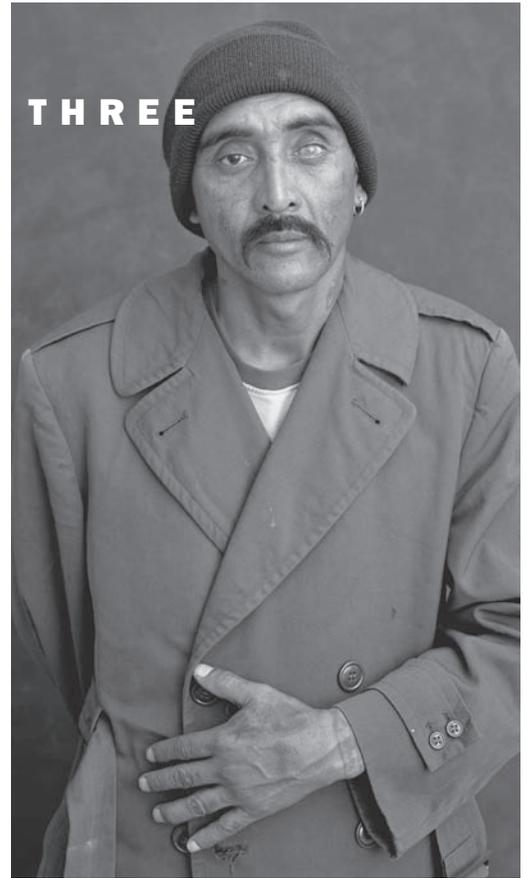


# The State of Public Mental Health Services Across the Nation



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,<sup>1</sup> 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

<sup>1</sup> 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.

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.

