Behavioral Health Is Essential To Health • Prevention Works • Treatment Is Effective • People Recover

Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015

Substance Abuse and Mental Health Services Administration

SAMHSA

www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Acknowledgments

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under SAMHSA IDIQ Prime Contract #HHSS283200700029I/Task Order HHSS2834002T with SAMHSA, U.S. Department of Health and Human Services (HHS). Mitchell Berger served as the Government Project Officer.

Disclaimer

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

Public Domain Notice

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

Recommended Citation

Substance Abuse and Mental Health Services Administration, *Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies, 2015*. HHS Pub. No. (SMA) SMA-17-5029. Rockville, MD: Substance Abuse and Mental Health Services Administration;2017.

Electronic Access and Copies of Publication

http://store.samhsa.gov/. Or call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

Originating Office

Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857.

HHS Publication No. (SMA) SMA-17-5029. Printed in 2017.

Nondiscrimination Notice

SAMHSA complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SAMHSA cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad.

Contents

Chapter **Page**

Executive Summary ... 1

Chapter 1: Introduction ... 4

Purpose ... 4

Background ... 4

State Mental Health Agencies ... 4

Single State Agencies for Substance Use Services ... 5

Overview of the Remainder of the Report ... 5

Chapter 2: Information Sources and Limitations ... 8

2.1 State Mental Health Agency Profiling System ... 8

2.2 State Mental Health Agency Controlled Revenues and Expenditures Study ... 9

2.3 The Uniform Reporting System ... 9

2.4 Single State Agency Controlled Revenues and Expenditures ... 10

2.5 Substance Use Prevalence, Client, and Provider Data ... 10

2.6 Limitations ... 10

Chapter 3: Organization and Structure of State Mental Health Agencies ... 13

3.1 Key Highlights ... 13

3.2 State Mental Health Agency Location in State Government ... 13

3.3 State Mental Health Agency Relationships With Other State Agencies ... 15

Single State Agency for Substance Abuse Services ... 15

State Intellectual Disability Agency ... 15

State Medicaid Agency ... 16

State Housing Authority ... 16

State Public Health Agency ... 16

3.4 State Mental Health Agency Service Responsibilities ... 17

State Psychiatric Hospitals 18
Mental Health Services for Children and Adolescents 18
Services for Alzheimer's Disease 18
Services for Organic Brain Syndrome 18
Services for Traumatic Brain Injury 18
Services for Autism 18
SMHA Services for Individuals With Criminal Justice System Involvement 20
Forensic Service Responsibilities of the SMHA 20
Reorganization of SMHAs 20
3.5 Eligibility for State Operated or Funded Mental Health Services 21
Chapter 4: Organization, Types, and Numbers of Mental and Substance Use Disorder Service Providers 24
4.1 Key Highlights 24
4.2 Organization of Mental Health Services and Provider System 24
4.3 Community Mental Health Services 25
Mechanisms Used to Fund and Administer Community-Based Mental Health Services 25
Initiatives to Restructure Community-Based Mental Health Services 26
Controlling Entry to State Hospitals 27
Privatization of Community Mental Health Services 27
4.4 State Psychiatric Hospitals 27
Reorganization of State Psychiatric Hospitals 27
Psychiatric Inpatient Bed Availability 28
Privatization of State Psychiatric Hospitals 29
4.5 Forensic Mental Health Services 29
4.6 Public Substance Use Disorder Prevention and Treatment Systems 29

Chapter 5: Characteristics of Individuals the State Mental Health Agency and Single State Agency Systems Serve ... 33

5.1 Key Highlights ... 33

5.2 Individuals State Mental Health Agencies Served, FY 2014 ... 33

Demographic Characteristics of Individuals Served ... 33

Utilization Rates of Individuals Served, by Race and Ethnicity and by Sex ... 35

Individuals Served, by Service Setting ... 36

Individuals Served Through Medicaid and Other Funding Sources ... 36

Employment Status of Individuals Served ... 37

Residential Settings of Individuals Served ... 37

5.3 Individuals for Whom Single State Agencies Provided Substance Use Disorder Services, FY 2013–2014 ... 38

Characteristics of Individuals Admitted to Publicly Supported Treatment for Substance Use Disorders ... 42

Prevention: Population Served and Services Provided ... 45

Chapter 6: State Mental Health Agency Efforts to Address Health-Mental Health Integration ... 52

