is necessary if comprehensive community services are to become a reality.

Issues exist with Medicaid's restrictive medication policies. The OCHA uses a tiered approach for psychiatric medications, with co-pays and prescription limitations. Although appeal processes exist, these can impede access to appropriate, effective care and result in psychiatric crises.

The state is beginning to pay attention to cultural competence needs. In December 2008, ODMHSAS sponsored a statewide training of trainers by the National Multicultural Institute, but more is needed if it is to provide culturally competent services to its diverse population.

If Oklahoma can successfully implement its state plan, it could become a national leader in comprehensive, recovery-oriented mental health care. But, the state has one of the lowest per capita rates of mental health funding in the nation.

ODMHSAS' dynamic leadership and considerable goodwill in the mental health community can help build the political support necessary for sustained investment in the plan's vision. However, broader leadership is needed. In particular, the legislature needs to give high priority to mental health care reform. To succeed, this state must transform potential into promise.

Innovations

- Mental health and drug courts
- Collaborations with Department of Corrections and Department of Health
- Peer recovery support specialist certification
- Inclusive transformation grant process

Urgent Needs

- Invest in comprehensive plan
- Expand ACT and other evidence-based practices
- Expand cultural competence activities
- Supportive housing

Consumer and Family Comments

- *"Medications are constantly changing and when I find some that work, the doctor says the Medicaid agency has to approve it and it doesn't approve it."*
- *"Funding is always an issue, but advances such as ACT teams and mental health court and drug courts, which have been proved to be effective, are in jeopardy because of cutbacks in funding."*
- *"Link between the hospital system and the outpatient community system is uncoordinated. It can take too long to get outpatient care after the hospitalization is complete."*
- *"People with mental health problems are quite often placed in jails and prisons instead of mental health facilities and held indefinitely, because the mental health facilities are so inadequate that they don't have room for the new person."*

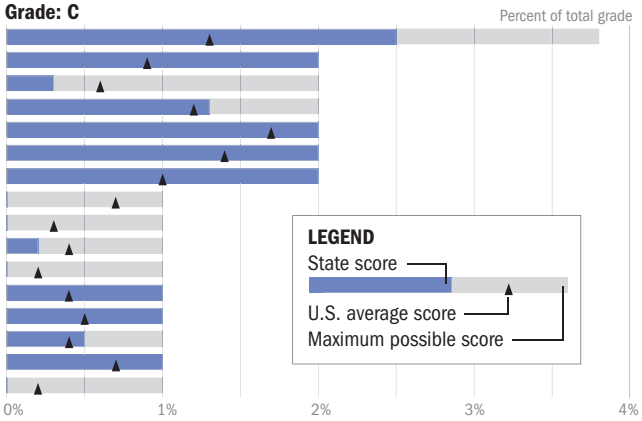
NAMI Score Card: OREGON

Grade: C

Category I: Health Promotion & Measurement

Grade: C

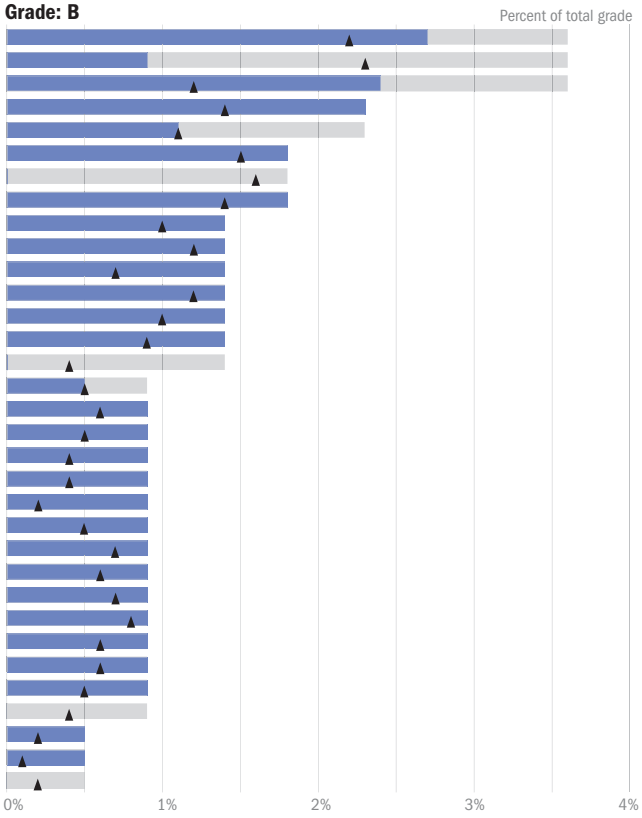
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: B

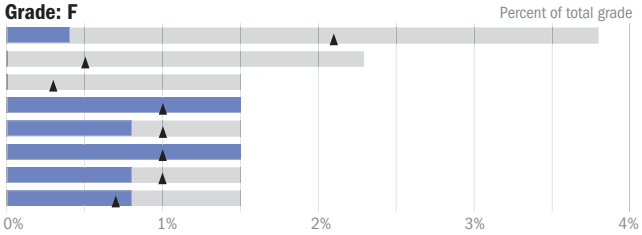
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: F

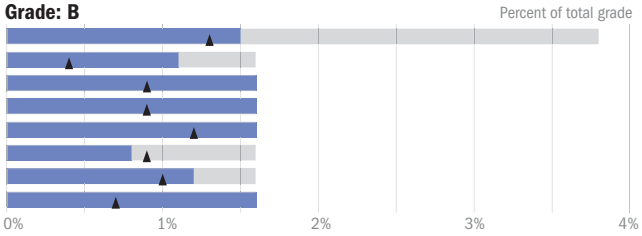
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: B

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Oregon

Innovations

- Emphasis on evidence-based practices and recovery
- Early Assessment and Support Team (EAST) program
- "N2K" Nursing Education Program

Urgent Needs

- Address Oregon State Hospital failures
- Community placements for consumers in state hospital
- More consistent and accessible community mental health services

Consumer and Family Comments

- *"Services at the state hospital have been provided in very old facilities with limited staffing BUT many of the staff appear to truly care, which is amazing considering their extremely difficult and undercompensated jobs."*
- *"The move toward community-based wraparound supports and services in our state is the best thing."*
- *"It would have been helpful if there had been a hospital bed available to her (she was uninsured) BEFORE she became suicidal, had a struggle with a policeman, and wound up in the forensic unit at the state hospital. Services at the local level are so limited for the uninsured."*

Oregon has a diverse landscape that mirrors the many faces of its public mental health system. The state has many pockets of excellence, yet services can vary significantly between counties and regions.

Oregon has a reputation for innovation in its Medicaid program and health care in general, but the same cannot be said for mental health care. In 2006, the state received a C. Three years later, the grade remains the same.

The Addictions and Mental Health Division (AMH) administers public mental health services, including state hospitals. AMH contracts with nine regional Medicaid managed care Mental Health Organizations that deliver services through the state's 33 community mental health programs (CMHPs) and specialty providers. For non-Medicaid services, the state contracts directly with the CMHPs and specialty providers.

The community mental health care programs offer an array of services, with increasing emphasis on evidence-based practices (EBPs) and recovery-focused care. Josephine County was one of the first in the nation to successfully adopt the evidence-based supported employment model. A locally-developed program, the Early Assessment and Support Team (EAST), provides outreach and early intervention to young adults who experience the first symptoms of psychosis. The program is being expanded to communities throughout Oregon.

AMH has long emphasized housing for persons with serious mental illness, a cornerstone of recovery. In addition, AMH has encouraged implementation of EBPs and development of peer supports.

The state deserves recognition for collaboration with the Oregon Health Career Center's "N2K" Nursing Education Program, which allows Oregon State Hospital (OSH) employees to participate in a fast track program to earn a Registered Nurse (RN) degree at a community college in return for service at OSH for 30 months upon graduation. OSH, as employer, pays for tuition and provides flexible scheduling.

But, while Oregon paints a picture of widespread availability of EBPs, consumers and families express dismay at the lack of uniformity of access and services throughout the state and persistent challenges with system navigation. While many find reasonable care within the state's Medicaid program, people who are not Medicaid-eligible find access to treatment limited and focused mostly on crisis services. Not surprisingly, the numbers of individuals with serious mental illnesses who end up in emergency rooms, jails, prisons, or forensic wards of the state hospital continue to grow.

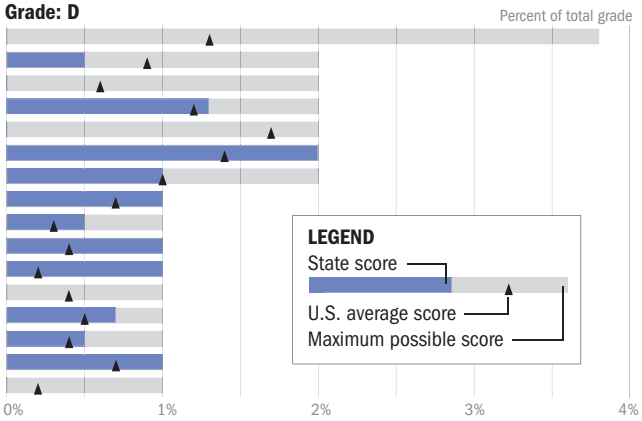
In 2006, the U.S. Department of Justice (DOJ) launched an investigation of the overcrowded and understaffed OSH. In early 2008, it released its findings. The report cited failures to: adequately protect patients from harm; provide adequate psychiatric and psychological treatment; provide adequate nursing care; provide adequate discharge planning; and ensure appropriate community placements. In addition, the report cited inappropriate use of restraints and seclusion.

State lawmakers had already approved a master plan for building new state hospital facilities, but significant workforce shortages and challenges to developing community placements for forensic patients have hampered the state's ability to address the DOJ findings. Advocates have called for development of more uniform and accessible services that promote integration of care for mental illnesses, substance abuse, and other health conditions. Reducing demand for state hospital care also is a necessity.

Leadership and sustained investment are needed to make progress toward achieving an evidence-based and cost-effective mental health care system. Oregon's citizens deserve better than a C.

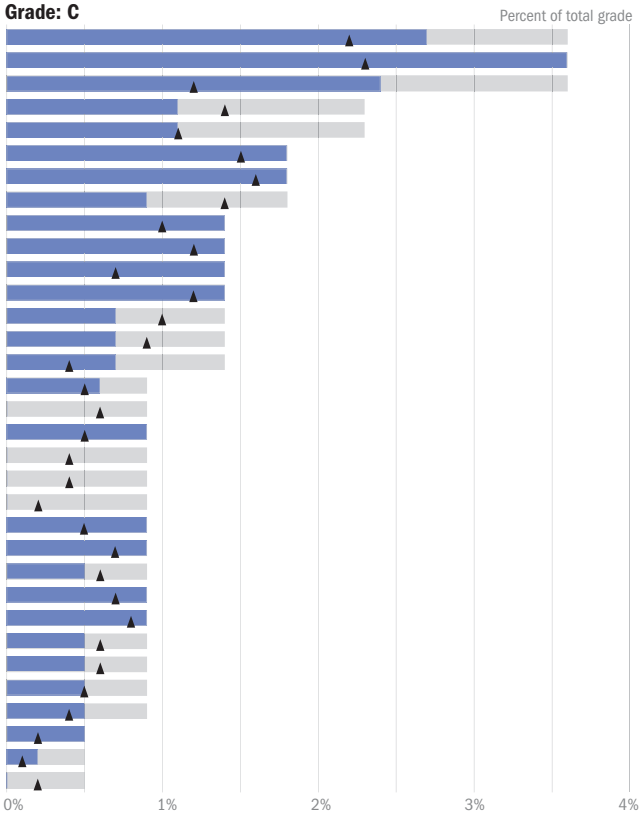
NAMI Score Card: PENNSYLVANIA — Grade: C

Category I: Health Promotion & Measurement — Grade: D



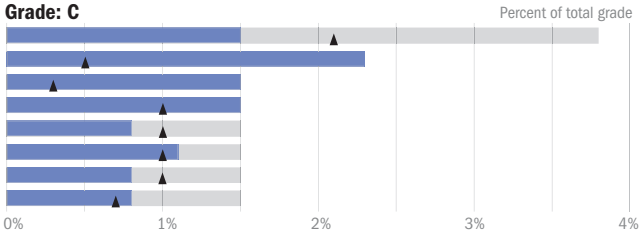
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components

Category II: Financing & Core Treatment/Recovery Services — Grade: C



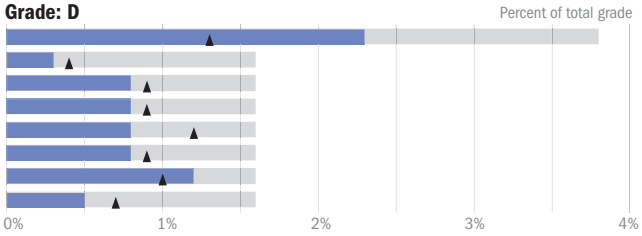
- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families

Category III: Consumer & Family Empowerment — Grade: C



- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs

Category IV: Community Integration & Social Inclusion — Grade: D



- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita

Pennsylvania

Innovations

- National leader in reducing use of seclusion and restraints
- Consumer and family satisfaction teams in the counties
- Implementation of ACT, IDDT, and other evidence-based practices

Urgent Needs

- Adequate mix of hospital and community services
- Expand mental health courts and jail diversion programs statewide
- Statewide police Crisis Intervention Teams

Consumer and Family Comments

- *"At my center, there is generally a one- to two-month wait between the intake interview and the initial meeting with the psychiatrist, and a month can be a long wait when you're really struggling."*
- *"Public mental health services provided a safety net for me when I had nothing."*
- *"Consumers cannot recover and cannot reach their full potential without a place of their own."*

In 2006, the state received a D grade. Three years later, it has received a C, which represents progress, although not a standard of excellence. Now the challenge is to build on that momentum.

Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) has been working closely with consumer and family advocates in the state to design and implement community mental health services that are evidence-based and outcome-driven. At the same time, inadequate funding and continuing disagreements about what constitutes the appropriate mix between hospital care and community services cast uncertainties on the future.

The state is a national pioneer in reducing the use of seclusion and restraints in its hospitals. Since 1998, it has achieved an astounding reduction of more than 99 percent. It is similarly a leader in its use of consumer and family satisfaction teams in each county to assess the quality of services, while implementing its HealthChoices Medicaid managed care system. Additionally, OMHSAS appears to have a strong commitment to expanding evidence-based practices such as Assertive Community Treatment (ACT) and integrated dual diagnosis treatment (IDDT), although gaps in these services still exist in many parts of the state.

Pennsylvania recognizes that housing is a necessary cornerstone for services and recovery and is providing technical assistance to 15 counties to develop supportive housing in their communities. It has also made a strong commitment to training and employing peer specialists.

Additionally, OMHSAS is collaborating with the Pennsylvania Commission on Crime and Delinquency to develop or enhance mental health jail diversion courts. Five courts currently exist, and eight more are planned. Jail diversion programs are very much needed, as people with serious mental illnesses continue to be disproportionately incarcerated in Pennsylvania's jails and prisons.

Despite these positive innovations, there are storm clouds on the near horizon. Like many states, Pennsylvania is facing serious budget problems, and the economic downturn comes just as the state has closed Mayview, a state hospital which serves Pittsburgh and surrounding areas. Many advocates are concerned that adequate services are not in place to effectively address the needs of former Mayview patients in the community, most of whom require intensive services and supports. In 2008, the *Pittsburgh Post-Gazette* documented 10 recent deaths or serious incidents involving local residents with mental illnesses, some of whom were former Mayview patients.[1] Other hospitals in Western Pennsylvania are overburdened trying to serve individuals who previously would have gone to Mayview.

Eliminating state hospitals without adequate services in the community will exacerbate already serious problems, placing vulnerable people at great risk, and increasing burdens on criminal justice systems.

Legislation modeled after New York State's "Kendra's Law" to provide court-ordered outpatient treatment (assisted outpatient treatment) is under consideration in Pennsylvania. Enactment of this legislation would be helpful, as long as resources for services are available.

Pennsylvania has reached a critical juncture in choosing how services should be structured for people with the most severe mental illnesses and in what settings these services should be delivered. At a time of economic uncertainty, Pennsylvania must try to determine whether it should continue closing hospitals despite a significant shortage of community-based services, particularly in the rural regions that make up most of the Commonwealth. How Pennsylvania responds to this challenge will go far in determining if Pennsylvania is truly ready to achieve a state-of-the-art mental health care system.

[1] Joe Fahy, "Referrals to Western Psych Halted: State Intervenes After Rash of Incidents Involving Outpatients," *Pittsburgh Post-Gazette*, July 24, 2008.

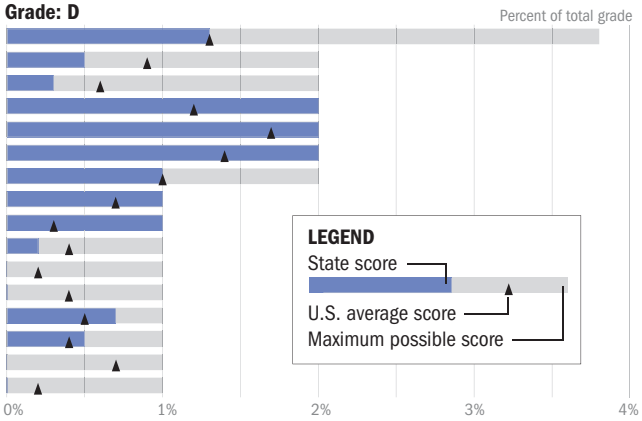
NAMI Score Card: RHODE ISLAND

Grade: C

Category I: Health Promotion & Measurement

Grade: D

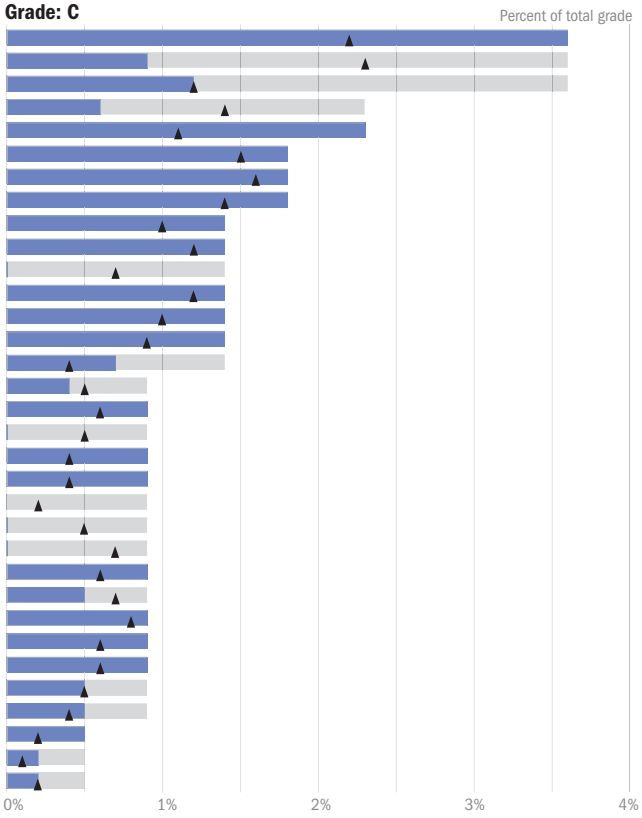
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

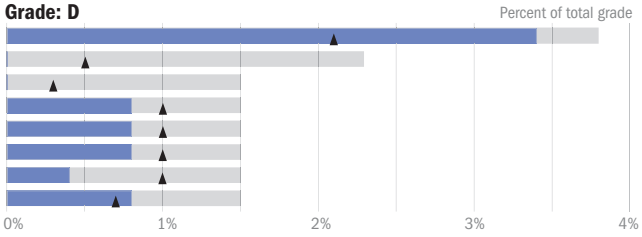
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: D

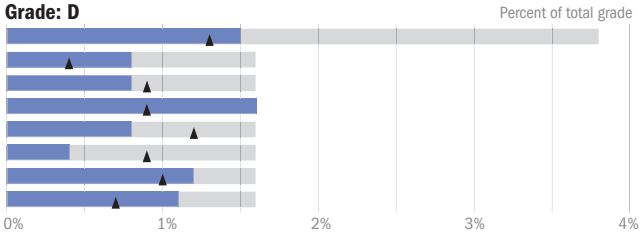
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Rhode Island

In 2006, Rhode Island's mental health care system received a grade of C. Three years later, the grade remains the same.