### 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,

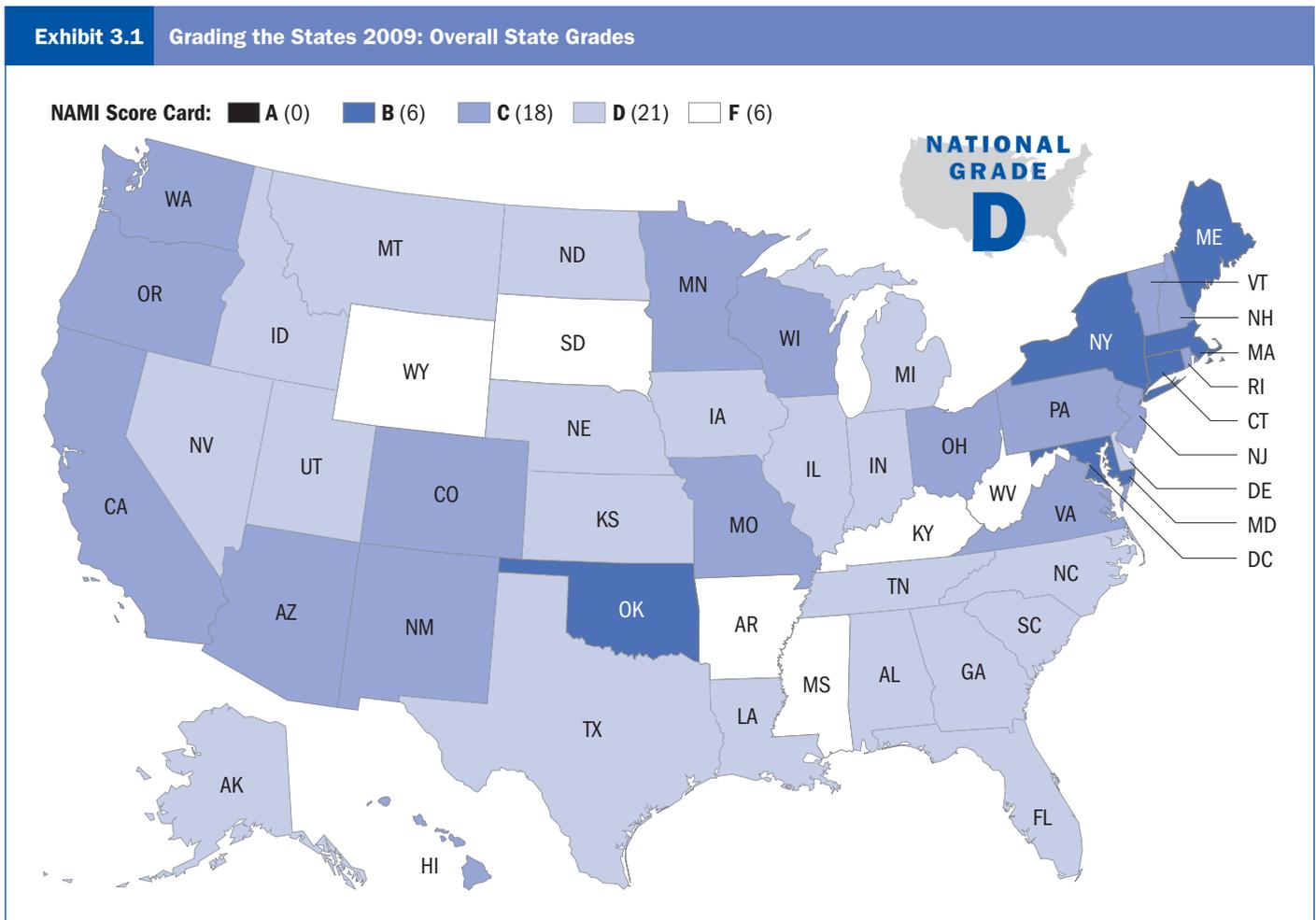


Table 3.1

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

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

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.<sup>2</sup> 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.

#### 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.<sup>3</sup> 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.

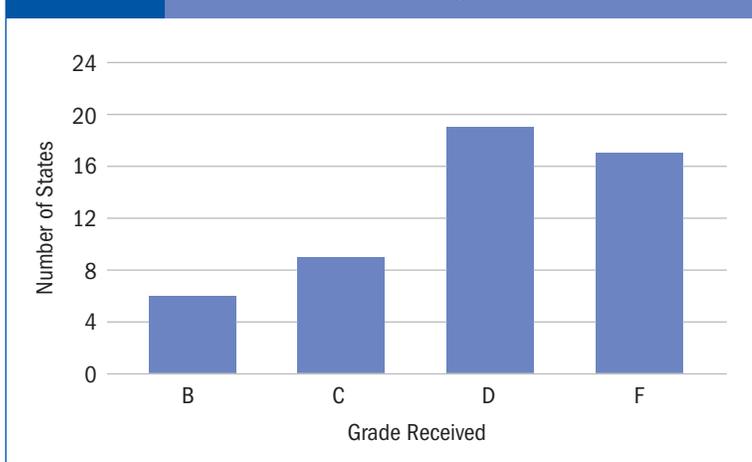
#### Where can innovative practices be found?

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

<sup>2</sup> 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](http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Technical%20Report%20on%20Morbidity%20and%20Mortality%20-%20Final%2011-06.pdf).

<sup>3</sup> 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.

**Exhibit 3.2** Distribution of 2009 Category I Scores



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,<sup>4</sup> 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.<sup>5</sup>

<sup>4</sup> Connecticut, Hawaii, Iowa, Maryland, Michigan, New Jersey, New Mexico, New York, Oklahoma, Rhode Island, Wisconsin, Maine, Massachusetts, North Dakota, and Tennessee.

<sup>5</sup> Arkansas, Connecticut, Delaware, Florida, Georgia, Maine, Maryland, Massachusetts, Mississippi, Missouri, and Rhode Island.

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.<sup>6</sup> 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.<sup>7</sup> 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

<sup>6</sup> 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.

<sup>7</sup> 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,<sup>8</sup> 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.<sup>9</sup>

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)<sup>10</sup> and whether it offered equivalent inpatient and outpatient benefits for mental illnesses and/or substance use disorders. Only 13 states<sup>11</sup> offered plans to cover the uninsured that met, or nearly met, this standard. As a partial step, 16 states<sup>12</sup> have passed legislation to extend the age for dependent coverage (including non-students), allowing some parents to cover young adult children under their policies.

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

<sup>9</sup> 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>.

<sup>10</sup> 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.

<sup>11</sup> See first bullet under “innovative practices.”

<sup>12</sup> Colorado, Connecticut, Delaware, Florida, Indiana, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Jersey, New Mexico, Texas, Utah, and Washington.