6.1 Key Highlights ... 52

6.2 Integration, Colocation, and Other Initiatives to Integrate Physical and Behavioral Health ... 52

Integration of Mental Health and Primary Care ... 52

Colocation of Mental Health and Primary Care ... 53

Physical Health Screening ... 54

Substance Use Treatment and Trauma Initiatives ... 54

6.3 Implementation of Electronic Health Records and Sharing Electronic Health Information ... 55

Organization and Funding of Information Management Functions ... 55

Electronic Health Records ... 58

Personal Health Records ... 62

Chapter 7: Major Policies of State Mental Health Agencies and Single State Agencies 64
7.1 Key Highlights 64
7.2 Evidence-Based Practices 65
Evidence-Based Practices for Mental Health 65
Implementation of Evidence-Based Practices 67
7.3 Involuntary Mental Health Treatment 69
Involuntary Patient Treatment 70
SMHA Access to Information About Involuntary Commitments 70
Delivery Settings for Forensic Clients and Sex Offenders 71
Forensic Bed Availability 71
Sex Offenders 72
Legal Status of Patients in State Psychiatric Hospitals 72
Outpatient Commitment 73
7.4 Other Major SMHA Policy Initiatives 73
Prevention Initiatives 73
Recovery Support 74
Crisis Intervention 74
7.5 State Initiatives to Address the Opioid Epidemic 75
Overview 75
State Prioritization of the Current Opioid Problem 76
State Task Forces 77
Trends in State Data on Prescription Drugs and Heroin Abuse 80
Preventing Prescription Drug and Heroin Abuse 81
Medication Prescribing Guidelines 86
Addressing the Discrimination Associated With Drug Abuse 87
Medication-Assisted Treatment and Naloxone 89
Treatment Outcomes and Data Reporting 93

Prescription Drug Monitoring Program ... 95
Other Information and Resources ... 97
Conclusion ... 98
Chapter 8: Financing Mental and Substance Use Disorder Services ... 99
8.1 Key Highlights ... 99
8.2 SSA and SMHA Expenditures ... 99
SSA and SMHA Funding Sources ... 102
SSA and SMHA Funding Over Time ... 108
8.3 Financing State Mental Health Agency Services ... 109
State Mental Health Agency Revenues and Expenditures for Mental Health Services, FY 2014 ... 112
SMHA Expenditures per Individuals Served ... 114
SMHA Expenditures by Type of Mental Health Program ... 118
SMHA-Controlled Expenditures by Age of Individuals Served ... 121
Expenditures by Type of Mental Health Service ... 124
Funding Sources for SMHA Mental Health Services ... 126
Financing Community Mental Health Services ... 130
State Mental Health Agency Funding Sources for Community Mental Health Services, FY 2014 ... 132
Financing State Psychiatric Hospitals, FY 2014 ... 133
State Psychiatric Hospital Expenditures per Patient Day by Type of Patient ... 135
Trends in State Mental Health Agency Revenues and Expenditures ... 139
SMHA Expenditures for Forensic Expenditures Over Time ... 141
Trends in SMHA Funding Sources Over Time ... 142
8.4 Financing of Single State Agency Substance Use Disorder Services ... 144
Single State Agency Expenditures for Substance Use Disorder Services ... 144
Funding Sources for Substance Use Disorder Services ... 147
Medicaid Spending for Substance Use Disorder Services ... 149

Trends in Single State Agency Expenditures and Funding Sources 150

Glossary 154

Appendixes

A: Profiles of State Mental Health Agencies A-1
B: Profiles of Single State Agencies for Substance Abuse Services B-1

Tables

Table **Page**

Table 1. Organization of State Mental Health Agencies Within State Governments, FY 2015 14

Table 2. State Mental Health Agency Relationships With Other State Government Agencies, FY 2015 16

Table 3. State Mental Health Agency Service Responsibilities, FY 2015 19

Table 4. State Mental Health Agency Responsibilities for Providing Mental Health Services to Individuals With Criminal Justice Involvement, FY 2015 20

Table 5. Eligibility Criteria for State Mental Health Agency Operated or Funded Mental Health Services, FY 2015 21

Table 6. Number of Facilities State Mental Health Agencies Operate and Fund, FY 2015 25

Table 7. Target Population of State Psychiatric Hospitals for Acute, Intermediate, and Long-Term Inpatient Care, by Age, FY 2015 27

Table 8. Single State Agency Supported Providers of Primary Prevention and Treatment, by State, FY 2013 30

Table 9. Number of Individuals Receiving Single State Agency-Supported Substance Use Disorder Treatment or Support Services, by Nation and State, FY 2013–2014 40

Table 10. Number of Individuals/Person Exposures Served by Single State Agency Sponsored Substance Abuse Prevention Strategies in FY 2013–2014, by State 46

Table 11. Budget for Information Management for Each State, FY 2015 57

Table 12. Number of States Implementing Electronic Health Record Functions in State Psychiatric Hospitals, by Function, FY 2015 60

Table 13. Number of State Mental Health Agencies Implementing or Planning to Implement Evidence-Based Practices, FY 2015 65

Table 14. Number of Evidence-Based Practice Programs in States and Number of Individuals Receiving These Programs, FY 2015 66

Table 15. Number of States Reporting Funding Sources of Evidence-Based Practices, FY 2015 68

Table 16. Number of States Assessing or Monitoring Fidelity of Evidence-Based Practices, FY 2015 69