More than a decade ago, Rhode Island had one of the best mental health systems in the country. Its Department of Mental Health, Retardation and Hospitals (MHRH) was a leader in providing evidence-based community mental health services. In the face of severe economic distress, however, the state is moving to cut social services.

Yet, even as the dire budget situation drives policy, the state has created an additional program called "RIACT II," which is a less intensive service delivery model based on Assertive Community Treatment (ACT) principles, for individuals who do not need the level of traditional ACT services. MHRH also has increased the number of "step down" beds which serve as an intermediate level of 24-hour care between inpatient hospital care and outpatient community programs.

An innovative, Web-based Rhode Island Network of Care provides information for individuals, families, and other agencies on mental health services, laws, and related topics, and a "211" telephone system has been developed to help the public access mental health resources. Even though the mental health system is under stress, the state continues to provide an impressive array of evidence-based practices (EBPs), including ACT, supported employment, integrated dual diagnosis treatment, and illness management and recovery, as well as reentry programs for jail inmates with serious mental illnesses and an expansion of certified clubhouses.

Nonetheless, cracks are emerging in Rhode Island's system. After uninsured individuals in psychiatric crisis are assessed in emergency rooms, they face long waits for admission. Meanwhile, the state is reducing the capacity of its one state psychiatric hospital, relying instead on general hospitals for inpatient beds on psychiatric units. As the state hospital census declines, it remains to be seen whether adequate services will exist in the community. Pressing issues include shortages of mental health services for transition age youth, older adults, people without health insurance, and individuals reentering the community from jails and prison. In a time of funding crisis, consumers and families are seeking additional opportunities to provide input on policies, services, and monitoring of the mental health system.

Social service advocates are alarmed by a proposed Medicaid waiver that will cap funding and the state's responsibility for providing care. The waiver will change Medicaid-funded mental health care from an entitlement to a limited, defined benefit that no longer guarantees access to care.

To keep its core of EBPs intact during a time of diminishing resources, MHRH will need to be creative and collaborative. It also will require political commitment and leadership from the governor and legislature.

By taking such steps, potential will still exist for Rhode Island—once a national leader in mental health services—to rise again to a high level of achievement.

Innovations

- Expansion of ACT and certified clubhouses
- Web-based information "network of care"
- "211" telephone access to mental heath care

Urgent Needs

- Increased training for police
- Mental health services for people without insurance
- Access to a continuum of supportive housing and treatment options
- Adequate inpatient capacity

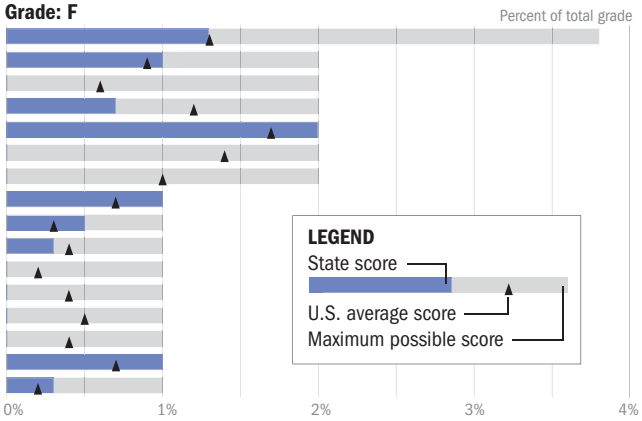
Consumer and Family Comments

- *"The best thing about the public mental health system in RI is the people . . . they care. They want to figure out how they can give the best care to Rhode Islanders despite hard economic times."*
- *"Very difficult to get into the system . . . Waiting periods are long."*
- *"Few hospital beds, few doctors, no housing, no central location for services, no dollars."*

NAMI Score Card: SOUTH CAROLINA — Grade: D

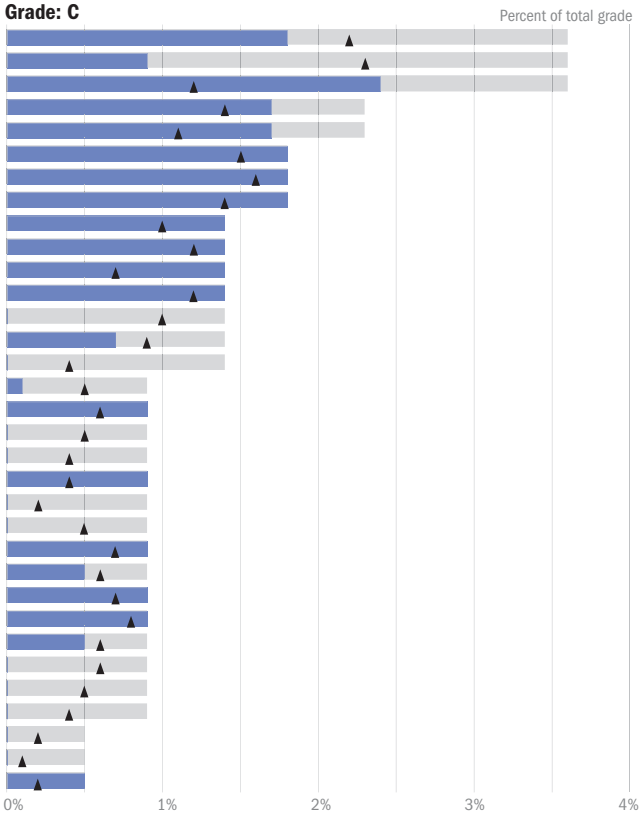
Category I: Health Promotion & Measurement — Grade: F

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment — Grade: C

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
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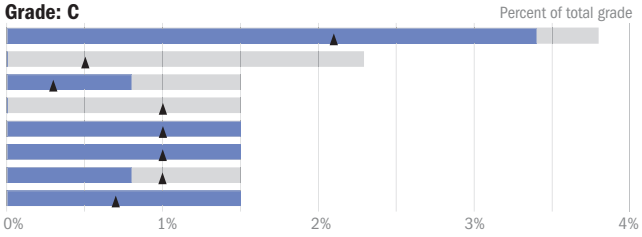
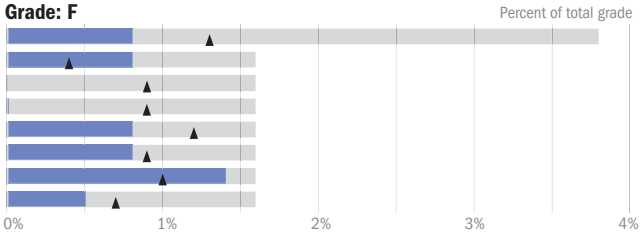


Category IV: Community Integration & Social Inclusion — Grade: F

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



South Carolina

In 2006, South Carolina's mental health system received a B grade, one of the few states to reach the B range. In 2009, its grade is a D. This precipitous drop reflects the devastation of community mental health care at a point when the state is struggling with a budget crisis.

The South Carolina Department of Mental Health (DMH) is an independent agency reporting to the South Carolina Mental Health Commission. The agency's employees provide mental health services at state hospitals and 17 community mental health centers.

South Carolina supports a number of innovative programs. For example, a private foundation, the Duke Endowment, has given several million dollars to provide every rural hospital emergency room with 24/7 access to board-certified psychiatrists via telemedicine. DMH is also enlisting psychiatric residents at the state's two medical schools to do some of their required training at state facilities.

In Columbia, the Impact Program provides intensive case management and treatment to high users of crisis services. Mental health professionals are on-site at the Alvin S. Glenn Detention Center to provide crisis intervention, assessment, and discharge planning—coordinating with the local mental health court and substance abuse providers.

DMH created a DVD for first-responder training of law enforcement and emergency medical services. The state also has police Crisis Intervention Team (CIT) programs in many communities, five mental health courts, and Medicaid benefits that are suspended, rather than terminated, during incarceration and restored upon release.

Because of the significant military presence in the state, South Carolina launched a major initiative in 2008 for mental health and substance abuse treatment for members of the National Guard and their families.

But significant service gaps exist. Housing is one—the state's vision does not go far beyond stabilization of symptoms and life in custodial community residential care facilities (CRCFs). Since 2006, closings of CRCFs and, in one case a death due to neglect in a CRCF, have filled local newspapers. DMH's response to NAMI's survey indicated that only 210 clients receive DMH-sponsored rent subsidies. Lack of affordable supported housing options hamper hospital discharge planning.

The state's evidence-based practices (EBPs)—Assertive Community Treatment (ACT) and supported employment—show fidelity to national models but are not available statewide. There is limited access to services in rural areas and shortages of both inpatient and community mental health workers. Access to psychiatric medication can be restricted under the state Medicaid program for those who choose the managed care option.

Innovations

- Telepsychiatry in rural hospital emergency rooms
- Impact Program in Columbia
- Services for veterans

Urgent Needs

- Expansion of evidence-based practices
- CIT and jail diversion
- Mental health services in jails and prisons
- Housing options
- Access to care in rural areas

Consumer and Family Comments

- *"The commitment and capabilities of public mental health staff varies. It is amazing how in the face of continual economic cut-backs that many of these individuals have remained committed to their job."*
- *"The services I receive are of first-class quality. I am deeply concerned about this quality being maintained with state funding so greatly reduced."*
- *"It is difficult to get into help quickly without a long waitlist. Once I realized I was in trouble, I tried to get help but was put off as long as a month for care. I ended up being involuntarily committed to a psychiatric facility."*

South Carolina's D grade reflects a lack of housing options, lack of EBPs, and variation in service availability and quality across the state. The state reports no certified clubhouse programs, dual diagnosis treatment, permanent supported housing, or jail diversion programs. Lack of mental health treatment in jails and prisons prompted a class action lawsuit against the Department of Corrections.

Heading into 2009, a $40 million cut in DMH's budget—25 percent of its total budget—has shattered many hopes. Staff have been cut.

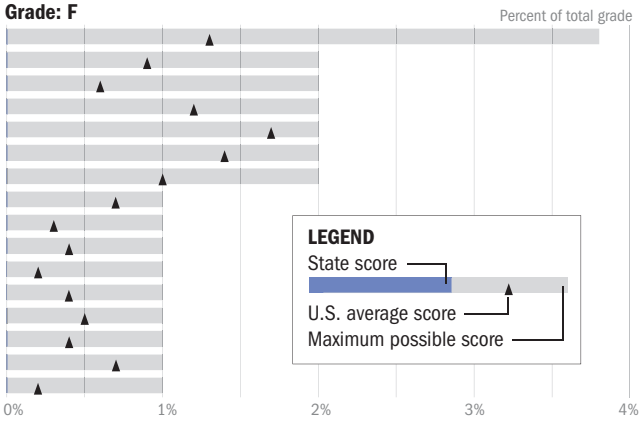
In 2008, the state legislature formed a "Delivery of Behavioral Health Care Services" Study Committee to recommend solutions to the mental health crisis by February 2010. Mental health advocacy organizations, the Sheriffs' Association, the University of South Carolina Medical School, and others have established a "Partners in Crisis" group, chaired by mental health court Judge Amy McCulloch, to address the deteriorating condition of mental health services.

The precarious nature of South Carolina's standing today is a clear signal that political will is needed to restore past levels of care and maintain momentum for reform. During a period of financial crisis, this will be a difficult challenge.

NAMI Score Card: SOUTH DAKOTA — Grade: F

Category I: Health Promotion & Measurement — Grade: F

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services — Grade: F

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
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Family Psychoeducation (availability)
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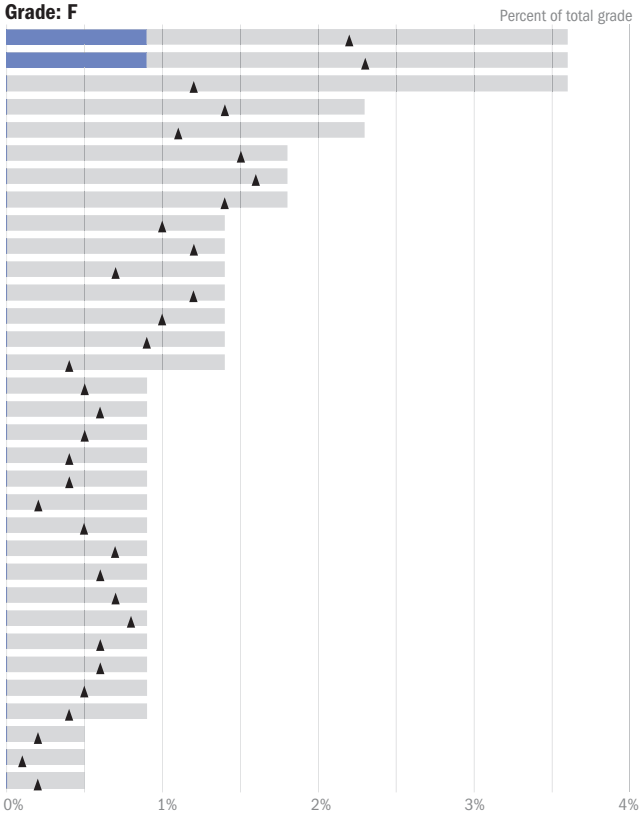
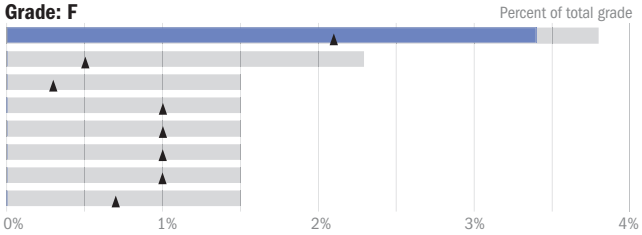


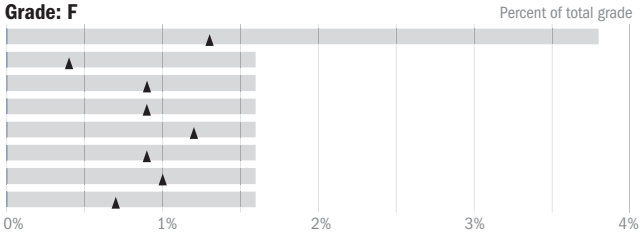
Category III: Consumer & Family Empowerment — Grade: F

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: F

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



South Dakota

In 2006, South Dakota's mental health care system received an F grade. Three years later, the grade remains the same.

South Dakota was the only state in the nation that declined to respond to NAMI's survey on which this report is primarily based. Consumers and family members praise case workers who "work their hearts out," but they see little progress in the system.

The Division of Mental Health (DMH) in the Department of Human Services (DHS) contracts with 11 private, non-profit community mental health centers (CMHCs) that serve the state's 66 counties. Only Minnehaha County (Sioux Falls) can be considered urban—the rest are rural or frontier. DHS also oversees the Human Services Center, the state hospital, located in Yankton. The Division of Medical Services (DMS) runs the state's Medicaid program.

In a collaborative effort with the Governor's Health Care Commission's Subcommittee on Mental Illness and Depression, the South Dakota Council for Mental Health Centers, and the Western Interstate Commission for Higher Education (WICHE) mental health program, DMH received a Wellmark Foundation grant in 2007 to support depression treatment in nine community health centers. The pilot program is intended to improve screening and treatment for people experiencing depression and to better integrate care. In another improvement effort, DMH and the state's four Individualized and Mobile Programs of Assertive Community Treatment (IMPACT) are working to develop recovery-oriented outcome data and to improve fidelity to the national evidence-based ACT model.

Each community mental health center is promoting treatment of co-occurring disorders by using the Comprehensive, Continuous, Integrated System of Care (CCISC) model. A federal incentive grant should give implementation of evidence-based integrated treatment a boost in 2009. DMH is also promoting more recovery-oriented and person-centered care, peer supports, and peer advocacy.

The state has developed a special, higher "rural rate" to reimburse CMHCs for services provided in remote areas. It also includes telemedicine as a Medicaid-reimbursable service to mitigate shortages of mental health professionals. However, many rural communities are still unable to take advantage of telemedicine because they lack the necessary equipment. Training current staff in the CMHCs is also a challenge—both to provide recovery-oriented, integrated care and culturally competent services. The state's diverse communities include nine Native American tribes.

Lack of affordable housing and supported employment are also significant barriers to recovery.

South Dakota's struggle to provide appropriate mental health care is reflected both in the fact that its mental health spending ranks far below the national average and the bulk (63 percent) of its budget is spent on the state hospital. On average, in the rest of the country, state hospitals account for only 27 percent of state mental health spending.

In South Dakota, community-based services are basically starving. Ironically, with a lack of adequate community-based treatment and alternatives to hospitalization, the state hospital is straining to meet demand.

After two consecutive F grades, South Dakota needs to take a hard look at its mental health care system. The state needs a clear, comprehensive plan, and political leaders need to make improvement a priority—which will require investment to build an effective community-based system of care.

Until that happens, the state will continue to fail its citizens.