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.<sup>13</sup>

#### 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.<sup>14</sup>
- **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

<sup>13</sup> National Institute of Mental Health (NIMH), “Mental Illness Exact 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>.

<sup>14</sup> 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 in-

crease 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.<sup>15</sup> 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.<sup>16</sup> The plan clearly identifies goals, objectives, actions, performance indicators, and measurement strategies. It also integrates diversity

<sup>15</sup> 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.

<sup>16</sup> 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.

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

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.

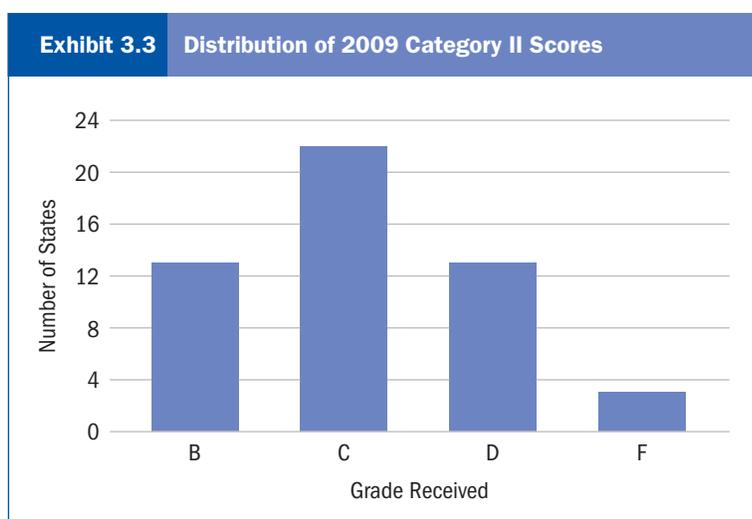
With 43 percent of states earning a C grade, and almost one-third (31 percent) earning a D or an F, there is still considerable room for improvement. Three key findings from NAMI's assessment of financing and core treatment/recovery services provide clear direction for states.

### 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).<sup>17</sup> 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

<sup>17</sup> 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).<sup>18</sup>

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

*“Lo mejor es que tienen un equipo de ACT el cual me ayudó mucho a recobrar las riendas de mi vida.”<sup>19</sup>*

—Consumer from New York

Medicaid programs in ways that put recipients at risk of losing needed care. In West Virginia’s redesigned Basic Plan, mental health services<sup>20</sup> 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.

#### *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.

<sup>18</sup> These are the numbers of states that received less than full scores on the related items in our survey.

<sup>19</sup> Translation: “The best thing is that they have an ACT team, which helped me a lot to recover the reins of my life.”

<sup>20</sup> 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.<sup>21</sup> 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.<sup>22</sup> 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.<sup>23</sup>

<sup>21</sup> Gary S. Cuddeback et al., “How Many Assertive Community Treatment Teams Do We Need?” *Psychiatric Services* (American Psychiatric Association, 2006), 1803.

<sup>22</sup> 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).<sup>24</sup> This is down from an estimated 126,849 beds in 2000, and 197,139 beds in 1990.<sup>25</sup>

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).<sup>26</sup>

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).<sup>27</sup> 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

<sup>23</sup> 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).

<sup>24</sup> 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.

<sup>25</sup> 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>.

<sup>26</sup> 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.

<sup>27</sup> 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.

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.<sup>28</sup>

#### 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.

<sup>28</sup> 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<sup>29</sup> 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<sup>30</sup> 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.<sup>31</sup> 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/>.

<sup>29</sup> Colorado, DC, Illinois, Louisiana, Maryland, North Carolina, Oregon, Pennsylvania, and South Carolina.

<sup>30</sup> 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.

<sup>31</sup> 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.