Table 17. Number of State Mental Health Agencies Able to Access Information About Involuntary Treatment (N=43 States), FY 2015 70

Table 18. Total and per Capita SSA and SMHA Expenditures for M/SUD Services, FY 2014....100

Table 19. SSA and SMHA Funding by Major Payment Source, FY 2014 104

Table 20. Percentage of SSA and SMHA Funds from Major Payment Sources, FY 2014....106

Table 21. SSA and SMHA Major Funding Sources, FY 2008 to FY 2014....108

Table 22. Types of Medicaid Waivers Used to Pay for Mental Health Services, FY 2015 110

Table 23. SMHA-Controlled Expenditures, per Capita Expenditures, and Under 138% of FPL per Capita Expenditures for Mental Health Services, FY 2014....113

Table 24. SMHA Expenditures per Individual Served, FY 2014 116

Table 25. State Mental Health Agency Controlled Expenditures and Per Capita Expenditures by Type of Mental Health Program and State, FY 2014 119

Table 26. State Mental Health Agency Controlled Total and per Capita Expenditures, by Age Group, FY 2014 (in Millions) 122

Table 27. State Mental Health Agency Controlled Mental Health Revenues by Revenue Source, FY 2014 128

Table 28. Number of States Using Funding Sources to Finance Community Mental Health Services, by Type of Service, 2015 (N=46 States) 130

Table 29. Number of SMHAs Using Funding Sources for Mental Health Services in State Psychiatric Hospitals, by Hospital Patient Group and Type of Service, 2015 (N=45 States) 134

Table 30. State Psychiatric Hospital Inpatient Expenditures per Patient Day for Civil Status Patients, by State, FY 2014....136

Table 31. State Psychiatric Hospital Inpatient Expenditures Per Patient Day for Forensic Status Patients and Sex Offenders by State, FY 2014 138

Table 32. Annual Percentage Change in State Mental Health Agency Controlled Expenditures for Mental Health in Current and Population and Inflation Adjusted Dollars, FY 2001–2014....141

Table 33. Expenditures of Single State Agencies, by Service Provided, FY 2014 (Expenditures in Millions) 145

Table 34. Single State Agency Funding Sources, FY 2014....147

Table 35. Trends in Single State Agency Expenditures and Funding Sources, FY 1985–2014 150

Figures

Figure **Page**

Figure 1. Primary Mechanisms State Mental Health Agencies Use to Fund Community Mental Health Services, FY 2015 26

Figure 2. Percentage Distribution of Consumers Served, by Age (in Years), FY 2014 34

Figure 3. Percentage of Consumers Served, by Race and Ethnicity, FY 2014....34

Figure 4. Utilization Rates of Individuals Served, by Age (in Years) and Sex, FY 2014 35

Figure 5. Utilization Rates of Individuals Served, by Race and Ethnicity and by Sex, FY 2014....36

Figure 6. Percentage of Individuals by Medicaid and Funding Sources and by Race/Ethnicity, FY 2014....37

Figure 7.Percentage of Individuals by Residential Setting, FY 2014....38

Figure 8. Primary and Other Substances Abused at Admission to Publicly Supported Substance Use Disorder Treatment, FY 2012....42

Figure 9. Age Distribution (in Years) of Individuals Entering Single State Agency Supported Treatment, FY 2012....43

Figure 10. Racial Distribution of Individuals Admitted to Single State Agency Supported Substance Use Disorder Treatment, FY 2012....44

Figure 11. Primary Outcomes at Discharge From Standard Outpatient Treatment, FY 2011–2012....45

Figure 12. Age Distribution (in Years) of Individual Prevention Service Recipients, FY 2013–2014....48

Figure 13. Age Distribution of Population Prevention Service Recipients, FY 2013–2014....48

Figure 14. Age Distribution of Individual and Population Prevention Recipients Versus the General Population, FY 2013–2014....49

Figure 15. Racial Distribution of Individual Prevention Services Recipients, FY 2013–2014....50

Figure 16. Racial Distribution of Population Prevention Services Recipients, FY 2013–2014....50

Figure 17. Mental Health Information Management Systems, Stand-Alone and in Combination With Other Information Management Systems, by State, FY 2015 56

Figure 18. State Psychiatric Hospital Electronic Health Record Systems, FY 2015....................59

Figure 19. States' Ratings of the Importance of Prescription Drug Abuse to Single State Agencies, 2012–2015 76

Figure 20. States' Ratings of Importance of Heroin Abuse to Single State Agencies, 2014–2015...77

Figure 21. States With Prescription Drug Abuse Task Force, 2012–2015 78

Figure 22. States With Heroin Abuse Task Force, 2014–2015 79

Figure 23. Number of States That Enacted Prescription Drug or Heroin Abuse Legislation...80

Figure 24. Number of States Reporting Increases in Heroin Overdose, 2014–2015....................81