Innovations

- Depression screening and treatment in primary care
- Efforts to improve outcome measurement
- Promotion of co-occurring disorders treatment

Urgent Needs

- Supportive housing
- Supported employment
- Workforce development
- Crisis services and alternatives to hospitalization

Consumer and Family Comments

- *"I have a case manager who comes to my town every other week. Her schedule is rigid and the office appears to be closing permanently. However, her services right now are a major part of my stability. She is my touchstone."*
- *"The case managers are often 22-23 years old with little to no understanding of mental illness. They are poorly trained, underpaid, and transition out of the field within one to two years."*
- *"I would like peer support groups and a drop-in center to be available if I need it. There is no drop-in center in my immediate area. I have to drive an hour to get to it."*

NAMI Score Card: TENNESSEE — Grade: D

Category I: Health Promotion & Measurement — Grade: D

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
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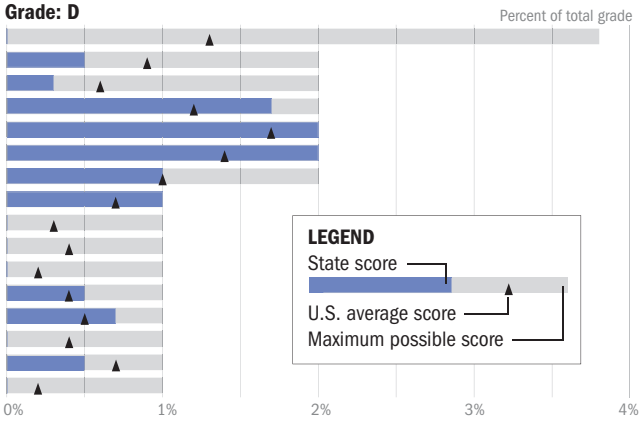

Category II: Financing & Core Treatment/Recovery Services — Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
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Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
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Illness Self Management & Recovery (availability)
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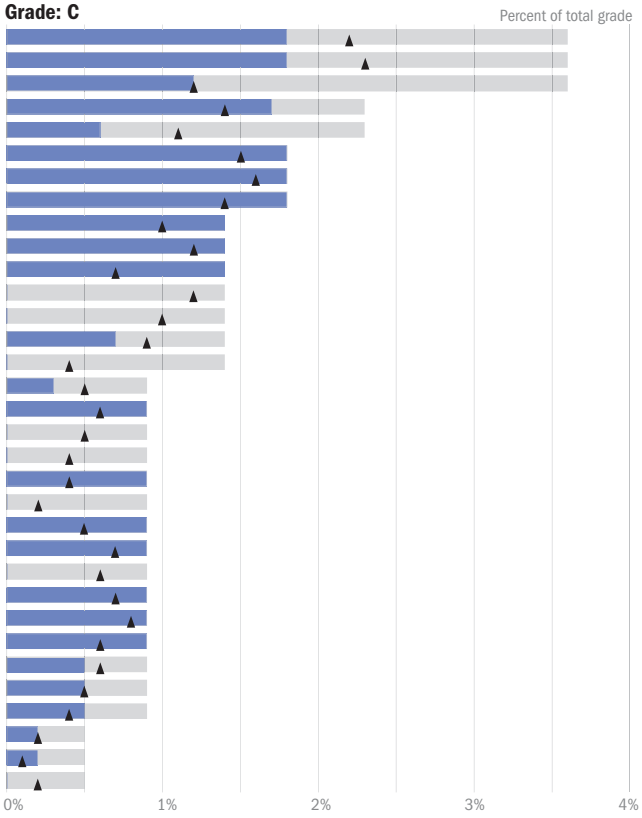

Category III: Consumer & Family Empowerment — Grade: C

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
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State Supports Family Education Programs
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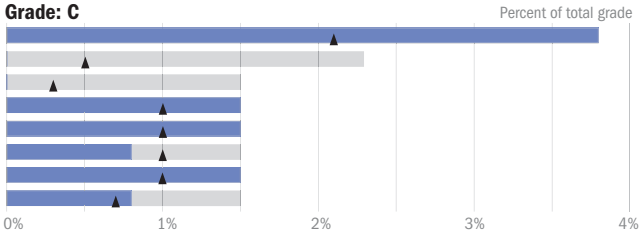
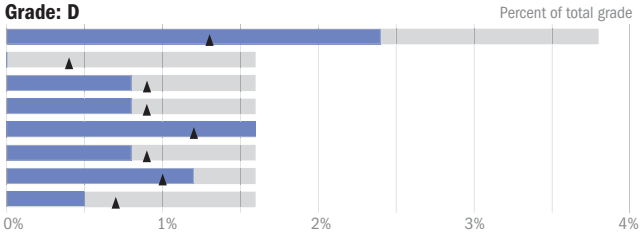


Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Tennessee

Innovations

- National leader on supportive housing
- Progress on jail diversion and law enforcement training
- Peer support centers throughout the state

Urgent Needs

- Expand the safety net program for former TennCare recipients
- Protect funding
- Address severe workforce shortages

Consumer and Family Comments

- *"When one doctor's caseload is so enormous, how can they possibly offer much more help than a write for meds and a caring but un-insightful 'How are you today?' If you are not close to killing yourself or hurting others, then you're stable enough for a quick dismissal. Where is the therapy?"*
- *"The new Crisis Stabilization Units were a great comfort. We were thankful that he could get crisis services without having to be committed. Now that may be in jeopardy."*
- *"Funding is the thing I would most like to see changed in the system. Services are limited because of a lack of funding. Attracting stable, high caliber staff is difficult."*

In 2006, Tennessee's mental health care system received a grade of C. Three years later, the grade has fallen to a D.

The recent history of Tennessee's public mental health system is closely linked to that of the TennCare program. TennCare was once the nation's most expansive program for the uninsured. However, in 2005, the state significantly narrowed eligibility criteria.

Today, TennCare resembles a traditional Medicaid program. Comprehensive mental health services remain available for individuals who qualify for Medicaid, but others are deprived of these needed services. While 21,000 individuals with serious and persistent mental illnesses who were dropped from TennCare in 2005 were offered a "mental health safety net" program, it provided fewer services. This change created service disruptions, confusion, fragmented financing, and new burdens on the mental health system.

Heading into 2009, the state's budget shortfall is expected to reach $1 billion; department heads are preparing for cuts of up to 20 percent, which would be devastating for an already under-funded mental health system. The Department of Mental Health and Developmental Disabilities (DMHDD) may have to serve 32,000 more people (dropped from TennCare) with no additional funds.

DMHDD has strong leadership and, despite formidable challenges, is making progress.

Most notably, Tennessee remains a national leader in supportive housing. In 2000, the DMHDD's "Creating Homes Initiative" (CHI) leveraged DMHDD funds with other state and federal funds. As of June 2008, CHI had created 7,200 supportive housing options, with a goal of 8,200 by the end of 2008. While housing needs still exceed availability in Tennessee, CHI is worthy of broad replication.

There is also slow progress in addressing the large number of people with mental illnesses in the criminal justice system. Memphis' police Crisis Intervention Team (CIT) program is nationally prominent. Johnson City, Kingsport, and Greeneville recently implemented similar programs, and Chattanooga has one pending. Inexplicably, major communities like Nashville and Knoxville have yet to follow suit. DMHDD also has funded a project to connect the criminal justice and mental health systems in every region; however, the program's funding may be cut.

Shortages in acute care inpatient psychiatric beds exist. However, there are three new Crisis Stabilization Units (CSUs) in Nashville, Cookeville, and Columbia, supplementing the CSU in Chattanooga. Tennessee is expanding use of telemedicine through local community mental health agencies to reach individuals in rural areas. DMHDD also supports 48 peer support centers statewide.

Since 2005, Tennessee's Medicaid program has imposed some of the nation's most draconian restrictions on access to psychiatric medications. Several critical medications are excluded, and vulnerable individuals must "fail" on the state's preferred medications before gaining access to non-preferred medications, which may have been previously successful for them.

Due to low reimbursement rates and high administrative burdens, many mental health professionals do not accept TennCare. Severe workforce shortages, particularly in rural areas, have resulted. DMHDD does not have a comprehensive workforce plan to address this.

Tennessee is on a downward slide. Changes to TennCare have put great strains on the system, and many people don't have access to needed services. Further cuts may prove devastating. Although economic pressures are real, solutions do not lie in depriving the state's most vulnerable citizens of services needed for recovery.

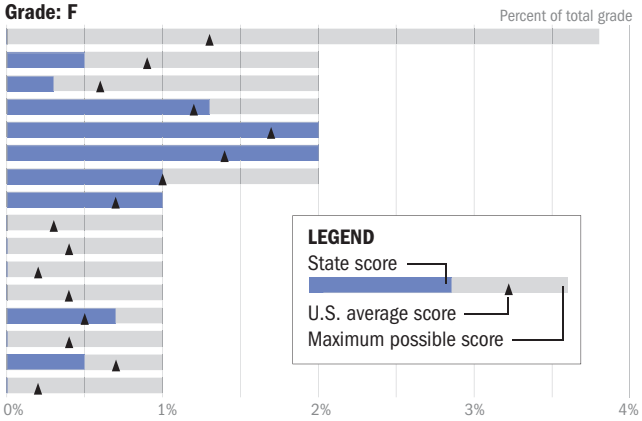
NAMI Score Card: TEXAS

Grade: D

Category I: Health Promotion & Measurement

Grade: F

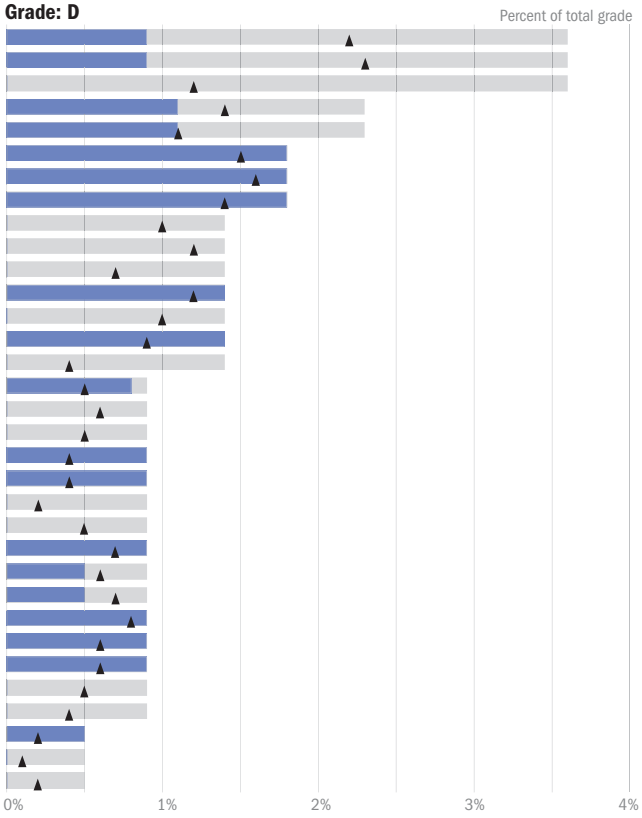
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

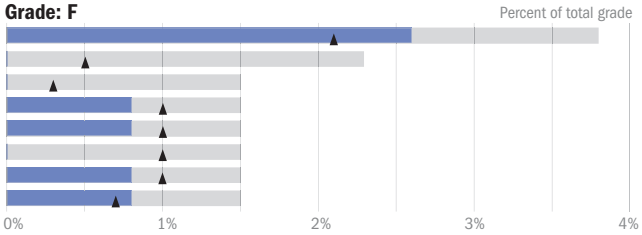
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: F

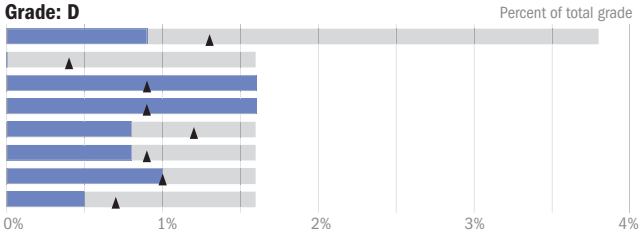
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Texas

Innovations

- Mental health crisis services redesign
- Local Planning and Network Development
- Bexar County Jail Diversion Program

Urgent Needs

- Equitable funding for Local Mental Health Authorities
- Improve access to services in all areas
- Expand health insurance coverage to uninsured persons
- Address cultural competence and workforce shortage

Consumer and Family Comments

- *"The NorthStar indigent program [is the best service] because otherwise I would not be able to afford my psychiatrist/meds."*
- *"Lack of continuity from one provider to the next [is the worst part of the system]. There needs to be a continuum of care—much like with the military—where records are carried with the consumer or centralized for better continuity and more effective health care management."*
- *"Too much money is spent reactively: i.e., for consumers in crisis. If more money was put into proactive use for consumers, the money would be used more productively."*
- *"Services were inadequate. Services were non-existent. Language access was NOT available. Access to any psychiatrist is extremely difficult—usually a two month wait. We are in distress with no help available."*

Texas' mental health care system is dwindling and faces a multitude of challenges. In 2006, it received a C grade. Three years later, it has dropped to a D.

Among the reasons for its decline are its low commitment to supported housing, lack of efforts to reduce the use of restraints and seclusions, and lack of cultural competence—to name only a few.

Texas has the second-highest population in the nation, with large percentages of foreign-born and uninsured residents, and the highest uninsured population—almost 25 percent. It has remote rural and frontier areas and is positioned in the hurricane-prone Gulf region. Those factors all affect the need for mental health services.

Historically, Texas has under-funded mental health care. It ranks 49th in mental health expenditures per capita. The Department of State Health Services (DSHS) administers mental health services through contracts with 39 Local Mental Health Authorities (LMHAs) and NorthSTAR, the state's Medicaid managed care plan. In 2004, DSHS established Resiliency and Disease Management (RDM) as a statewide component for system transformation to better match the intensity of services with individual needs for recovery. DSHS conducts fidelity assessments of LMHAs to ensure adherence to evidence-based practices (EBPs) as part of RDM.

In 2007, five DSHS on-site fidelity reviews revealed lack of appropriate training of staff in EBPs. In addition, LMHA self-assessments showed some decline in statewide fidelity averages. Overall, inadequate data collection and reporting impede the state's ability to accurately measure program performance and outcomes.

In 2005, Texas received a five-year federal mental health transformation grant of $92.5 million. In 2007, the legislature granted $82 million to redesign mental health and substance abuse crisis services through 2009. The focus on crisis services is commendable, but does not address the need for an overall continuum of care that can help avert crises in the first place.

The state is moving to address structural conflicts in the mental health system, in which community mental health centers both manage and distribute funds to providers, while also providing direct services themselves. In 2008, LMHAs began a Local Planning and Network Development initiative involving negotiated rulemaking with providers. So far, the basic process seems to be working, but it remains to be seen whether the initiative will successfully open the system to additional providers.

Unfortunately, an equity issue exists within the system. Funding for the LMHAs is not related to population density, which results in inadequate capacity. In turn, lack of community services results in significantly overcrowded emergency rooms and inappropriate use of prisons as warehouses for people with mental illness.

One notable strength is the Bexar County Jail Diversion Program of the Center for Health Care Services in San Antonio, which is recognized as both a state and national model. It is particularly innovative due to its community collaboration and increased access to care.

For the seventh most diverse state in the nation, Texas is extremely deficient in cultural competence. It is a glaring weakness. Furthermore, Texas has no plan or activities geared toward recruiting and developing a competent workforce, and significant shortages of mental health professionals exist in rural areas.

Texas has not demonstrated reductions in the use of restraints and seclusion in state hospitals, and inpatient conditions continue to generate reports of abuse. Moreover, the state's failure to publicly report data on seclusion and restraints limits the system's transparency and accountability.

Greater investment is needed in order for the state to truly transform and move toward an evidence-based, cost-effective mental health care system. Leadership and political will must make that commitment. Otherwise, Texas will continue its troubling slide backwards.

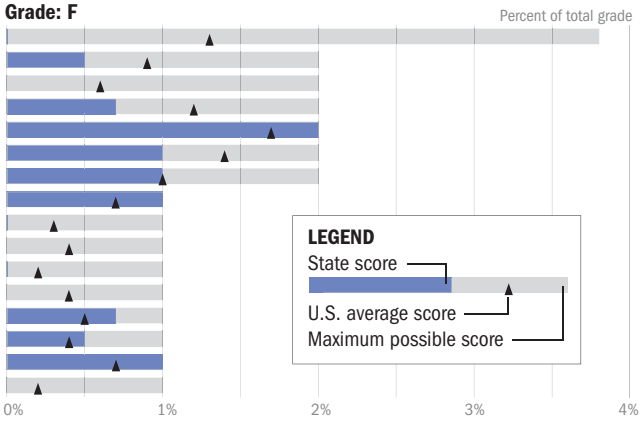
NAMI Score Card: UTAH

Grade: D

Category I: Health Promotion & Measurement

Grade: F

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
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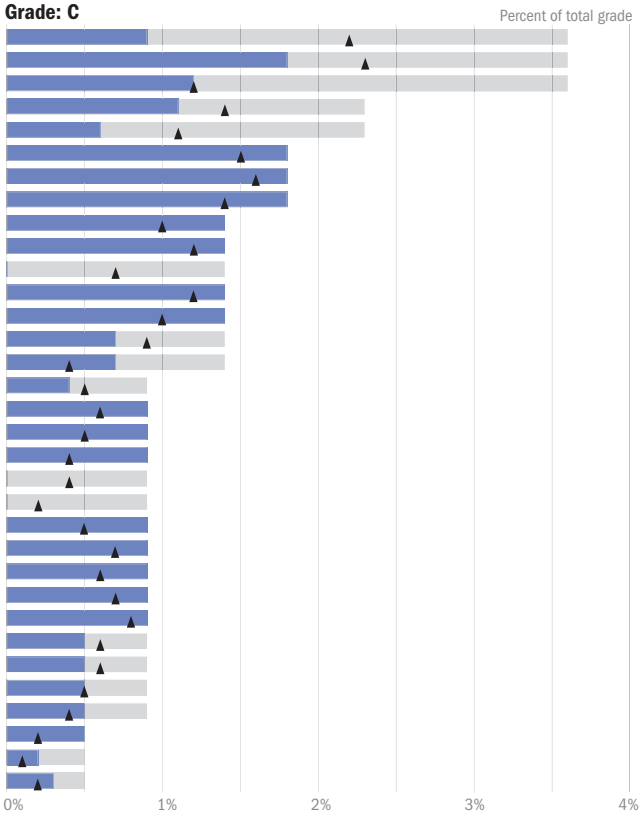
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: C

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
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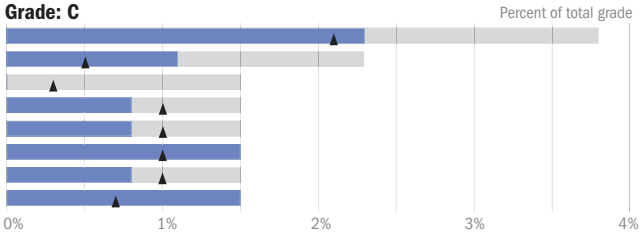
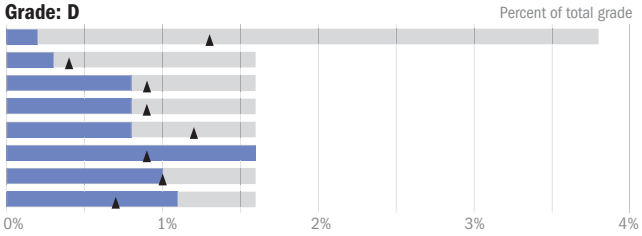


Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Utah

In 2006, Utah's mental health care system received a grade of D. Three years later, the grade remains the same, but conditions may soon worsen.