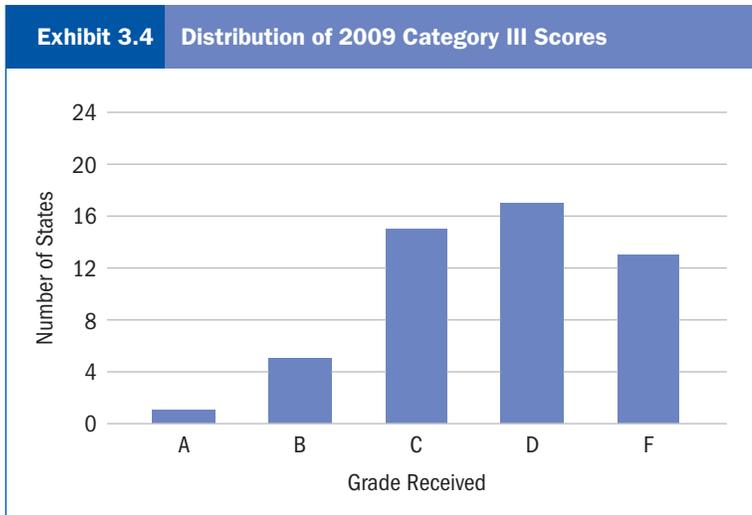
A startlingly high percentage of these veterans are coming home at risk of posttraumatic stress disorder and depression.<sup>32</sup> Military sexual trauma, untreated substance abuse, marital discord, and high divorce rates are also being reported. NAMI believes state mental

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.<sup>33</sup>

<sup>32</sup> 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/>.

<sup>33</sup> 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.



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<sup>34</sup> 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

<sup>34</sup> 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](http://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.<sup>35</sup>

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.<sup>36</sup>

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,<sup>37</sup> and 15 states received high scores for their support of peer education programs.<sup>38</sup> 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-

<sup>35</sup> 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/news\\_releases/060215\\_consumer.htm](http://www.samhsa.gov/news/news_releases/060215_consumer.htm).

<sup>36</sup> 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.

<sup>37</sup> 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.

<sup>38</sup> 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<sup>39</sup> 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.

<sup>39</sup> 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.

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.

## **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.

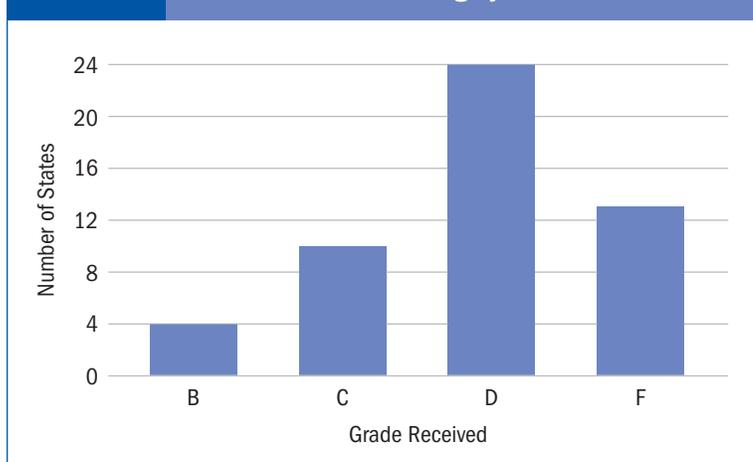
States performed more poorly in this category than in any preceding category. These results are illustrated in Exhibit 3.5.

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

**Exhibit 3.5** Distribution of 2009 Category IV Scores



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<sup>40</sup> 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.

<sup>40</sup> 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.<sup>41</sup> 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.

<sup>41</sup> 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 Statistics, 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.<sup>42</sup> 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.<sup>44</sup>

- 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.<sup>45</sup> 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 así con este tipo de pacientes."*<sup>43</sup>

—Consumer from South Carolina

<sup>42</sup> 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.

<sup>43</sup> 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."

<sup>44</sup> Available at [http://www.dmh.state.ms.us/anti\\_stigma.htm](http://www.dmh.state.ms.us/anti_stigma.htm).

<sup>45</sup> Available at [www.nj.gov/mhstigmacouncil](http://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.<sup>46</sup> 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

<sup>46</sup> 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.<sup>47</sup> These states are Mississippi, Louisiana, New Mexico, Kentucky, Alabama, Texas, Missouri, Georgia, South Dakota, and South Carolina.<sup>48</sup> 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.<sup>49</sup>

Many rural communities also face growing ethnic and cultural diversity, deteriorating infrastructure, limited employment opportuni-

ties, 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.<sup>50</sup>

<sup>47</sup> “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.

<sup>48</sup> E-mail communications with staff of the Economic Research Service, U.S. Department of Agriculture, October 1, 2008.

<sup>49</sup> 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).

<sup>50</sup> 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](http://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.