Figure 25. Educational Campaigns and Strategies for the General Public, 2012–2015 82

Figure 26. Educational Campaigns About Shift From Prescription Drug Abuse to Heroin, 2014–2015...83

Figure 27. Educational Campaigns About Heroin Abuse, 2014–2015..84

Figure 28. States With Prescription Drug Abuse Prevention Initiatives for Special Populations, 2012–2015...85

Figure 29. States With Education for Prescribers, Pharmacists, and Patients and Families, 2012–2015...86

Figure 30. States Issuing Prescribing Guidelines for Providers 87

Figure 31. States With a Requirement for Pain Clinics to Register With State...........................87

Figure 32. States With Initiatives to Address Discrimination, 2014–2015 88

Figure 33. Types of Initiatives to Address Discrimination, 2014–2015......................................89

Figure 34. Proportion of States With Expanded Financial Support for Medication-Assisted Treatment...90

Figure 35. Distribution of Naloxone Overdose Reversal Kits to Clients and Families, 2014–2015...91

Figure 36. Stages of Implementation of Naloxone Training and Access Programs in States, 2015 92

Figure 37. States With Laws or Regulations Governing Naloxone Administration, 2014–2015 ...93

Figure 38. Number of States Collecting Data on Patient Outcomes of Patients, 2014–2015 ...94

Figure 39. Number of States That Evaluate Prescription Drug Abuse Prevention Initiatives, 2014–2015 ...95

Figure 40. Single State Agency Roles With the Prescription Drug Monitoring Program, 2014–2015 ...96

Figure 41. States' Rating of Usefulness of Prescription Drug Monitoring Program Data, 2012 and 2015 ...97

Figure 42. Number of States With Training or Technical Assistance Needs ...97

Figure 43. Fiscal Year 2014 Per Capita SMHA and SSA Expenditures, by State ...102

Figure 44. Percentage of SSA and SMHA Funding by Major Source, FY 2014 ...103

Figure 45. Percentage Change in Total SSA and SMHA Funds, FY 2008–FY 2014 ...108

Figure 46. Medicaid Reimbursement Approaches for Mental Health Services, by State, FY 2015 ...109

Figure 47. Total Per Capita State Mental Health Agency Controlled Expenditures for Mental Health Services, FY 2014 ...113

Figure 48. State Mental Health Agency Controlled Expenditures by Type of Mental Health Program, FY 2014 ...118

Figure 49. Expenditures for Mental Health Services in State Psychiatric Hospital and Community Mental Health Programs, by Age, FY 2014 ...124

Figure 50. Total SMHA-Controlled Expenditures by Type of Mental Health Services, FY 2014 ...125

Figure 51. Community Mental Health and State Psychiatric Hospital Expenditures, by Type of Mental Health Service, FY 2014 ...126

Figure 52. Percentage of SMHA-Controlled Revenues for Mental Health Services by Funding Sources, FY 2014 ...127

Figure 53. Percentage of SMHAs using the SAMHSA MHBG to Fund Specific Mental Health Services, 2015 ...132

Figure 54. Funding Sources for Community Mental Health Services, FY 2014 ...133

Figure 55. Funding Sources for State Psychiatric Hospitals, FY 2014 135

Figure 56. State Mental Health Agency Controlled Expenditures for Mental Health, FY 2001 Through FY 2014 (Current and Inflation-Adjusted) 140

Figure 57. Expenditures for Forensic Patients and Sex Offenders as a Percentage of Total State Psychiatric Hospital Expenditures, FY 1983 Through FY 2014 142

Figure 58. State Mental Health Agency Controlled Revenues for Mental Health Services, FY 2001 Through FY 2014...143

Figure 59. Percentage of Major State Mental Health Agency Funding From State and Federal Sources, FY 2001 Through FY 2014 144

Figure 60. Frequency Distribution of Single State Agency per Capita Spending on Substance Use Disorder Services, FY 2014 146

Figure 61. How Single State Agencies Spend Budgets on Primary Prevention and Other Services 147

Figure 62. Sources of Funding for Single State Agencies, 2013–2014 149

Figure 63. Trends in Single State Agency Share Spent on Substance Use Disorder Prevention and Treatment, FY 1985–2014 151

This page intentionally left blank

Executive Summary

Biennial reports titled *Funding and Characteristics of Single State Agencies for Substance Abuse Services and State Mental Health Agencies* summarize states' work in addressing mental and substance use disorders (M/SUDs). These *State Profiles*, as documents in this series are more readily known, provide important insight into the nature of behavioral health prevention and treatment services across the nation. Information is developed through materials compiled directly from states and from a number of existing SAMHSA data sources.