Looking ahead to 2010, the governor has proposed cutting 15 percent from all executive department budgets. Mental health services would lose $8.6 million, which may affect 14,000 persons receiving services. At Utah State Hospital, 30 beds would be eliminated. Advocates say the mental health care system is taking a disproportionate hit relative to other health programs, assuming as much as 70 percent of the burden of the proposed budget cuts.

Utah faces challenges as a rural state with a continuing need for investment in its mental health care system, despite the state budget crisis. In 2008, the Pew Center on the States named Utah the best managed state of the year. That honor will be sorely tested in 2010 by the proposed severe service cuts.

The Division of Substance Abuse and Mental Health (DSAMH) oversees the state hospital and contracts with local mental health authorities that deliver services through 11 community mental health centers. Several rural counties share a single center. If DSAMH receives a disproportionate share of budget cuts as anticipated, this framework will be stretched to the breaking point.

Utah's strengths are its emphasis on accountability and outcome measurement and its responsiveness to consumers and families. DSAMH requires all publicly funded mental health and substance abuse providers to use a statewide system for assessing and monitoring outcomes. Consumers and family members have a say in ensuring adequate emphasis on recovery measures. This should serve as a model for other states.

In response to consumer feedback, Utah now provides training and technical assistance for community providers on strengths assessment and person-centered planning. People are more than their symptoms. This is a key principle of a recovery-driven system.

The state has strongly supported police Crisis Intervention Teams (CIT), which is crucial to reducing the pressure on the system. Utah also provides unrestricted access to medication through an exemption from the state Medicaid program's preferred drug list.

For a state that cares about tracking outcomes, Utah has invested surprisingly little effort in ensuring fidelity to evidence-based practices. In response to NAMI's survey for this report, DSAMH provided no examples of fidelity measures for the vast majority of practices. This lack of standards will complicate its efforts to prudently manage budget shortfalls.

Innovations

- Statewide system for assessing and monitoring outcomes
- CIT
- Statutory exemption of psychiatric medications from Medicaid's preferred drug list

Urgent Needs

- Preserve access to existing services
- Mental health care for the uninsured
- Increase evidence-based practices with fidelity to standards
- Increase statewide treatment, housing, and support services

Consumer and Family Comments

- *"When our son who lives with schizophrenia was psychotic, there were no beds in the state. We would have driven anywhere."*
- *"I do not drive. Getting to an appointment means two trains and one bus."*
- *"Provide more ACT services to people who may not be able to make it to the center."*
- *"Our CIT program is growing. There is more awareness and more officers are needed but they are on the right track."*
- *"Hire more people of color."*

Utah has not kept pace with its changing demographics. Utah's foreign-born population has more than doubled since 1990, but cultural competence of the mental health care system is severely lacking. In addition, the state has a primary care network program for the uninsured that does not include any mental health services. Covering the uninsured continues to be a challenge in Utah, and the exclusion of mental health services exacerbates the problem for consumers. Some local mental health centers have sought to address this deficiency, but more state leadership is needed.

Individuals with serious mental illnesses continue to crowd jails and prisons, because they cannot access treatment and do not have sufficient housing and support services. More effort is needed in some areas, and progress needs to be continued in others. The state's emphasis on outcome measurements should not be an end in itself, but rather a foundation for wise investments that improve treatment and outcomes.

Leadership by the governor and legislature, careful management, and an overall commitment to some of the state's most vulnerable citizens are essential for steering the mental health care system through the budget storm. The hope is that progress will occur, but right now, the future looks grim in Utah.

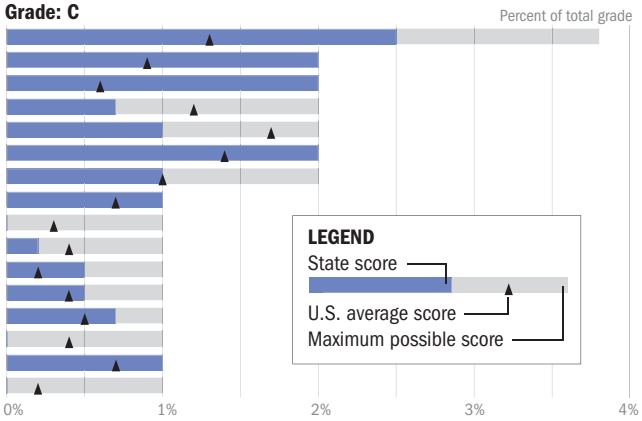
NAMI Score Card: VERMONT

Grade: C

Category I: Health Promotion & Measurement

Grade: C

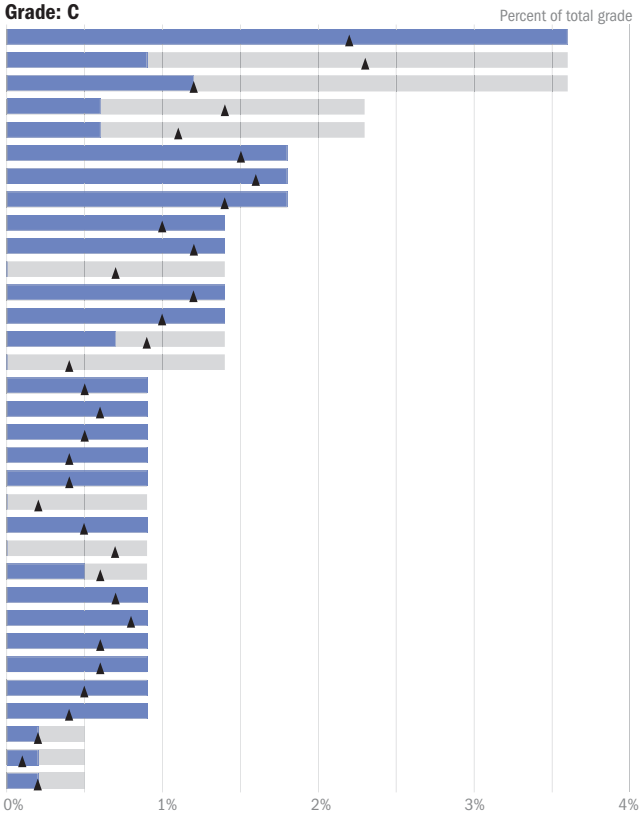
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: C

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
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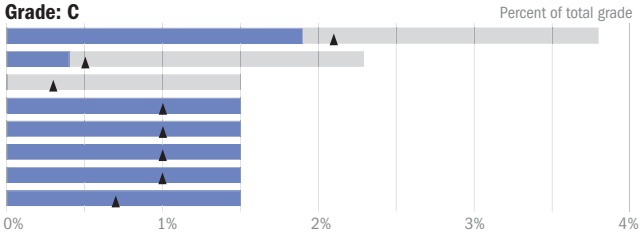
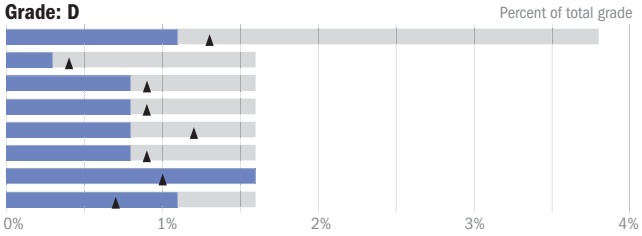


Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Vermont

Innovations

- State police academy training
- WRAP and culture of peer-led crisis services
- Veterans' services
- Increased crisis beds

Urgent Needs

- Leadership for a comprehensive replacement solution to Vermont State Hospital
- Continue hospital quality of care improvement
- Maintain gains in housing and veterans' services
- Address mental health workforce shortage

Consumer and Family Comments

- *"The system is devoted to recovery and consumer-run services."*
- *"Many of my family member's treatment providers have moved away due to low pay scale and poor support by the agencies employing them."*
- *"Support services are not available 24/7. The state needs a better 'step down' system after hospitalization."*
- *"Alternatives to restraint and seclusion must be improved statewide."*

Vermont has made progress in recent years, but can do far better. In 2006, its mental health care system received a C grade. Three years later, the grade is the same. The question today is whether the state will address a complex set of public mental health challenges during hard economic times, and seek to move forward.

Conditions have improved at Vermont State Hospital (VSH), which the U.S. Department of Justice (DOJ) found to be far short of modern standards of care in 2005. Improvements in community services through the Vermont Futures Plan is a sensible, but unfulfilled, attempt to regionalize operations from the outdated facility in Waterbury and replace it with community-based programs and services.

In 2007, Vermont restored the Department of Mental Health (DMH) to the status of a separate department after four years under the Department of Health. This was a welcomed move that is already having a positive impact on mental health services.

The state has a strong culture of peer-led services, family support, and involvement. Its homegrown Wellness Recovery Action Plan (WRAP) is taught across the state. Housing for consumers has increased. Progress also has been made in jail diversion and in universal training of state police and other officers for dealing with individuals in psychiatric crisis.

Because of high National Guard participation, Vermont has a high per capita death rate in the Armed Forces, and returning service members are at psychiatric risk. The state has responded by expanding its "Vet to Vet" peer program. It has also developed two grants for early intervention with at-risk veterans to prevent homelessness and to avoid criminalization. "Trauma-informed care," an approach that recognizes the centrality of psychological trauma for veterans and other consumers, is improving the state's sophistication of care.

Yet, challenges remain—particularly, finding and keeping a professional workforce. Recent efforts to increase community mental health budgets—and thereby professional salaries—have come to a halt.

VSH needs to continue on its path of progress. The hospital's conditions have improved to the point that the DOJ has finally packed its bags, and the state is monitored biannually, showing steady progress. For the first time, the hospital has received institutional accreditation; however, the federal Centers for Medicare and Medicaid Services has decertified the facility since 2003 and recently reaffirmed that decision, although DMH is appealing. Reversal of the decision could save the state about $9 million per year.

The larger concern is where Vermont will provide services that once were centralized at VSH. Positive steps have included increased crisis capacity in Brattleboro, Rutland, St. Albans, St. Johnsbury, and a residential treatment facility, "Second Spring," in Williamstown. A peer-operated crisis alternative program is planned for 2009. The town of Waterbury, the current home of VSH, has signaled its willingness to provide inpatient hospital beds, but that will not achieve the goal of decentralization and improving statewide access. With the exception of Waterbury, no town seems to want to step forward to take responsibility "to own the beds."

Both state and local leadership—and cooperation—are critical to complete the Vermont Futures Plan. The challenge includes finding the money to solve the state's problems. The state is doing many of the right things, but the key is to finish the job.

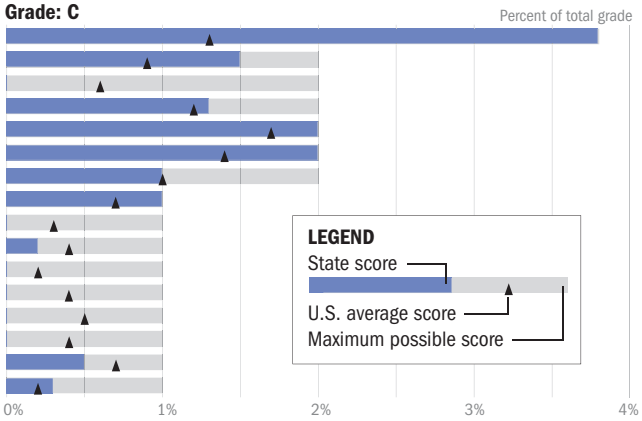
NAMI Score Card: VIRGINIA

Grade: C

Category I: Health Promotion & Measurement

Grade: C

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: C

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
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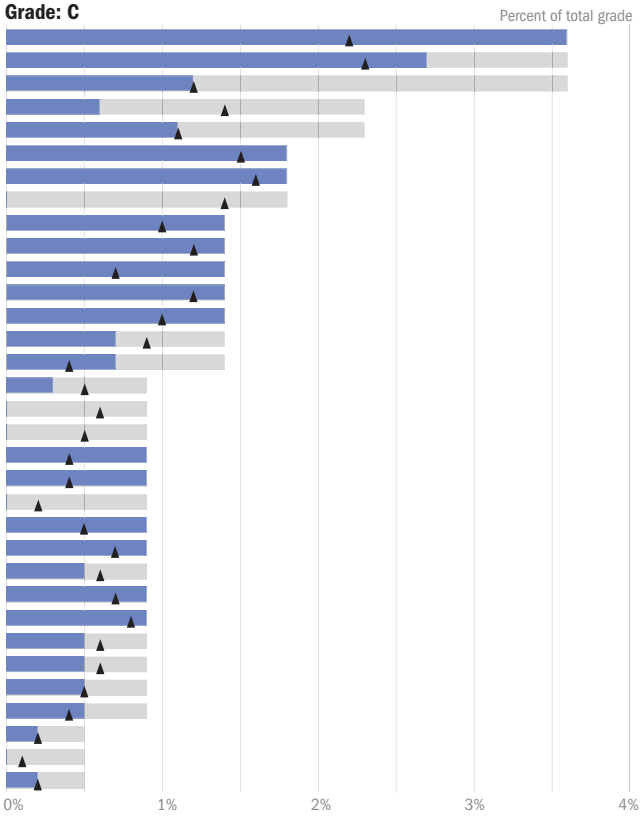
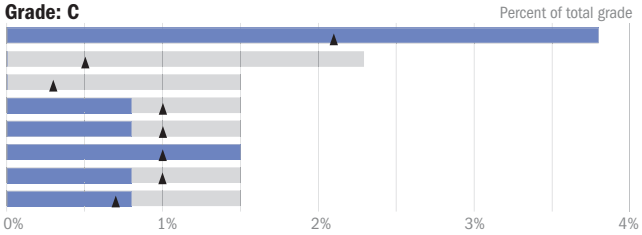


Category III: Consumer & Family Empowerment

Grade: C

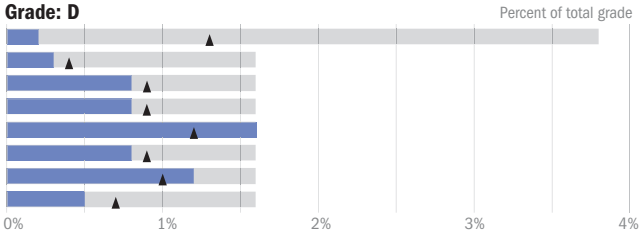
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Virginia

Innovations

- Co-occurring disorders treatment efforts
- Eighteen ACT programs and fidelity to model standards
- Down payment to increase community services

Urgent Needs

- Expand community services, including case management and crisis services
- More housing options
- Health care coverage for uninsured persons that includes mental health care

Consumer and Family Comments

- *"The system in place failed my sister. She was released from the hospital the day before she shot herself in the head."*
- *"Housing available for people being discharged from the hospital is horrific!! There needs to be a period of time after hospitalization for re-introduction into the community. . . My experience with case managers is that if they are aware that a family member is still involved . . . they feel it absolves them of all responsibility."*
- *"There was no counselor in the hospital any of the four times he went."*

In 2006, Virginia's mental health care system received a D grade. Three years later, it has moved up to a C. It took a profound, extraordinary tragedy to move Virginia forward, but concerns exist that the state may still retreat.

The state system came under intense scrutiny following the 2007 tragedy at Virginia Polytechnic Institute and State University (Virginia Tech), where 32 faculty members and students were killed by a student with a history of severe mental illness. The tragedy raised public awareness of gaps in mental health care—in Virginia and nationally.

Even before the tragedy, the state Supreme Court had organized a law reform commission to review state mental health laws. Following the tragedy, Governor Tim Kaine appointed an investigative task force that probed deeper into the failure of the system. The net result included a broadening of Virginia's commitment laws and a $42 million increase in community health services over two years. The expectation was that community service boards (CSBs), which deliver Virginia's mental health services, would use the new money as a "down payment" for improvements. Moving into 2009, however, much of the funding was taken away as a result of the state's budget crisis.

If Virginia's mental health care system is to be strengthened, the state Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) will need sustained support from both the governor and legislature. Otherwise, it faces severe obstacles in building momentum for progress.

Virginia's strengths include a commitment to evidence-based practices (EBPs) such as Assertive Community Treatment (ACT). The state supports 18 ACT programs, which generally lead to fewer hospitalizations and fewer contacts with the criminal justice system. The state also secured a federal grant to improve treatment of individuals with co-occurring disorders. Virginia has moved in the right direction on cultural competence by establishing an office inside DMHMRSAS to address disparities in care, but still has a long way to go in planning and implementation.

Even without the state budget crisis, funding is a major problem. The state has repeatedly cut community mental health budgets in the past. The "down payment" for reform that followed the Virginia Tech tragedy was nowhere near what is needed to overcome this history of neglect. Many of the CSBs lack comprehensive services. Some EBPs are available in only a few parts of the state. In addition, counties and cities vary greatly in the amount of funding they contribute to services, resulting in a very uneven system of care.

Lack of housing for people ready for discharge—and housing options in general—are another major problem in Virginia. Investment in a complete, community-based continuum of care needs to be a priority.

The state has failed to enact any health care reform programs to cover uninsured persons. This is a significant concern since the state Medicaid program's low eligibility levels mean that many people with serious mental illness do not have coverage.

Due to the Virginia Tech tragedy, the state Supreme Court's law reform commission, the investigative task force, the governor, and the legislature are well aware of the shortcomings of the state's mental health system. The real question is whether that awareness will translate into a long-term commitment to reform, which can only come through political will and sustained investment.

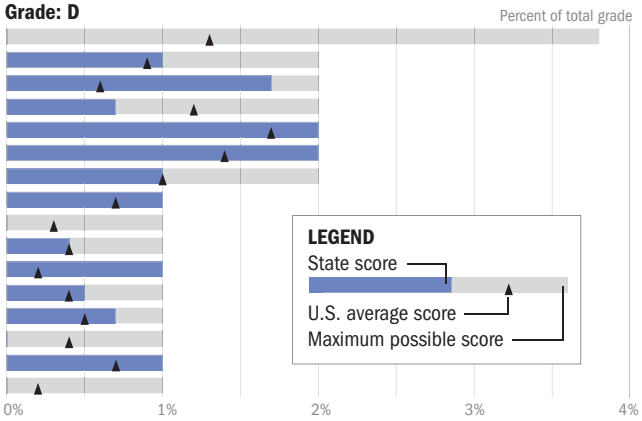
NAMI Score Card: WASHINGTON

Grade: C

Category I: Health Promotion & Measurement

Grade: D

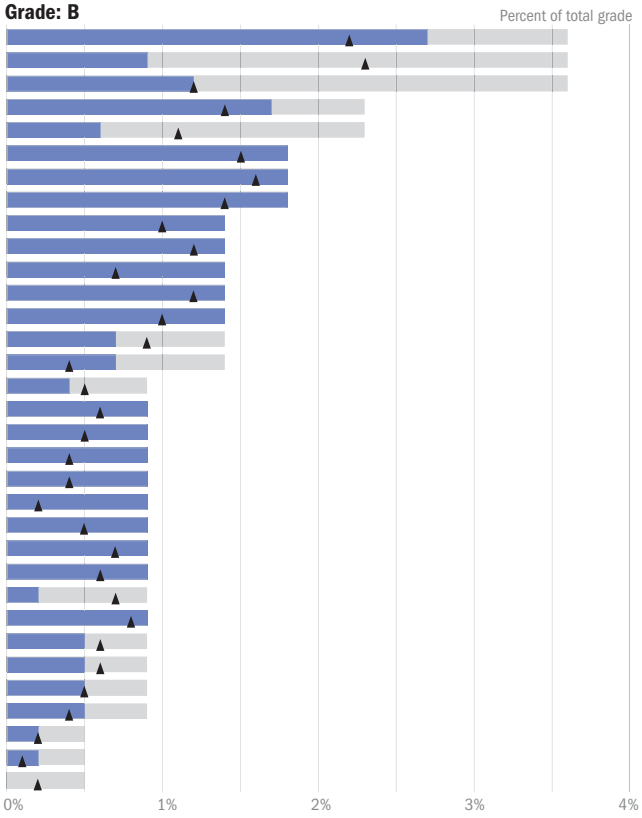
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: B

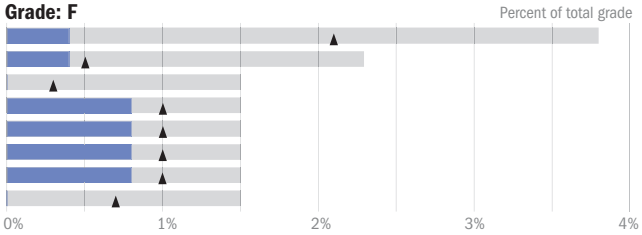
- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: F

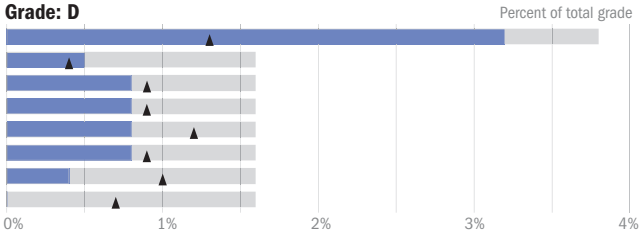
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Washington

Innovations

- ACT programs with strong adherence to fidelity standards
- Reductions in seclusion and restraint in state hospitals
- Progress on jail diversion and community reentry

Urgent Needs

- Eliminate regional disparities in services
- Increase acute care treatment beds and crisis stabilization programs
- Fund services for uninsured individuals ineligible for Medicaid
- Fix problems with involuntary treatment laws

Consumer and Family Comments

- *"The cutbacks in service have adversely affected the community as a whole . . . Especially overwhelming the court and jail systems."*
- *"Peer counselors have started to become more and more available. That is huge for assisting keeping people out of crisis services."*
- *"If my son had gotten the care he needed the first time . . . he would have had a much better chance of recovery. It took three hospital stays before he received follow-up care . . . Now it is costing the state more by not addressing the problem the first time."*

In 2006, Washington's mental health care system received a D. Three years later, the state received a C. Modest improvements have occurred, but serious problems and gaps remain, compounded by looming budget cuts. Washington's reliance on autonomous regional service networks creates broad variations in availability and quality.

The state Department of Social and Health Services' Mental Health Division (MHD) is responsible for mental health services. MHD then contracts with 12 Regional Service Networks (RSNs) for community services. The RSNs contract with local mental health agencies. The MHD appears to lack authority to require specific services and doesn't track comprehensive service and outcome data across the state.

Inadequate funding is a major problem. In 2008, a 13th RSN in Pierce County refused to contract for services with state funds because the funds were insufficient to maintain—let alone expand—service levels.

In response, Governor Christine Gregoire has sought to invest in community-based services. The MHD also has exerted strong leadership in funding 10 Assertive Community Treatment (ACT) teams with fidelity to the national model. While 10 teams barely scratches the surface, it is an important step.

MHD is doing a good job improving safety and reducing restraints and seclusions in its two state psychiatric hospitals, particularly at Eastern State Hospital near Spokane.

Washington has made modest progress on jail diversion and community reentry. Legislation from 2007 aims to facilitate local diversion of individuals charged with misdemeanors. Legislation is pending to suspend, rather than terminate, Medicaid benefits for individuals incarcerated for under a year.

MHD has made a strong commitment to empowering consumers through an office of consumer partnerships, a statewide consumer council, and a peer counselor training and certification program.

Still, major problems abound. Services for individuals most at risk are almost entirely lacking in many parts of the state. MHD admits this significant shortage of acute care facilities, due to state hospital reductions and closures of general hospital psychiatric treatment units.

Washington never fully recovered from 2004's loss of $82 million in federal Medicaid funds, due to tightening of federal rules. Like other states, it faces a significant budget deficit which will likely get worse before it improves. Providing services for the non-Medicaid-eligible uninsured with serious mental illnesses is especially daunting.

A 2005 law authorized counties to impose a one-tenth of one percent sales tax on all purchases, to fund new mental health, chemical dependency, or therapeutic court services. Unfortunately, only eight of 31 counties have implemented the tax.

Recent high profile tragedies, involving murders committed by people with serious mental illnesses, have highlighted the state's involuntary treatment laws. In each case, the person with mental illness was not getting appropriate treatment. State law permits involuntary treatment for people who meet the criteria for "gravely disabled," but this is narrowly interpreted. Families, often best-positioned to see an impending crisis, cannot petition for emergency treatment. In some areas, there are no beds for people under emergency commitment orders.

Washington is making progress, particularly in implementing ACT and other evidence-based practices. But progress cannot be sustained without adequate funding, and much work is still needed. The economic crisis makes the challenges more difficult, but not impossible to overcome.

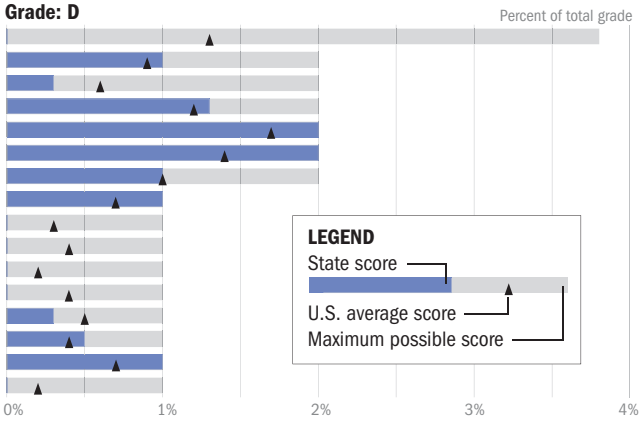
NAMI Score Card: WEST VIRGINIA

Grade: F

Category I: Health Promotion & Measurement

Grade: D

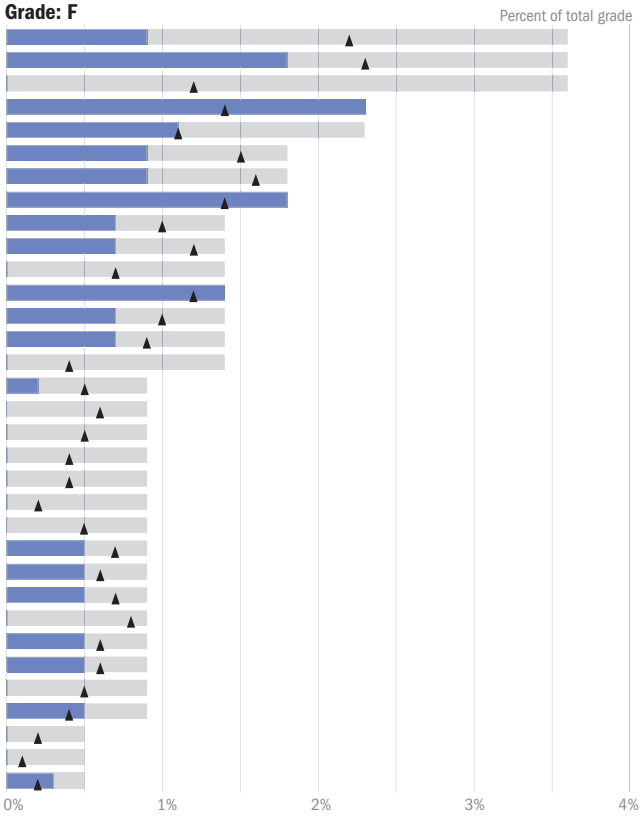
- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: F

- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
- No Cap on Monthly Medicaid Prescriptions
- ACT (availability)
- Certified Clubhouse (availability)
- State Supports Co-occurring Disorders Treatment
- Illness Self Management & Recovery (Medicaid pays)
- Family Psychoeducation (Medicaid pays)
- Supported Housing (Medicaid pays part)
- Supported Employment (Medicaid pays part)
- Supported Education (Medicaid pays part)
- Language Interpretation/Translation (Medicaid pays)
- Telemedicine (Medicaid pays)
- Access to Antipsychotic Medications
- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
- Integrated Dual Diagnosis Treatment (availability)
- Permanent Supported Housing (availability)
- Housing First (availability)
- Illness Self Management & Recovery (availability)
- Family Psychoeducation (availability)
- Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: F

- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
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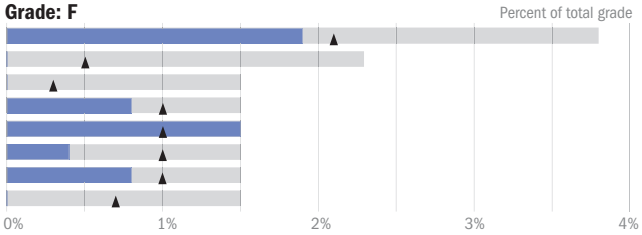
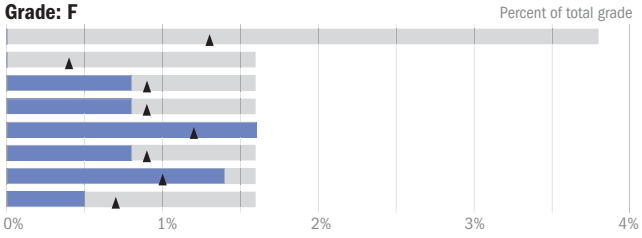
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: F

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



West Virginia

In 2006, West Virginia's mental health care system received a D grade. Three years later, the grade has fallen to an F. An already inadequate system is deteriorating. One reason is the horrendous redesign of its Medicaid program.

The West Virginia Bureau for Behavioral Health and Health Facilities is the state's mental health agency, residing within the West Virginia Department of Health and Human Resources (DHHR). The state Medicaid agency is also part of DHHR.

West Virginia has received poor national reviews for the redesign of its Medicaid program. The new program, Mountain Health Choices, offers two plans: Basic and Enhanced, with the Basic plan offering fewer benefits. Individuals who receive Medicaid because they are SSI recipients are not enrolled in Mountain Health Choices; they remain in traditional Medicaid. Confusion reigns in the state about who is in which plan—Basic, Enhanced, or traditional Medicaid—and the scope of benefits.

The Basic plan has *fewer* benefits than traditional Medicaid. Except for limited visits to psychologists and psychiatrists, there is *no* coverage of inpatient psychiatric hospital care, chemical dependency, or mental health services, and limited or no access to other medical services. It also limits prescriptions to four per person per month. Excluding mental health coverage is an outright contradiction of the New Freedom Commission's statement that mental health is essential to overall health.

On the plus side, the West Virginia Council for the Prevention of Suicide is a positive step to lessen high suicide rates, especially among young adults. Coalition partners include consumers and family members, providers, education, public health, and corrections representatives. The coalition works to increase awareness of the state's significant suicide rate and early warning signs of self-injuring behavior and has developed specific suicide prevention plans by age group. The state has one mental health court. Several communities are developing police Crisis Intervention Teams (CIT).

The state mental health agency uses mental health block grant funds to support the West Virginia Mental Health Consumers Association (WVMHCA). WVMHCA provides alternative, nontraditional services, such as transitional housing, supportive employment, peer support programs, including groups at the state hospitals, and a peer support specialist certification program. These consumer-run programs are a bright spot in mental health services in the state.

The state is weak in many areas. Services—such as acute and long-term care for individuals with co-occurring disorders—are scarce or non-existent in small towns and rural areas. Involuntary commitments at the two state hospitals continue to increase because of the lack of community treatment services and lack of supported housing. The hospitals are overcrowded, with forensic patients occupying many of the state hospital beds. Some areas have long waiting lists for services.

Mountain Health Choices is a disaster. It has set the state back in meeting public health needs, financially destabilized providers, and deprived some consumers of needed services in a state that already suffered from uneven access to care and a lack of evidence-based practices.

West Virginia faces many challenges: poverty, the rural nature of the state, and lack of investment in community mental health. Sadly, its leadership example in the face of crisis has been primarily to demonstrate what poor, rural states should *not* do.

Innovations

- West Virginia Mental Health Consumers Association programs
- One mental health court

Urgent Needs

- Redesign Medicaid plan—the right way
- Evidence-based practices
- Supportive housing and workforce development
- Crisis intervention, jail diversion, and reentry programs

Consumer and Family Comments

- *"Services are difficult to locate, and persons employed do not seem to always know what is available or even how to readily access those services. People are continually being told that funding has been cut."*
- *"I have lost my Medicaid since my child is now over 18. We cannot afford to get insurance, so I am weaning myself off my meds and will be 'winging' it . . ."*
- *"Services are adequate to keep him alive but not as a functioning person."*
- *"The state is in 'crisis' in regards to the overuse of inpatient facilities."*
- *"WV does 'med checks,' not treatments."*

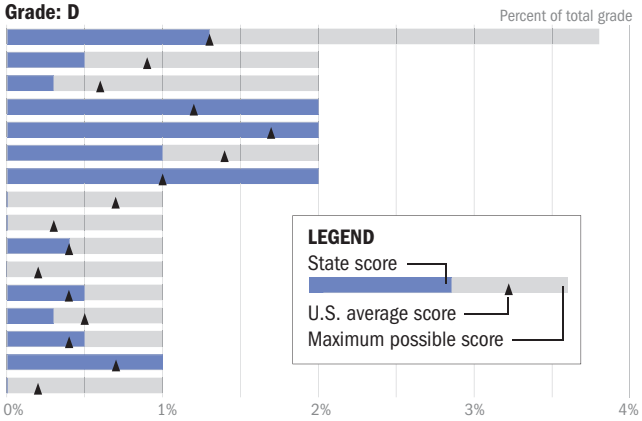
NAMI Score Card: WISCONSIN

Grade: C

Category I: Health Promotion & Measurement

Grade: D

- Workforce Development Plan
- State Mental Health Insurance Parity Law
- Mental Health Coverage in Programs for Uninsured
- Quality of Evidence-Based Practices Data
- Quality of Race/Ethnicity Data
- Have Data on Psychiatric Beds by Setting
- Integrate Mental and Primary Health Care
- Joint Commission Hospital Accreditation
- Have Data on ER Wait-times for Admission
- Reductions in Use of Seclusion & Restraint
- Public Reporting of Seclusion & Restraint Data
- Wellness Promotion/Mortality Reduction Plan
- State Studies Cause of Death
- Performance Measure for Suicide Prevention
- Smoking Cessation Programs
- Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: B

- Workforce Availability
- Inpatient Psychiatric Bed Capacity
- Cultural Competence - Overall Score
- Share of Adults with Serious Mental Illness Served
- Assertive Community Treatment (ACT) - per capita
- ACT (Medicaid pays part/all)
- Targeted Case Management (Medicaid pays)
- Medicaid Outpatient Co-pays
- Mobile Crisis Services (Medicaid pays)
- Transportation (Medicaid pays)
- Peer Specialist (Medicaid pays)
- State Pays for Benzodiazepines
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- Certified Clubhouse (availability)
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- Clinically-Informed Prescriber Feedback System
- Same-Day Billing for Mental Health & Primary Care
- Supported Employment (availability)
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- Housing First (availability)
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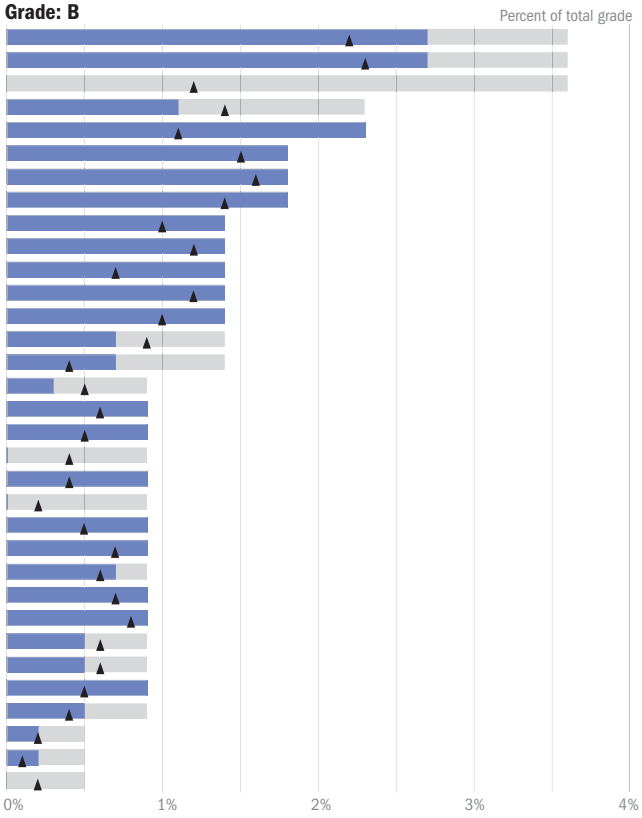
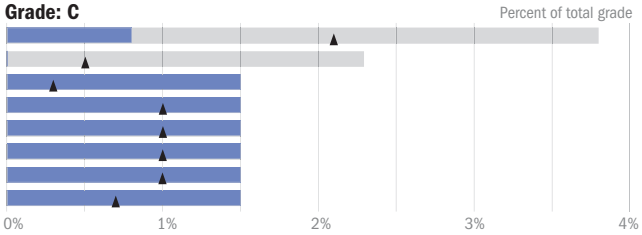


Category III: Consumer & Family Empowerment

Grade: C

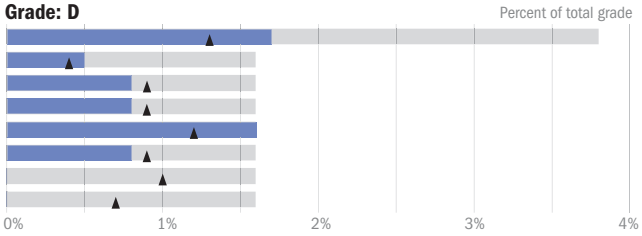
- Consumer & Family Test Drive (CFTD)
- Consumer & Family Monitoring Teams
- Consumer/Family on State Pharmacy (P&T) Committee
- Consumer-Run Programs (availability)
- Promote Peer-Run Services
- State Supports Family Education Programs
- State Supports Peer Education Programs
- State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: D

- Housing - Overall Score
- Suspend/Restore Medicaid Post-Incarceration
- Jail Diversion Programs (availability)
- Reentry Programs (availability)
- Mental Illness Public Education Efforts
- State Supports Police Crisis Intervention Teams (CIT)
- Mental Health Courts - Overall Score
- Mental Health Courts - per capita



Wisconsin

Innovations

- Mental health and primary care collaboration
- Wellness and recovery focus
- Smoking cessation programs

Urgent Needs

- Statewide financing and data systems
- Fidelity to evidence-based practice standards
- Cultural competence
- CIT and jail diversion expansion and mental health courts

Consumer and Family Comments

- *"Being publicly funded usually means under-funded."*
- *"Assertive Community Treatment is excellent on paper but hasn't met his needs because of ever-increasing work loads of the case managers. Things have gone from good to fair to lousy in the last couple of years. Medication alone just can't do it for him."*
- *"It is frustrating that counties are responsible for the person rather than the state. My son wanted to live in La Crosse, but until he actually moved there, he could not receive services . . . He ended up being hospitalized multiple times and in groups homes, etc."*
- *"Inpatient units still treat people badly. They still don't take into consideration people's normal temperament or behaviors and also their culture or ethnicity."*

In 2006, Wisconsin received a B grade. Three years later, the state receives a C. This slippage can be attributed to the limited access and availability of services; the inequities of the state's complex, decentralized system; slowness in implementing evidence-based practices (EBPs); and inattention to cultural competence. The system's sluggishness hinders progress.