The goals of the State Profiles are the following: (1) expand the historic and contextual sources of descriptive information about this nation's behavioral health systems; (2) offer a current snapshot of concerns, competence, and challenges within the field; and (3) give the state mental health agency (SMHA) commissioners and single state agencies (SSAs) for substance use disorders an overview of what states are implementing to improve their behavioral health systems. The 2015 edition of the State Profiles addresses some questions asked in prior years as well as topical issues such as electronic health records.

The 2015 State Profiles report is structured in a manner intended to make it user-friendly for state behavioral health councils, policymakers, individuals, families, and other stakeholders. A *Key Highlights* section at the beginning of each results chapter allows a quick overview of the chapter's significance, but the text, tables, and figures that follow the summary allow the reader to understand the larger context.

This report provides insight into several important dynamics. The following are among the more notable findings:

- The majority of states have combined the planning and delivery of mental health and substance use disorder services into a single state government agency (Chapter 3).
- There are 8,500 providers in 48 states; community-based nonprofit organizations such as community mental health centers and psychosocial rehabilitation programs constitute 87 percent (n=7,381) of these providers.
- All states continue to operate psychiatric inpatient beds for individuals with the highest level of service needs (Chapter 4).
    - The majority of states (n=35) reported experiencing shortages of psychiatric inpatient beds, and over half the states (n=26) have shortages of forensic inpatient beds. Psychiatric inpatient bed shortages have caused some states to experience resistance to additional closures of state hospital beds, but SMHAs are working with community mental health providers to implement crisis and other services to reduce the need for inpatient services.
- In 2014, 98 percent of the 7.3 million individuals that SMHAs serve received mental health services in community settings such as medical provider offices (Chapter 5).
    - Only six percent of individuals received services in other psychiatric inpatient settings (with a utilization rate of 1.3 per 1,000).

    - Only two percent of individuals received services in state psychiatric hospitals (with a utilization rate of 0.5 per 1,000).
    - Only one percent of individuals received services in residential treatment centers (with a utilization rate of 0.2 per 1,000).

- Most individuals that state systems serve are young and poor; disproportionate numbers of those who are served represent racial and ethnic minorities (Chapter 5).

- Information management systems for mental and substance use disorder services are combined in 25 states, presaging the day when the availability of integrated data can improve the understanding and evaluation of effective, multimorbid treatment interventions (Chapter 6).

- Most SMHAs (n=35) have implemented electronic health records (EHRs) in their state psychiatric hospitals. In 25 states, the EHR system used in state psychiatric hospitals meets the Health Information Technology for Economic and Clinical Health (HITECH) Act *meaningful use* requirements for exchange of electronic health information. Only 10 states have agreements in place to share state psychiatric hospital EHR data with a health information exchange (HIE) (Chapter 6).

- Prevention of SUDs has been included in the block grants to states since the early 1980s, and the Substance Abuse Prevention and Treatment Block Grant (SABG) requires states to use at least 20 percent of their annual grant for primary prevention of SUDs. Many SMHAs also are implementing mental illness prevention programs. Although states cannot use SABG funds to pay for mental disorder prevention activities, the potential for joint learning between substance use prevention and mental health is timely (Chapter 6).

- Collectively, the SSAs and SMHAs control $45.8 billion in services, with $40.8 billion of that amount within the SMHA. In fiscal year 2014, the SMHA average per capita expenditure was $127.08, and the average SSA per capita expenditure was $15.61 (per capita expenditures are total expenditures divided by state population). In the past 2 years, the effects of the 2007 through 2009 financial recession have lessened, and states have returned to small increases in spending on these services (Chapter 8).

This page intentionally left blank

Chapter 1: Introduction

Purpose

This report integrates information from existing federal, state, and other data systems into one source to allow readers to understand the organizational structure, major policy initiatives, services provided, and financing of single state agencies (SSAs) for substance abuse services and state mental health agencies (SMHAs). The goal of this report is to identify common national trends in services for individuals with mental and substance use disorders (M/SUDs) and to understand the states' mental health and substance use systems. Readers may use this report to identify individual states that could have a policy, service, or financing approach of interest.[1] The glossary includes definitions and descriptions of acronyms used throughout the report.

Background

SMHAs and SSAs are the state government agencies that governors designate to coordinate and ensure the delivery of high quality services to individuals with M/SUDs. SSAs and SMHAs serve an essential safety net function by providing critical care to individuals with the most severe illnesses and those without insurance coverage or other support for their treatments.

SSAs and SMHAs often are combined administratively into a single behavioral health state agency to promote the coordination and delivery of services to individuals with mental or substance use disorders—particularly for individuals with co-occurring M/SUDs. However, SSAs and SMHAs each may have unique funding requirements, and they are subject to different state legal requirements.

State Mental Health Agencies

SMHAs organize, coordinate, and directly operate some mental health services and allocate funds to community providers for additional mental health services not provided directly by the SMHA. In FY 2014, SMHA systems served more than 7.3 million individuals at a cost of $41.0 billion. The services provided or supported by SMHAs included direct psychiatric treatments and medications as well as a variety of critical supports such as housing, employment, education, and primary care coordination to help individuals recover and be able to live in their own communities.