The state funds services in 72 counties, but the counties provide the non-federal share of Medicaid funding and are responsible for providing or purchasing most services. Counties and localities contribute varying amounts to mental health care spending, above what the state provides. The decentralized nature of the system limits the Division of Mental Health and Substance Abuse Services' (DMHSAS) control over local services. Availability and quality vary widely.

Wisconsin is a national leader on wellness and recovery. DMHSAS promotes the concept that mental health is essential to overall health by working to integrate primary care medicine and mental health services. It supports smoking cessation programs in the two state hospitals and in community programs. It also promotes inclusion of peer specialists in provider care and directly funds 10 consumer-run community programs.

The state funds consumer, family, and public education. Working with Wisconsin United for Mental Health, a coalition of consumer, provider, and advocacy groups, DMHSAS provides education and awareness training to employers, schools, health care providers, news media, and the general public. Although the state is known to value consumer and family views, it does not promote the use of consumer and family monitoring teams to review conditions in its hospitals and community programs.

Wisconsin supports five "Fountain House" model certified clubhouses and a limited number of high-quality Assertive Community Treatment (ACT) teams. However, the state's 79 Community Support Programs (CSPs), which are generally based on ACT principles, fall far short of national ACT standards. DMHSAS has acknowledged that the pioneering 1989 CSP standards, the first in the nation to create a Medicaid ACT benefit, need to be upgraded. Other community programs such as integrated dual diagnosis treatment, supported employment, and other EBPs also lack fidelity to national standards.

DMHSAS is seeking to fill a gap between office-based outpatient counseling and CSP intensity. A new level of care, called Comprehensive Community Services (CSS), is being implemented, but it will take some time to know how well CSS fills the need. Access to medication is restricted under Wisconsin's Medicaid program. A prior authorization process exists for psychiatric medications that are not on the state's preferred drug list, but waiting times can impede clinical response and recovery.

Many counties lack police Crisis Intervention Teams (CIT) and mental health courts. Only two jail diversion programs and one reentry program exist in the entire state.

Wisconsin is one of the lower-performing states on cultural competence. DMHSAS is working on a plan for improvement. It also seeks ways to improve critical event reporting and analysis, and to address workforce shortages in rural areas. The challenge, however, lies in turning plans into reality.

Wisconsin offers a vision of recovery, wellness, and consumer and family inclusion; but, strategically, the vision is limited by its mental health care system's county-by-county fragmentation. The state needs a longer, broader vision of transformation and adequate investment for the future.

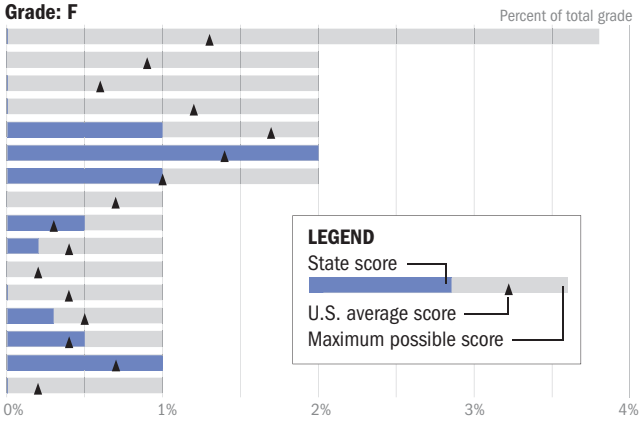
NAMI Score Card: WYOMING

Grade: F

Category I: Health Promotion & Measurement

Grade: F

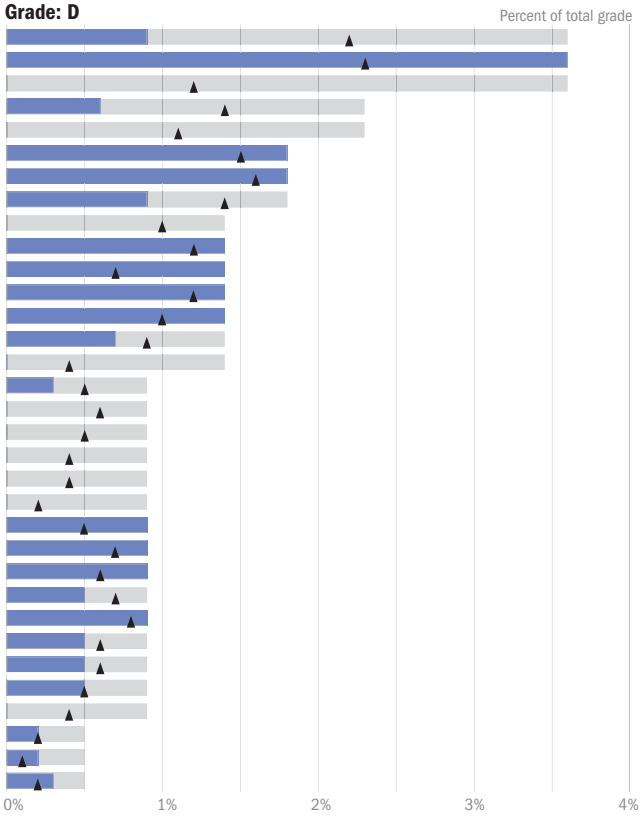
Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



Category II: Financing & Core Treatment/Recovery Services

Grade: D

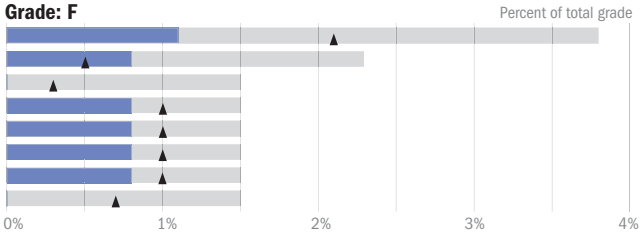
Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



Category III: Consumer & Family Empowerment

Grade: F

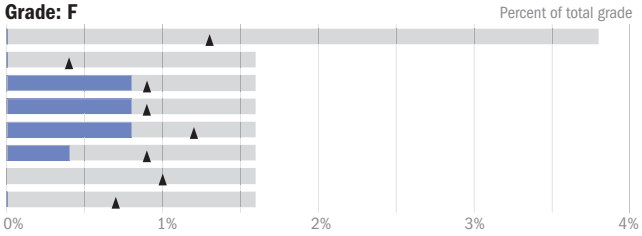
Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion

Grade: F

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



Wyoming

In 2006, Wyoming's mental health care system received a D grade. Three years later, it receives an F, a disappointment for a state that has sought to make at least some investments in mental health services in recent years.

Inadequacy in housing and workforce development, as well as few evidence-based practices under the state Medicaid program, are primarily responsible for the grade drop.

The Wyoming Department of Health's Mental Health and Substance Abuse Services Division (MHSASD) contracts with a network of 15 community mental health centers in five regions (Central, Northeast, Basin (Northwest), Southeast, and Southwest) that serve the state's 23 counties. The Wyoming State Hospital in Evanston, the subject of past legal action over poor conditions for patients, is part of a separate division of the Wyoming Department of Health.

The legislature's Select Committee on Mental Health and Substance Abuse Services has played an important role in identifying and prioritizing pressing needs in this sparsely populated rural state. In 2007, the legislature increased spending by $18 million in an effort to meet those needs—but more is needed.

Wyoming has funded a crisis stabilization pilot program that has helped reduce the need for hospitalizations. Crisis stabilization services serve a vital role and are particularly needed given that Wyoming State Hospital is straining to keep up with demand. MHSASD is also collaborating with consumers, families, and other state agencies to promote a more coordinated, cost-efficient, and client-driven "system of care" approach to serving people with multiple needs. To raise public awareness, the state has held public hearings with a "listening panel" of government leaders in which consumers share their stories about the impact of lack of social acceptance and inclusion.

Wyoming has implemented a new outreach program that provides veterans with information and referral to mental health services. It has peer support specialists in several of the state's community mental health centers and supported employment programs in a couple of regions. Both efforts help promote recovery and should be expanded to all five regions.

Despite new investment, mental health services remain sparse and inadequate, with many areas lacking psychiatric care and reasonable access to needed services and supports. Safe and affordable housing and transportation are significant challenges—along with a shortage of mental health workers, particularly psychiatrists, and opportunities for workforce training.

Although conditions appear to have improved at the state hospital, there is still a need to integrate it with a statewide continuum of care. Without an array of accessible and effective services throughout the state, including jail diversion programs, Wyoming is likely to continue to face a high suicide rate and the significant costs of placing individuals with serious mental illnesses in hospitals or jails.

Simply put, Wyoming's F is an indication that the system is inadequate to meet the needs of its citizens. For progress to be made, greater investments need to be made and sustained over time.

Innovations

- "System of care" collaboration
- Veterans mental health outreach program
- Peer support specialists
- Crisis stabilization pilot programs

Urgent Needs

- Safe and affordable housing
- Expand crisis stabilization
- Workforce development
- Transportation

Consumer and Family Comments

- *"We have had one psychiatrist who has been with the mental health system for a long time. This psychiatrist is dedicated to the community. She is the best thing in our area."*
- *"We are a very rural area and it is not uncommon to have to drive 50 miles to receive help. When a person needs care, it needs to be available and that is just not the case in my community."*
- *"My employer (I was employed at a public mental health center) saw my improvement and offered me an opportunity of a lifetime. They asked me if I would like to be a peer support specialist."*
- *"My family member has had two involuntary commitments in the past five years. Both times, he was forced to stay in a local jail because mental health beds were not available in local hospitals or in the only state mental hospital."*

APPENDIX

Methodology and Information Sources

This appendix presents the questionnaire items and scoring approach used for NAMI's 2008 Survey of State Mental Health Agencies and Consumer and Family Test Drive, and also presents information on secondary data sources used to score the states.

I. NAMI's 2008 Survey of State Mental Health Agencies

Numbers Served and Priorities

1. Please provide an unduplicated count of the number of adults living with mental illnesses served by your state Mental Health Agency in FY 2007.

   States were not scored on this question.

2. Please provide an unduplicated count of the number of adults living with *serious* mental illnesses served by your state Mental Health Agency in FY 2007.

   The reported number was compared to an estimate of the number of adults living with a serious mental illness in the state. The resulting ratio was ranked by size, grouped into quartiles from low to high, and states were assigned points from 1 (low) to 4 (high).

3. How does your state Mental Health Agency define "serious mental illness"?

   States were not scored on this question. The answers were used for background information.

4. Please break down the number of adults living with serious mental illnesses served (Item 2 above) *by race/ethnicity*.

   States scored between 0 and 2 points, depending on the comprehensiveness of the reported data (e.g., the state reported data on both race and ethnicity).

5. Does your state Mental Health Agency prioritize services to people living with serious mental illnesses through service eligibility criteria and/or benefit design?

   If yes, please describe how (and if this prioritization is expected to change in the near future).

   States were not scored on this question. The answers were used for background information.

6. Does your state have formal policies to ensure that adults living with serious mental illnesses and active co-occurring substance use disorders are not refused admission to, or discharged from, mental health care due to substance abuse?

   Please provide any details/clarifications you may have about these policies.

   Each state scored between 0 and 2 points, depending on the strength of the state's response. That score then was combined with the scores for Items 7 and 8.

7. Does your state have formal policies to ensure that adults living with serious mental illnesses and active co-occurring substance use disorders are not refused admission to, or discharged from, substance abuse treatment due to a serious mental illness?

   Please provide any details/clarifications you may have about these policies.

   Each state scored between 0 and 2 points, depending on the strength of the state's response. That score then was combined with the scores for Items 6 and 8.

8. Does your state promote (by regulation, training, and/or funding incentives) co-occurring disorder competency among mental health providers serving adults living with serious mental illnesses?

   If yes, please provide any details you may have about the extent or nature of this support/promotion.

   Each state scored between 0 and 3 points, depending on the strength of the state's response. That score then was combined with the scores for Items 6 and 7.

Mental Health Parity, Medicaid, and Funding

9. Does your state have a law governing insurance coverage of mental health disorders or a mental health parity law? If yes, which, if any, of the following apply to the law? *(Check all that apply)*

☐	It excludes small group plans
☐	It allows for an exemption if the resulting cost increase exceeds a specified percentage
☐	It requires that specified mental health benefits be made available, but only as a plan option

Which disorders are covered by the law and how? *Check all that apply*.

Serious Mental Illnesses (SMI)	Broad Range of Mental Health Disorders (MH)	Substance Use Disorders (SUD)	
☐	☐	☐	Types of disorders covered by the law (SMI, MH, SUD)
☐	☐	☐	It allows unequal cost-sharing between the covered disorders and other health conditions (e.g., different co-pays, co-insurance, and/or deductibles)
☐	☐	☐	It specifies a minimum or maximum benefit for the covered disorders
☐	☐	☐	It requires equal benefits (parity) for the covered disorders

Each state scored between 0 and 4 points depending on the strength and comprehensiveness of the state law: no parity law or applies only to state employees (0 points); parity law with minimum or maximum benefits and/or optional mental health coverage (1 point); parity law with small group exclusions, unequal cost sharing, and/or cost increase exemptions (2 points); parity benefits for serious mental illness (3 points); and parity benefits for broad range of mental health and substance use disorders (4 points).

10. Does your Medicaid state plan reimburse providers, in whole or in part, for any of the following services? By "in part," we mean that the plan may only reimburse for a component of the service/practice listed. *Check all that apply*.

☐	Targeted case management for individuals with serious mental illnesses
☐	Assertive Community Treatment
☐	Illness Self Management and Recovery
☐	Family psychoeducation
☐	Supported housing
☐	Supported employment
☐	Supported education
☐	Mobile Crisis Services
☐	Peer Specialist Services
☐	Language access services such as professional translators or interpreters
☐	Transportation
☐	Mental health services via interactive video-conferencing (Telemedicine/Telemental health)

Each service/practice scored as 0 or 1 point, depending on whether the state Medicaid plan covers the service. (States were also given points towards their cultural competence composite score if the Medicaid plan covers language access services and transportation.)

11. Does your state charge co-pays for outpatient mental health services for mandatory Medicaid beneficiaries living with serious mental illnesses who qualify for Medicaid based on their disability?

    If yes, how much are these co-pays?

    Each state scored between 0 and 2 points: 2 points for no co-pays; 1 point for co-pays for some groups of people and/or services, but service not denied for non-payment; co-pay possible but usually waived; etc.; 0 points otherwise.

12. Does your state currently offer coverage of benzodiazepines for people dually eligible for Medicaid and Medicare and enrolled in the Medicare Part D program?

    Each state scored 0 (for no/don't know) or 1 point (for yes).

13. Does your state Medicaid agency restrict access to antipsychotic medications through a preferred drug list (PDL) or some other restriction such as prior authorization or step therapy?

    If yes, what PDL or other restrictions does your state use?

    What (if any) consumer protections are available in your state to facilitate access to medications not on the PDL (e.g., immediate telephonic approval for physician orders)?

    Each state scored between 0 and 2 points, depending on severity of the restrictions and (if there are restrictions) the adequacy of consumer protections.

14. Does your state limit the total monthly number of prescriptions that can be covered by Medicaid for beneficiaries?

    If yes, what are the specific limits?

    Each state scored between 0 and 2 points: 2 points for no limits; 1 point for limits of seven or more prescriptions and/or restrictions for certain sub-groups of individuals; 0 for limits of six or fewer prescriptions per month.

15. Does your state have a written mandate requiring that the state Pharmacy and Therapeutics (P&T) committee include a member who is an adult living with a serious mental illness or a family member affected by serious mental illness?

    Each state scored between 0 and 2 points: 2 points if the state answered yes; 1 point if the state answered either yes or no but added there is no mandate OR that a mandate is not needed because state has an open formulary; 0 points otherwise.

16. Does your state have a prescriber feedback system to educate physicians and others prescribing antipsychotic medications?

    Each state scored between 0 and 2 points, depending on the strength of the state's response (partial credit was given for more limited efforts, such as pilot programs, specific drugs, or feedback that is not prescriber-specific).

17. Does your state allow providers (other than those in rural health clinics) to bill Medicaid for both behavioral health (mental health and/or substance abuse services) and other types of services on the same day?

    Each state scored either 0 (for no/don't know) or 1 point (for yes).

    If yes, has your state proactively notified providers that this can be done?

    If yes, we would like to see a copy of this notification or other documentation (see checklist at the end of this questionnaire).

    States were not scored on this question.

18. Has your state implemented one or more programs to expand access to health insurance coverage for uninsured adults? (Do not include a high-risk pool program or an expansion of eligibility for the state's existing Medicaid program).

    If yes, do all of these programs include some treatment for mental health conditions? *Check all that apply:*

Serious Mental Illnesses (SMI)	Broad Range of Mental Health Disorders (MH)	Substance Use Disorders (SUD)	
☐	☐	☐	Do any of these programs provide equal *outpatient* benefits for SMI, MH, or SUD disorders and other health conditions?
☐	☐	☐	Do any of these programs provide equal *inpatient* benefits for SMI, MH, or SUD disorders and other health conditions?

Each state scored between 0 and 7 points: 1 point if the state has one or more programs to expand access to health insurance coverage for uninsured adults AND all of these programs include some treatment for mental health conditions; 1 additional point for every box checked in the table (with the broad range of mental health disorders assumed to include all serious mental illnesses whether or not that column was checked); 0 points otherwise.

19. Does your state have a policy of suspending, rather than terminating, Medicaid benefits during incarceration?

Each state scored either 0 (for no/don't know) or 1 point (for yes). This score then was combined with the score for Item 20.

20. Does your state have procedures for restoring Medicaid benefits immediately upon release from incarceration?

    If yes, please provide any details you may have about the extent or nature of these procedures.

Each state scored either 0 (for no/don't know) or 1 point (for yes). This score then was combined with the score for Item 19. States were eligible for another point for showing additional commitment to suspension/restoration of Medicaid benefits post-incarceration, for a total of 3 possible points.

Olmstead

21. Does your state have a comprehensive, effectively working Olmstead Plan (not a Council or group but a detailed plan)?

    If yes, we would like to see your state's Olmstead Plan (see checklist at the end of this questionnaire).

    Does the plan include *(check all that apply)*...

	Psychiatric Hospitals	Nursing Homes	Unspecified Setting
An estimate of the number of people living with mental illnesses who are currently institutionalized and eligible for services in community-based settings?	☐	☐	☐
A description of the procedures for identifying people living with mental illnesses who are currently institutionalized and who could be served in the community?	☐	☐	☐
Measurable outcomes/targets for how many people living with mental illnesses will be offered community placement?	☐	☐	☐
Specific timetables for moving qualified people living with mental illnesses into community-based settings?	☐	☐	☐

A description of the procedures for identifying people living with mental illnesses in the community who are at risk of placement in an unnecessarily restrictive setting?	☐
A review of the funding sources (both Medicaid and other funding sources) available to sustain a range of community-based housing?	☐

States were not scored on this question. The answers were used for background information.

Evidence-Based Practices and Other Community Services

22. Does your state's Mental Health Agency or other agencies currently offer or fund any of the following evidence-based practices and other services for adults? (Check all relevant cells)

Evidence-Based Practice (EBP) or Other Service	Available	
	In Parts of State Only	Statewide
EBP - Assertive Community Treatment (ACT)	☐	☐
EBP - Supported Employment	☐	☐
EBP - Integrated Dual Diagnosis Treatment for People with Co-Occurring Mental Illness and Substance Abuse Addiction	☐	☐
EBP - Illness Management and Recovery	☐	☐
EBP - Family Psychoeducation (SAMHSA-identified model)	☐	☐
Permanent Supported Housing (PSH)	☐	☐
Housing First (one model of PSH)	☐	☐
Pre- and Post-Booking Jail Diversion Programs for adults living with serious mental illnesses	☐	☐
Re-entry Programs for prisoners/jail detainees living with serious mental illnesses who are returning to the community	☐	☐
ICCD-Certified Clubhouses	☐	☐
Consumer-Run Programs	☐	☐

Each state scored as follows for each service or practice: 0 (not available); 1 point (available in parts of the state only); or 2 points (available statewide).

23. For those evidence-based practices (EBPs) and other services your state's Mental Health Agency or other agencies offer or fund, please provide (if available) the number of programs, the number of people served, and (if applicable) the fidelity standard and/or certification used. For the EBPs, please include only those programs that adhere to the evidence-based model.

Evidence-Based Practice (EBP) or Other Service	Number of Programs	Number of Adults or Families Served (FY2007)	Fidelity Measure/ Certification Used
EBP - Assertive Community Treatment (ACT)			
EBP - Supported Employment			
EBP - Integrated Dual Diagnosis Treatment for People with Co-Occurring Mental Illness and Substance Abuse Addiction			
EBP - Illness Management and Recovery			
EBP - Family Psychoeducation (SAMHSA-identified model)			
Permanent Supported Housing (PSH)			
Housing First (one model of PSH)			
Pre- and Post-Booking Jail Diversion Programs for adults living with serious mental illnesses			
Re-entry Programs for prisoners/jail detainees living with serious mental illnesses returning to the community			
ICCD-Certified Clubhouses			
Consumer-Run Programs			

Each state scored between 0 and 3 points, depending on how well it reported data on all of the programs/services checked off in Item 22. (States were not scored on the actual numbers of people/programs but whether they have this information to report.) For ACT only, NAMI calculated the numbers of people receiving ACT (or an estimate of this number if only the number of ACT teams was reported) relative to the number of adults with serious mental illness in the state. States then were ranked by these per capita ACT rates and scored as follows: 4 points for enough ACT to serve 15 or more people (per 1,000 adults with serious mental illness); 3 points for enough ACT to serve 7 to 14.9 people; 2 points for enough ACT to serve 3 to 6.9 people; 1 point for any ACT up to 2.9 people; and 0 points otherwise.

24. Does your state promote (by regulation, training, and/or funding incentives) the use of peer-run services (e.g., peer specialists, peer-run support groups and/or drop-in centers, bridgers and crisis diversion models and workers)?

If yes, please provide any details you may have about the extent or nature of this support/promotion.

Each state scored between 0 and 2 points, depending on the strength of the state's response.

25. Does your state Mental Health Agency offer any programs/services specifically designed for adults living with serious mental illnesses (including post-traumatic stress disorder or PTSD) who are part of National Guard families transitioning back from combat deployments in Iraq and Afghanistan?

If yes, are these programs/services for National Guard service members, their family members, or both? (Check all that apply)

☐	National Guard Service Members
☐	Family Members of National Guard Service Members
☐	Don't know

Please describe these programs/services briefly (including any details about numbers served, funding sources/amounts, etc.).

If no (or don't know), does your agency have any plans to develop any specialized programs or services for these National Guard service members and their families?

Each state scored between 0 and 3 points, depending on the strength of the state's response.

System Capacity for Inpatient and Crisis Beds

26. Does your state track or monitor the average wait time for an inpatient psychiatric bed for adults admitted to hospitals from an emergency room/department?

    If yes, what is this average wait time and how was this number generated?

    Each state scored between 0 and 3 points, depending on the strength of the state's response. (States were not scored on the actual wait times, but whether they have this information and are able to report it.)

27. Does your state track or monitor psychiatric bed capacity for adults living with serious mental illnesses by setting (e.g., long-term/continuing inpatient care beds, short-term/acute crisis psychiatric beds, and sub-acute/step-down/crisis stabilization outpatient beds)?

    If yes, please provide us with your most recent state-wide bed counts (by setting). *Feel free to use an alternate categorization of bed settings if needed*.

	Inpatient Beds		Community Beds
Suggested categorization of psychiatric bed settings—	Long-term/ continuing inpatient care beds	Short-term acute crisis psychiatric beds	Sub-acute/step-down/ crisis stabilization outpatient beds
OR *Optional Alternate* categorization of psychiatric bed settings—			
Number of beds—			

Each state scored between 0 and 2 points: 2 points for significant data that appears to be useful for state planning/policy purposes, including some approximation of the number of community-based beds; 1 point for some data on the number of beds in at least one setting; 0 points for very limited or no data on the number of beds. (States were not scored on the actual numbers of beds, but whether they have this information to report.)

Consumer/Family Education and Accountability

28. Does your state Mental Health Agency provide support for any nationally-recognized family education programs such as NAMI's Family-to-Family Education program?

    If yes, please provide any details you may have about the extent or nature of this support.

    Each state scored between 0 and 2 points, depending on the strength of the support indicated in the state's response.

29. Does your state Mental Health Agency provide support for any nationally-recognized illness-self management and recovery programs such as NAMI's Peer-to-Peer Education program, WRAP, Bridges, etc.?

    If yes, please provide any details you may have about the extent or nature of this support.

    Each state scored between 0 and 2 points, depending on the strength of the support indicated in the state's response.

30. Does your state Mental Health Agency provide support for any nationally-recognized mental health provider training programs that have significant consumer and family involvement, such as NAMI's Provider Education program?

    If yes, please provide any details you may have about the extent or nature of this support.

    Each state scored between 0 and 2 points, depending on the strength of the support indicated in the state's response.

31. Does your state provide support for mental illness public education and anti-stigma efforts, especially those countering myths of permanent incapacity and violence?

    If yes, please provide any details you may have about the extent or nature of this support.

    Each state scored between 0 and 2 points, depending on the strength of the support indicated in the state's response.

32. Does your state require that consumer and family monitoring teams review conditions in various mental health treatment settings, and authorize these teams to conduct unannounced visits/inspections?

	State or County Psychiatric Hospitals	Other in-patient facilities	Community-based mental health programs
State requires that consumer and family monitoring teams review conditions in . . .	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know
State authorizes these teams to conduct unannounced visits or inspections in . . .	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

    Each state scored 1 point for each positive response for a maximum of 6 points.

33. Using empirical data, can your state demonstrate progress (since 2000) in reducing seclusion and restraint in various facilities operated, licensed, or certified by the state Mental Health Agency? *Check each column.*

Public Psychiatric Hospitals (State or County)	Publicly-funded or certified residential treatment facilities for adults living with mental illnesses	Publicly-funded general hospitals certified by or under contract with your agency
☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know	☐ Yes ☐ No ☐ Don't know

    If yes to any of these, we would like to see these data; you can de-identify these facilities if you must (see checklist at the end of this questionnaire).

    Each state scored between 0 and 5 points depending on the quality, scope, and timeliness of the empirical data submitted, and the extent of reductions demonstrated.

34. Are current data or reports relating to the use of seclusion and restraint in any of these facilities available to the general public in a user-friendly format on a state website?

    Each state scored either 0 (for no/don't know) or 1 point (for yes).

Cultural Competence and Disparities

35. Does your state Mental Health Agency have a comprehensive Cultural Competence Plan?

    If yes, we would like to see your state's Cultural Competence Plan (see checklist at the end of this questionnaire).

    Each state scored between 0 and 2 points: 2 points if the state had a cultural competence plan and attached it; 1 point if the state did not have a plan but provided evidence of efforts in this area; 0 points otherwise.

    Cultural competence plans also were reviewed and assigned a score of 0 to 9 points as follows: 1 point for each of the following 6 items (consumer, family, and community involvement in the planning process; penetration and retention rates by racial/ethnic group; incorporation of cultural competence standards and requirements for contracts and quality management plans; cultural competence training components for staff (at all levels), contractors, and other stakeholders; measurable cultural competence performance indicators, outcomes and timetables; and language access components), and up to 3 additional points for evidence of progress.

36. Has your state recently (within the past two years or so) formulated or revised a comprehensive state plan or strategy to eliminate/reduce disparities in mental health care for racial and ethnic minorities?

    If yes, we would like to see this plan/strategy (see checklist at the end of this questionnaire).

    Each state scored between 0 and 2 points: 2 points if the state has a disparities plan and the plan was attached; 1 point if the plan is part of other plans/efforts, or there is no plan but considerable efforts are taking place; 0 points otherwise.

37. Does your state promote (by regulation, training, and/or funding incentives) cultural competency among mental health providers serving adults living with serious mental illnesses?

    If yes, please provide any details you may have about the extent or nature of this support (e.g., contract language on cultural competence requirements, policies, standards, etc.).

    Each state scored between 0 and 2 points, depending on the strength of the support indicated in the state's response.

Health Promotion/Suicide Prevention

38. Does your state study the causes of death for people living with serious mental illnesses?

    If yes, does this study include information about race/ethnicity?

    Is this study available to the general public?

    Each state scored between 0 and 3 points depending on the number of "yes" responses. Deductions were taken for clarifications indicating that cause of death studies are limited to certain treatment settings or sub-groups of individuals.

39. Has your state recently (within the past two years or so) formulated or revised a comprehensive state plan or strategy, with quantifiable outcomes and a timetable, to promote wellness and reduce the morbidity/mortality of adults living with serious mental illnesses?

    We would like to see this plan/strategy (see checklist at the end of this questionnaire).

    Does this plan/strategy include information about race/ethnicity?

    Each state scored between 0 and 2 points: 2 points for wellness plans that were comprehensive, with quantifiable outcomes, a timetable, and information on race/ethnicity. States received fewer points for plans that have not yet been implemented.

40. Has your state established suicide prevention as a performance measure for your state mental health system?

    If yes, are there separate performance measures by race/ethnicity?

How is this measure defined or operationalized? What are the values of these measures now, and what are the targets or goals for the future?

Each state scored between 0 and 2 points, depending on the strength of the state's response.

41. Is your state currently funding or implementing any programs that integrate mental health care and general health care for adults living with serious mental illnesses?

If yes, please provide any details you may have about the extent or nature of these programs.

Each state scored between 0 and 2 points, depending on the strength of the state's response including presence of outcome measures.

42. Does your state fund smoking cessation programs in ...

Public psychiatric hospitals (state or county)?

Community mental health centers and other community mental health programs?

Each state scored between 0 and 2 points, depending on number of settings indicated by state's response.

Housing

43. Has your state recently (within the past two years or so) formulated or revised a comprehensive state plan or strategy, with quantifiable outcomes and a timetable, to address the long-term housing needs of adults living with serious mental illnesses?

If yes, we would like to see this housing plan/strategy (see checklist at the end of this questionnaire).

Does the plan include specific commitments or action steps to be taken by any of the following? *(Check all that apply)*

☐	State Department of Housing/Community Development
☐	State/Local Housing Authorities
☐	State Housing Finance Authority
☐	Other state agency (please specify):
☐	Other state agency (please specify):
☐	Don't know

Please provide any details you may have about the extent or nature of those commitments (especially financial commitments) that have already been fulfilled by these other agencies.

Each state was scored on Items 43 and 44 based on whether the state has: a recent and mental health-driven housing plan; quantifiable milestones/outcomes and timetables; partnerships with other state agencies involved in housing; and the numbers/types of dedicated or innovative housing financing mechanisms. Items 43 and 44 were each scored between 0 and 5 points for a total of 10 points.

44. Does your state have any type of dedicated or innovative financing mechanisms to support permanent supportive housing for people living with serious mental illnesses (e.g., rental subsidies, bridge subsidies, capital or bond financing)?

    If yes, please indicate what mechanisms are available and any details about dollar amounts, over what years, numbers of units or people, etc.

Housing Financing Mechanism	Rental Subsidies	Bridge Subsidies	Capitol/Bond Financing	Other:	Other:
Dollar Amount					
What Year(s)					
# Units/Slots					
No. of People					
Other:					
Other:					

Criminal Justice System

45. Does your state provide support for Crisis Intervention Team (CIT) programs or other nationally-recognized programs that foster more appropriate, effective, and safer responses to mental health crises by law enforcement?

    If yes, please provide any details you may have about the extent or nature of this support.

    Each state scored between 0 and 2 points, depending on the strength of the support indicated in the state's response.

46. Does your state have any mental health courts designed to help divert people living with serious mental illnesses from the criminal justice system into mental health treatment?

    If yes, how many mental health courts are in your state?

    How many people do these courts see in a year?

    Do these courts have access to dedicated or new resources to provide community-based treatments?

    If yes, what dedicated or new resources can these courts access?

    Each state scored between 0 and 4 points: 1 point for having one or more mental health courts; 1 point for reporting data on numbers of mental health courts in the state; 1 point for reporting data on number of people served by these courts; and 1 point for identifying dedicated and new resources available to support these courts, for a total of 4 points. (States were not scored on the actual numbers of courts or people, but whether they have this information to report.)

    The number of mental health courts relative to the number of adults with serious mental illness in the state was also calculated. States then were ranked by these per capita mental health court figures and scored as follows: 3 points for 6 or more courts per 100,000 adults with serious mental illness; 2 points for 3 to 5.9 courts; 1 point for any number up to 2.9 courts; and 0 points otherwise.

Workforce

47. Has your state recently (within the past two years or so) formulated or revised a comprehensive state plan or strategy, with quantifiable outcomes and a timetable, to address the mental health workforce needs?

    If yes, we would like to see this mental health workforce plan/strategy (see checklist at the end of this questionnaire).

Does this plan/strategy pay particular attention to increasing the racial/ethnic diversity of the state's mental health workforce?

Each state scored between 0 and 3 points, depending on evidence of a broad range of workforce goals, specification of desired outcomes and timelines, and exemplary planning activities. Each state scored from 0 to 3 additional points for addressing ethnic/racial diversity in their workforce planning.

Concluding Questions

48. Please share briefly the most pressing issue(s) facing your state with respect to serving adults living with serious mental illnesses.

States were not scored on this question. The answers were used for background information.

49. Please share briefly any area(s) of particular strength or innovation your state has demonstrated in solving a pressing mental health problem.

States were not scored on this question. The answers were used for background information.

As described in Chapter 2, in calculating states' category-specific and overall grades, each of these scores was "weighted" to reflect NAMI's best judgment of the relative importance of each measure. The weights used for each questionnaire item are reported in Chapter 2.

II. NAMI's 2008 Consumer and Family Test Drive

Purpose

The Consumer and Family Test Drive (CFTD) was used to determine the ease with which a consumer and/or family member can gather needed information about mental health from a state mental health agency's Web site and/or phone service. CFTD project staff developed a brief survey using domains from the NAMI National questionnaire associated with the larger *Grading the States* project.

Survey

The survey included 10 items pertaining to mental health issues, rated on a Likert scale of 0 to 4 in which:

0 = "no information found"
1 = information found "with great difficulty"
2 = information found "with some difficulty"
3 = information found "easily"
4 = information found "very easily"

The maximum total score per survey was 40 points. Survey items were basic, assessing accessibility of information such as "where to go for help for mental illness," "recovery and wellness promotion," and "how to apply for Medicaid." Two family members and two consumers were to survey each state. Each individual rater was to survey a state twice: once for the state's Web site and once for the state's phone service. This would yield a total of eight surveys per state.

Recruitment and Training of Raters

Consumers were recruited from NAMI New Hampshire's "In Our Own Voice" program presenters. Family members were individuals who had previously participated in NAMI NH programs, classes, or other activities. Since these consumers and family members had already volunteered much of their time toward mental health education and awareness, it was assumed they might be able to donate the considerable time necessary to complete the test drive surveys. In the end, nine consumers and nine family members were recruited.

Each participant was asked to survey at least 10 states. Four family members and three consumers were asked to take-on additional, unassigned, or uncompleted surveys. Participants received a stipend for completed surveys and were reimbursed for expenses such as postage and phone charges.