As this report highlights, SMHAs vary widely in (1) how they are organized within the state government, (2) how they pay for and organize their mental health service delivery systems, and (3) their fiscal and staffing resources. However, all SMHAs share some common functions:

- Educate the public about mental illness, combat discrimination and stigma surrounding mental illness, and support public health prevention activities for mental health.

[1] Previous State Profiles are available in the SAMHSA store at http://store.samhsa.gov/product/Funding-and-Characteristics-of-Single-State-Agencies-for-Substance-Abuse-Services-and-State-Mental-Health-Agencies-2013/SMA15-4926

- Plan the development of a comprehensive array of mental health services—including coordination with other state government agencies and local mental health and substance use disorder agencies—and submit an annual comprehensive community mental health block grant (MHBG) plan to the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Organize, coordinate, fund, and in some states directly operate a comprehensive system of community-based mental health services to meet the mental health treatment needs of individuals in their state.
- Monitor the performance and outcomes of their service system by collecting data and evaluating services.
- Serve a public safety function in providing and coordinating services to individuals with mental illnesses who are determined by courts to be dangerous to themselves or others.
- Operate and fund inpatient psychiatric beds that provide critical intensive treatment to individuals with high levels of need or those at risk of harm to themselves or others.

Single State Agencies for Substance Use Services

SSAs are a vital component in the national system for providing SUD services to the nation. Although SSAs dedicate a large majority of their resources to providing SUD treatment to individuals who are uninsured or have low incomes—a shared responsibility with Medicaid—they are responsible for providing substance use prevention services and leadership to the entire population of their state. In FY 2014, SSAs expended $4.95 billion on SUD and prevention services. Eighty-three percent of SSA expenditures were for SUD treatment, 11 percent for primary prevention, and 6 percent for administration and infrastructure.

The SSA-supported SUD treatment system served 2.7 million individuals in FY 2014. About 1.7 million of these individuals were new admissions during the year, whereas 800,000 initiated their treatment during a prior year.

States have developed substantial networks of primary prevention and treatment or other prevention providers over the years. About 2,450 primary prevention providers were funded with Substance Abuse Prevention and Treatment Block Grant (SABG) funds through the SSAs. About 7,800 providers of specialty SUD treatment used funding from state, local, or federal government (excluding Medicare or Medicaid) to provide care for people who were underinsured or had low incomes.

SSAs provided individual-based prevention services to 17.5 million people during FY 2013–2014. SSA-supported, population-based prevention strategies reached an estimated 484 million person impressions. These population-based prevention strategies included public service campaigns with mass media messages.

Overview of the Remainder of the Report

- Chapter 2 describes the data sources used for this report.

- Chapter 3 discusses the organization and structure of SMHAs.
- Chapter 4 presents the organization, types, and numbers of mental health and SUD service providers.
- Chapter 5 reviews the characteristics of individuals the SMHAs and SSAs serve.
- Chapter 6 discusses SMHA and SSA efforts to address health–mental health and health–SUD integration.
- Chapter 7 presents the major policies of SMHAs and SSAs.
- Chapter 8 reviews how SMHAs and SSAs finance mental health and SUD services and describes the roles of Medicaid, managed care, and SMHA-controlled revenues and expenditures.

The two appendices to this report provide individual SMHA and SSA summary profiles describing how each SMHA and SSA is organized within a state government, the SMHA and SSA responsibilities and roles, the number of individuals served, and the financing of services.

This page intentionally left blank

Chapter 2: Information Sources and Limitations

SAMHSA, Truven Health Analytics, the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI), the National Association of State Alcohol/Drug Abuse Directors (NASADAD), and the National Association of State Mental Health Program Directors (NASMHPD) identified the highest priority topics for inclusion in this report. NRI staff then developed the 2015 SMHA profile components to capture from SMHAs the information needed for this report. In May 2015, NRI sent eight profile components to all SMHA commissioners or directors and the agencies' designated contacts for completion during the spring and summer.

We developed this report using existing information whenever possible, and we augmented the content through additional information that NRI and NASADAD compiled.

The primary sources of information on SMHAs used for this report were the following:

- The FY 2015 cycle of the NRI SMHA Profiling System (SPS)[2]
- The NRI FY 2014 State Mental Health Revenues and Expenditures Study Results (hereinafter referred to as the Revenue and Expenditure Study)[3]
- The SAMHSA FY 2014 Uniform Reporting System (URS).[4]

The primary sources of information on SSAs used for this report were the following:

- Substance Abuse Prevention and Treatment Block Grant (SABG) State Annual Reports
- SAMHSA's Web Block Grant Application System (WebBGAS)
- National Survey on Drug Use and Health (NSDUH)
- Drug and Alcohol Services Information System (DASIS)
- Treatment Episode Data Set (TEDS).

Leaders from each SMHA and SSA received a draft of the full report and their state's information (see Appendices A and B) for review. The leaders then had an opportunity to update and verify their state data.

2.1 State Mental Health Agency Profiling System

The SPS is a database of information that describes the organization, funding, operation, services, policies, statutes, and clients of SMHAs. The information describes each SMHA's organization and structure, service systems, service eligibility requirements, emerging policy

---

[2] National Association of State Mental Health Program Directors Research Institute, Inc. (NRI). (2015). *2015 state mental health agency profiling system results*. Retrieved from http://www.nri-incdata.org/

[3] National Association of State Mental Health Program Directors Research Institute, Inc. (NRI). (2015). *The FY 2014 state mental health revenue and expenditure study results*. Retrieved from http://www.nri-incdata.org/

[4] Center for Behavioral Health Statistics and Quality. (2015). *2014 SAMHSA uniform reporting system output tables.* Retrieved from: http://www.samhsa.gov/data/us_map?map=1

issues, fiscal resources, client issues, information management, and research and evaluation structures.

Questions are grouped into components by topic area to facilitate SMHA review. Questions within each component address the specific needs of SMHA leaders, SAMHSA and other federal officials, and others interested in public mental health systems. The information supports decision-making, policy analysis, and research evaluation.

Leaders from 51 SMHAs completed various components: Evidence-Based Practices (EBPs) (n=49), Finance (n=48), Information Management (n=49), Involuntary Mental Health Treatment (n=49), Organization and Structure (n=50), Policy (n=49), Services (n=48), and SSA and SMHA Activities Related to Health Reform (n=48).

2.2 State Mental Health Agency Controlled Revenues and Expenditures Study

The Revenues and Expenditure Study describes the major expenditures and funding sources of the SMHAs. Each year, NRI works with SMHAs to document the expenditures for mental health services the SMHAs control and to determine the major funding sources of these expenditures. The methodology of this report is predicated on compiling actual (rather than estimated) revenues and expenditures under the direct control of the SMHA. The depiction of actual figures—developed only after the state's fiscal year (FY) is completed and billing is fully reconciled—is necessary for reporting valid and reliable data.

A set of Microsoft® Excel spreadsheets containing four tables was used as the data-collection instrument for the Revenue and Expenditure Study. The tables depict the mental health expenditures and revenues under the control of the SMHA. The funds include all state general funds to the SMHA, the federal MHBG, local funds (when required) to match state dollars, other funds the SMHAs control, and the total expenditures and revenues of the community mental health and state psychiatric hospital systems. For this report, analysts used the FY 2014 cycle of the Revenue and Expenditure Study data received from 49 states, the District of Columbia, and Puerto Rico to present the expenditures and funding sources of SMHAs (FY 13 data were used for Hawaii because FY 14 data were not yet available).

2.3 The Uniform Reporting System

The URS is a reporting system SMHAs use to compile and report annual data as part of the MHBG. The URS is part of the *Mental Health Service Block Grant Implementation Report*—approved by the Office of Management and Budget—that SMHAs are required to submit to the Center for Behavioral Health Statistics and Quality (CBHSQ) every year by December 1. The URS is part of an effort to use data in decision support and planning in public mental health systems and to support program accountability.

The URS, composed of 27 tables that the federal government developed in consultation with SMHAs, compiles state-by-state and national aggregate information. The data include numbers and sociodemographic characteristics of individuals the states served, outcomes of care, use of selected EBPs, client assessment of care, and insurance status. SAMHSA uses the tables to calculate the 10 mental health National Outcome Measures (NOMS) for state and national

reporting. This report used the FY 2014 data submitted by the 50 states, the District of Columbia, the five U.S. territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands), and the three Freely Associated States (Palau, the Federated States of Micronesia, and the Republic of Marshall Islands) to describe the clients the SMHAs served.[5]

2.4 Single State Agency Controlled Revenues and Expenditures

High quality budget data about SSAs are submitted to SAMHSA each year, as the SAMHSA SABG legislation and regulations require. In December 2015, NASADAD staff extracted SSA expenditure and revenue data from the SAMHSA WebBGAS reported in their 2015 SABG Reports. For most states, the most recent year of completed data was state FY 2014, which was July 2013 through June 2014. The data included total funding of primary and other prevention and treatment as well as amounts spent on set-aside funds for women's treatment, tuberculosis, and HIV for states that exceeded specified threshold values. We differentiated state-appropriated funding from SABG funding. The foregoing values are required to be reported and are subject to SAMHSA's review and verification.