In order to ensure inter-rater reliability, a two-hour orientation was held for all participants. Four individuals unable to attend received one-on-one orientation from NAMI NH research staff. The training focused on issues such as: how to search for a state mental health agency's Web site; when to consult the provided "cheat sheet" (NAMI NH provided phone and Web site information if the consumer and/or family member could not find it on his or her own); how long to spend on each item before checking the "No info found" box; how to include anecdotal information; how to score if multiple voice messages were left; and when to "give up" searching for information and provide a score. Because the survey sought numerical ratings on ease of access, training emphasized that factual information that was gathered need not be written down.

Data Collection

Data collection took place over a seven week period, from the end of September to early November, 2008. Throughout, project staff provided extensive phone technical assistance to raters. Raters' questions included: what to do about the need for a zip code or mailing address in order to access state information; how to access Web site documents that were in an electronic application they could not open on their computers (e.g., a PDF file); and what to do if state mental health agencies did not return their calls.

In all, 401 surveys were collected out of a possible 408 (one rater dropped out of the project and the surveys could not be re-allocated on time). All state surveys had consumer and family member representation. For seven states, six surveys were completed, while for the remaining 44 states, the full eight surveys were completed.

Scoring

The Test Drive was scored as follows: for each state, a mean score was obtained by using all completed phone and Web site surveys for that state and then calculating the average total survey score (out of a possible 40 points). States were then rank-ordered according to their mean scores and distributed into 10 groups of five states each. The top five states received 10 points, the next five received nine points, and so on. The last group of five states scored one point each. This unweighted score accounted for 25 percent of each state's Category II score and 3.8 percent of its overall score.

Data Collection Materials

Target State: *<NAMI NH to Complete>*
State Assigned to: *<NAMI NH to Complete>*

Web site Survey

Were you able to locate the state mental health authority Web site?

☐ Yes ☐ No

If so, how easy was it to locate the correct Web site?

☐ Easy ☐ Somewhat Easy ☐ Somewhat Difficult ☐ Difficult

Today's Date: _____ Start Time: _____ Finish Time: _____

Did you have any technical issues connecting to the Web site?

☐ Yes ☐ No

Telephone Survey

Were you able to locate the State mental health authority phone number?

☐ Yes ☐ No

If so, how easy was it to locate the correct phone number?

☐ Easy ☐ Somewhat Easy ☐ Somewhat Difficult ☐ Difficult

Today's Date: _____ Start Time: _____ Finish Time: _____

Did you leave a voice message, and not hear back within 24-48 hours?

☐ Yes ☐ No

Did you leave a *second* voice message, and not hear back within 24-48 hours *again*?

☐ Yes ☐ No

Did you leave a *third* voice message, and not hear back within 24-48 hours *again*?

☐ Yes ☐ No

Names/Positions of people with whom you spoke on the phone (if available):

1. _____
2. _____
3. _____
4. _____

Web site 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 5 minutes, check the box that reads, "No information found" and go onto the next question.

	0	1	2	3	4	Comments
I can find information from the state mental health authority's Web site 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 treatment and services						
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 use disorder)						
4. Supported housing						
5. How to apply for Medicaid						
6. The process of involuntary commitment to inpatient treatment facility (state psychiatric hospital)						
7. Mental illnesses and their treatment *in a non-English language*						
8. How to communicate feedback or complaints to the state mental health authority						
9. Medications for the treatment of mental illnesses (this may include medication side effects)						
10. Recovery and wellness promotion (quitting smoking, exercise, managing medications, managing relapse prevention, etc.)						

Telephone 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 onto the next question.

	0	1	2	3	4	Comments
I can find information from the state mental health authority's personnel 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 treatment and services						
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 use disorder)						
4. Supported housing						
5. How to apply for Medicaid						
6. The process of involuntary commitment to inpatient treatment facility (state psychiatric hospital)						
7. Mental illnesses and their treatment *in a non-English language*						
8. How to communicate feedback or complaints to the state mental health authority						
9. Medications for the treatment of mental illnesses (this may include medication side effects)						
10. Recovery and wellness promotion (quitting smoking, exercise, managing medications, managing relapse prevention, etc.)						

III. Other Information Sources Used to Score States

State-Level Estimates of the Number of Adults Living with Serious Mental Illnesses

Throughout this report, NAMI draws on the estimates of the numbers of adults (age 18 and over) with serious mental illness in each state based on the work of Charles E. Holzer, III, Ph.D. of the University of Texas Medical Branch in Galveston, Texas and Hoang T. Nguyen, Ph.D. of LifeStat LLC (see Table A.1).[1] Holzer's estimates are drawn from the National Institute of Mental Health's Collaborative Psychiatric Epidemiology Surveys (CPES). Drawing on a variety of risk factors (age, race, ethnicity, gender, poverty, etc.), a synthetic estimation approach is used to construct the prevalence of persons with a serious mental illness based on their overall distribution within each state.[2] All "per capita" measures used in NAMI's scoring draw on Holzer's estimates of the number of adults with serious mental illness.

Traditionally, the mental health community has generated and used a single global prevalence rate for serious mental illness (5.4 percent of adults age 18 and older). As directed by the Substance Abuse and Mental Health Services Administration (SAMHSA), states apply this rate to their resident state populations to estimate the number of people with serious mental illnesses in their state. This number is also reported in SAMHSA's Uniform Reporting System (URS) administrative data. While drawing on similar sources of epidemiological data, the Holzer estimates used here are more finely tuned than the URS. Holzer's estimates, which are also available at the sub-state level, have been used extensively for local area needs assessments and planning. More recently, they were used in a national study of mental workforce shortage funded by the Health Services Resources Administration (HRSA).

There are several important differences between the more common SAMHSA/URS estimates and those used by NAMI in this report:

The source of prevalence rates for serious mental illness used in each of the two estimates differs. The URS estimates are based on prevalence data from the National Comorbidity Survey (NCS), the first nationally representative mental health survey in the U.S. to use a fully structured research diagnostic interview to assess the prevalences and correlates of DSM-III-R disorders. The data for the NCS were collected between 1990 and 1992. Holzer uses epidemiological data that are both more current and more accurate for racial/ethnic mi-

Table A.1 Number of Adults with Serious Mental Illness by State

Alabama	186,541	Montana	38,961
Alaska	23,650	Nebraska	60,744
Arizona	220,909	Nevada	88,540
Arkansas	116,435	New Hampshire	42,818
California	1,175,006	New Jersey	258,617
Colorado	157,828	New Mexico	71,674
Connecticut	108,730	New York	672,924
Delaware	28,652	North Carolina	334,855
DC	22,811	North Dakota	24,131
Florida	660,443	Ohio	418,207
Georgia	348,789	Oklahoma	147,343
Hawaii	32,435	Oregon	137,345
Idaho	54,375	Pennsylvania	448,455
Illinois	420,841	Rhode Island	37,739
Indiana	226,713	South Carolina	170,022
Iowa	104,922	South Dakota	30,351
Kansas	95,110	Tennessee	246,003
Kentucky	181,441	Texas	832,795
Louisiana	182,593	Utah	82,362
Maine	51,248	Vermont	22,712
Maryland	175,173	Virginia	261,959
Massachusetts	210,815	Washington	218,585
Michigan	348,154	West Virginia	81,214
Minnesota	167,810	Wisconsin	188,057
Mississippi	125,269	Wyoming	19,733
Missouri	222,596		

Note: National total is 10,585,435.
Source: Charles E. Holzer, III, Ph.D. of the University of Texas Medical Branch in Galveston, Texas and Hoang T. Nguyen, Ph.D. of LifeStat LLC (see psy.utmb.edu for additional information).

[1] The estimates used in this study are also available online (see psy.utmb.edu). For a description of the general methodology used to derive these estimates, see: Charles E. Holzer, III et al., "Horizontal Synthetic Estimation: A Strategy for Estimating Small Area Health Related Characteristics," *Evaluation and Program Planning* 4 (1981): 29.
[2] Importantly, the Holzer definition of serious mental illness roughly parallels the definition used by SAMHSA. Specifically, Holzer's operationalization of serious mental illness (termed MHM2) includes a minimum impairment score, a minimum number of disability days, and a range of chronic conditions including bipolar I and II, mania, major depression with hierarchy, Dysthymia hierarchy, generalized anxiety, hypomania, major depressive episode, panic disorder, posttraumatic stress disorder, agoraphobia with/without panic, social phobia and specific phobia. Although schizophrenia is not specifically accounted for by this measure, an individual with schizophrenia may be included under one of the other criteria.

norities. Holzer's prevalence rates are drawn from the National Institute of Mental Health Collaborative Psychiatric Epidemiology Surveys (CPES) Combined Dataset. The CPES provides data on the distributions, correlates, and risk factors of mental disorders among the general population, with special emphasis on minority groups. CPES data come from three nationally representative epidemiological surveys: the National Comorbity Survey-Replication (NCS-R), the National Latino and Asian American Study (NLAAS), and the National Survey of American Life (NSAL). The data for these surveys were collected in 2001, 2002-2003, and 2001-2003, respectively. For more information about these surveys, see http://www.hcp.med.harvard.edu/ncs/ for the NCS and NCS-R and http://www.icpsrdirect.com/CPES/ for the CPES.

The actual prevalence rates used to develop the population estimates differ. To calculate the number of adults living with serious mental illness in each state for the URS, a single prevalence rate (the NCS-derived 5.4 percent figure) to each state's adult civilian (non-institutional) population. This calculation is done per the latest guidance from SAMHSA to states as reported in the Federal Register on June 24, 1999 (see http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=1999_register&docid=99-15377-filed.pdf).

With the Holzer estimates, prevalence of serious mental illness differs from one state to another. This is because states have different socio-demographic profiles (meaning their populations differ in terms of age, sex, race, poverty, etc.) in addition to different total populations. Holzer applies CPES-based rates of serious mental illness separately for each of these sub-populations and then aggregates them to the state level. The result is that state rates of serious mental illness vary from one state to another. In this sense, these estimates are more "fine-tuned" than those in the URS.

The way serious mental illness is defined and operationalized differs. While the exact coding used for the NCS is not publicly available, Holzer's approach to operationalizing serious mental illness seems to be somewhat more restrictive than what appears to have been done for the NCS estimates. Holzer requires that the age of onset (in years) be at least one year less than the respondent's current age (in years). In order to be identified as having a serious mental illness, Holzer also requires that a sample respondent have either (a) a mean rating of 7 or higher on Sheehan Disability Scale scores (across several domains of activity of life) or (b) have lost 120 days or more of regular activity in the past year.

Finally, neither set of estimates does a good job of including an important class of disorders, namely non-affective psychosis or schizophrenia. The NCS measured these very poorly and, despite improvements in the screen used to predict non-affective psychosis in the NCS-R (with fewer false positives), systematic non-response bias remains. In other words, the NCS-R underestimates the true prevalence of non-affective psychosis. While this is an important group of individuals to NAMI and many others, it is not a numerically significant omission. Mood disorders and anxiety-related disorders account for much larger shares of people living with serious mental illnesses than do psychotic disorders; and individuals with schizo-affective disorders are likely to be reflected in both sets of data considered here.

State-Level Estimates of Mental Health Workforce Shortage

Researchers at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill recently developed county-level estimates of (1) the need for mental health professionals, (2) the number of mental health providers available to meet these needs, and (3) levels of unmet need given (1) and (2).[3] Their need estimation was based on state-specific estimates of mental illness developed by Dr. Charles Holzer, III (see discussion above). The Sheps shortage estimates are a by-product of a contract the Sheps Center had with the Health Resources and Services Administration (HRSA) at the U.S. Department of Health and Human Services to develop a new method for designating mental health professional shortage areas (see http://bhpr.hrsa.gov/shortage/index.htm for more information about HRSA's health professional shortage areas). The purpose of HRSA's shortage area designation is to identify underserved areas or groups so that limited federal resources can be targeted appropriately.[4]

The Sheps team estimated the need for mental health professionals by people with and without serious mental

[3] The researchers were Joseph P. Morrissey, Ph.D., Thomas R. Konrad, Ph.D., Kathleen C. Thomas, Ph.D., and Alan R. Ellis, MSW.

[4] The estimates and documentation presented here do not necessarily reflect the official policies of the U.S. Department of Health and Human Services.

illness using national data from the National Comorbidity Survey Replication, the U.S. Census, and the Medical Expenditure Panel Survey. Provider supply was estimated based on a compilation of the best available data from state licensing boards, national credentialing organizations, and professional associations. The team estimated need and supply for two separate categories of mental health professionals (prescribers and non-prescribers), and then used these estimates to calculate each county's unmet need as a percentage of its total need. The aggregated, state-level estimates reported here reflect adjustments for the availability of primary care providers (who meet some of the need for mental health services) and for travel between counties.

The Sheps team found that nearly one in five counties (18 percent) in the U.S. has an unmet need for non-prescribers and nearly every county (96 percent) has an unmet need for prescribers and, therefore, some level of unmet need overall. On average, 35 percent of a county's need for mental health professionals is unmet. The Sheps estimate used in this report is quartile for percent of overall need for mental health professionals that is unmet, with 1 indicating a high level of unmet need (relative to the state's total need for mental health professionals) and 4 indicating a low level of unmet need.[5] In the bar charts that accompany each state's narrative, NAMI refers to this as "workforce availability" (the first item in Category II).

The method used examined the geographic distribution of mental health professionals without taking into account their distribution across service sectors (e.g. public vs. private) or consumer populations (e.g., those with and without serious mental illnesses). Incorporating these factors would result in a more detailed picture of need, supply, and unmet need.[6]

Additional information about the Sheps estimation project can be found in the following forthcoming publications:

- AR Ellis, TR Konrad, KC Thomas, and JP Morrissey, (submitted for publication), "Supply of Mental Health Professionals in U.S. Counties."
- TR Konrad, AR Ellis, CE Holzer, III, KC Thomas, and JP Morrissey (submitted for publication), "Need for Mental Health Professionals in U.S. Counties."
- KC Thomas, AR Ellis, TR Konrad, CE Holzer, III, and JP Morrissey (submitted for publication), "Shortage of Mental Health Professionals in U.S. Counties."
- J Morrissey, K Thomas, AR Ellis, and T Konrad (2007) *Development of a New Method for Designation of Mental Health Professional Shortage Areas.* Unpublished report prepared under contract HHSH-230200532038C with the Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services.
- J Morrissey, K Thomas, AR Ellis, and T Konrad (2007) *Geographic Disparities in Washington State's Mental Health Workforce,* Chapel Hill, NC: Cecil G. Sheps Center for Health Services Research. Available at http://www.mhtransformation.wa.gov.

State-Level Estimates of Hospital-Based Inpatient Psychiatric Bed Capacity

State estimates of inpatient psychiatric bed capacity are drawn from the American Hospital Association's 2007 Annual Hospital Survey. The primary source of data on hospitals in the United States, the survey has been conducted annually since 1946 and includes approval and accreditation codes from 16 different health care organizations. The data are used by a wide variety of organizations for the purposes of research, market assessments, benchmarking, and strategic planning.

AHA's Annual Survey of Hospitals covers all hospitals in the United States. In addition to hospitals registered with the AHA, the survey identifies non-registered hospitals through state and local hospital associations, the Centers for Medicare and Medicaid Services and other government organizations, and other national organizations such as the Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations) and the Federation of American Hospitals.

The overall response rate for FY 2007 was 78 percent but this rate varies among sub-groups of hospitals depending on size, ownership, service, geographical location, and membership status. The response rate of community hospitals, defined as all non-federal, short-term

[5] Note that two states in adjacent quartiles may actually have very similar levels of unmet need. This measure also masks wide variation by county (within a state) in levels of unmet need.

[6] Additional information about these estimates can be found from the resources listed and from Dr. Joseph P. Morrissey at (919) 966-5829 or joe_morrissey@unc.edu.

general, and other special hospitals, is generally higher than that of non-community hospitals. The AHA database includes the number of total *staffed* beds irrespective of whether the hospital responds to their survey, so NAMI is confident that we have captured most beds in state/local psychiatric hospitals, despite a lower than average response rate.[7]

Federal Investigations and Lawsuits

At the end of the scoring process, NAMI imposed a penalty on states with active US Department of Justice "CRIPA" investigations and states with open "Olmstead" cases, each described below.

The Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997a et seq., authorizes the U.S. Attorney General to conduct investigations and litigation relating to conditions of confinement in state or locally operated institutions. The goal of Department of Justice (DOJ) CRIPA investigations is to determine whether there is a pattern or practice of violations of residents' federal rights in state or locally-run facilities such as jails and prisons, mental health facilities, and nursing homes. Six states have active DOJ CRIPA investigations relating to the treatment of people with mental illness: California, Connecticut, the District of Columbia (Washington, DC), Georgia, Oregon, and Vermont. More information on these cases can be found at http://www.usdoj.gov/crt/split/mh.php.

A second penalty is applied to states with community integration lawsuits related to Olmstead. Olmstead refers a 1999 Supreme Court judgment in the case *Olmstead v. L.C.,* a case brought the Georgia State Commissioner of Human Resources (Tommy Olmstead) on behalf of two women with developmental disabilities who were also diagnosed with mental illness. They were voluntarily admitted to Georgia Regional Hospital for treatment in a psychiatric unit, and, at a later point, they decided they were ready to be discharged (professionals working with them agreed they were ready to move into a community setting with appropriate supports). Unfortunately, they were not discharged from the hospital and in 1995 the Atlanta Legal Aid Society filed this lawsuit, which eventually went before the Supreme Court. The Supreme Court ruled that under Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12101 et seq., the women had the right to receive care in the most integrated setting appropriate and that their unnecessary institutionalization was discriminatory and violated the Americans with Disabilities Act. For more information about states with lawsuits relating to Olmstead, including the open cases involving adults with mental illness in Connecticut, Florida, Illinois, New Jersey, New York, Pennsylvania, and Wyoming, see http://www.pascenter.org/olmstead/olmsteadcases.php.

[7] NAMI also called a random sample of 10 percent of non-responding state/local psychiatric hospitals serving adults to verify the total number of staffed beds. In most cases, the numbers matched those in the AHA database exactly and, in a small number of cases, there were some small discrepancies.

ABOUT THE PHOTOGRAPHS IN THIS REPORT

The photographs in this report are part of "FINE LINE," a traveling documentary of voices, stories, and portraits that confronts stereotypes and reveals the courage and fragility of those living with mental illnesses.

Photographer Michael Nye spent four years photographing and recording stories. His work draws you into each life by exploring issues of family, confusion, pain, abuse, treatment, and healing.

FINE LINE has traveled to over 45 cities in the past five years. Museums, universities, hospitals, and many other organizations have used FINE LINE as a center piece for community engagement and education. For more information about bringing FINE LINE to your community, please visit www.michaelnye.org.

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