2.5 Substance Use Prevalence, Client, and Provider Data

Data on the prevalence of SUD problems and attitudes toward SUDs came from SAMHSA's (2012–2013) NSDUH state-level statistics, published in December 2014. NSDUH is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 years and older. NSDUH provides accurate data on the level and patterns of alcohol, tobacco, and illegal substance use; tracks trends in the use of alcohol, tobacco, and various types of drugs; and assesses misuse. SAMHSA produces state-level prevalence estimates by combining 2 years of the annual survey, which is necessary in order to have sufficient precision on estimates for the smallest states.[6]

SSAs collect information about state prevention and treatment service systems, individuals served, and the nature of services delivered and report the results to SAMHSA in accordance with the SABG. The treatment data (i.e., characteristics of those served and service outcomes) are reported to SAMHSA through the TEDS part of DASIS or submitted to SAMHSA through the annual Block Grant (BG) Report. The SAMHSA website contains a description of TEDS[7] and various documents about DASIS. States similarly report prevention data and SSA financing information in their annual BG report. Data submitted to SAMHSA as part of a state's application or report are subject to SAMHSA's review and verification.

2.6 Limitations

Although there was a high response rate for each SPS component, the level of completion varied within each component or area. Some SMHAs did not complete every component, and some did

---

[5] Data can be accessed from the SAMHSA website at http://www.samhsa.gov/data/us_map?map=1

[6] Ibid.

[7] Substance Abuse and Mental Health Services Administration. (2014). Client Level Data / TEDS. [Web page]. http://www.samhsa.gov/data/client-level-data-teds

not fully respond to all questions; therefore, some information presented in this report is based on responses from fewer than the total number of reporting SMHAs.

Although this report includes SMHA-controlled expenditures, the reader should not assume that the revenues and expenditures reported include all expenditures for mental health services within a state government. State governments expend considerable resources for mental health services through other state government agencies that are not included in this report.

The majority of state government expenditures not fully depicted in this report are from Medicaid—one of the fastest growing expenditures of state governments in the past 20 years. Some SMHAs and state Medicaid agencies have conducted thorough analyses of Medicaid-paid claims files to determine total Medicaid expenditures for mental health. However, many of these expenditures are outside the control of the SMHA or the community mental health system that the SMHA funds. Medicaid expenditures discussed in this report are limited to the portion of Medicaid expenditures that the SMHS controlled or administered. Studies by SAMHSA[8] suggest that the total Medicaid expenditures for mental health may be double those controlled by SMHAs. The National Spending Estimates identified $39 billion in total Medicaid expenditures for mental health in FY 2009; according to the State Mental Health Profiles, in FY 2009 SMHA Medicaid revenues totaled $17.9 billion (46 percent of Medicaid spending for mental health).

Much of the data in the SUD profiles pertain only to "public sector" services and to individuals who are medically indigent and lack adequate insurance coverage and those who have low income. States have different standards governing financial eligibility for subsidized public-sector treatment services, and (to a large extent) this is reflected in the major differences across states in funding dedicated to public treatment and prevention.

Another major limitation is that very few SSAs capture Medicaid-related data on spending or services delivered. This is in marked contrast to spending on mental health, where a substantial number of SMHAs manage Medicaid funding for mental health services; therefore, these SMHAs capture data on spending as well as on the individuals who receive those services.

A further limitation on the scope of SSA and SMHA reporting across states is that additional funding for mental health and SUD services occurs through other health and human services agencies—such as child and family services and community health centers—as well as through various justice agencies, such as courts, prisons, and jails offering probation, parole, and pretrial services. There are significant differences across states as to how such services are organized, delivered, and financed.

This information was compiled from surveys distributed to SMHA and SSA contacts and from information in the systems noted above as of May 2015. Although every effort has been made to verify the accuracy of the data reported, it is important to note that some issues discussed in this report are subject to frequent and ongoing change.

---

[8] Substance Abuse and Mental Health Services Administration. (2013). *National expenditures for mental health services and substance abuse treatment, 1986–2009*. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/shin/content/SMA13-4740/SMA13-4740.pdf

This page intentionally left blank

Chapter 3: Organization and Structure of State Mental Health Agencies

3.1 Key Highlights

- The majority of SSAs and SMHAs are combined administratively into a single state agency, but there are many variations of SMHA organizational structures across the country.
- Most SMHAs are located in the state government with one administrative level between the SMHA commissioner or director and the Governor. In 12 states, the SMHA commissioner or director serves as a member of the Governor's cabinet.
- More than half of SMHAs are actively engaged in serving individuals involved with the criminal justice system, although only three have a direct responsibility for administering mental health services to individuals in jails or prisons.
- Most mental health services for children are shared between the SMHA and another state agency; such services are carved out entirely to a separate state agency in a few states.
- Some states limit services funded through state general funds or Medicaid to individuals who meet serious mental illness (SMI) or serious emotional disturbance (SED) criteria.
- The diversity of state agencies with an interest in mental health services necessitates agreements or memoranda of understanding with other state agencies to foster effective planning and delivery of services.

3.2 State Mental Health Agency Location in State Government

Every state has established an SMHA that serves as the key state government agency responsible for the organization, financing, and delivery of mental health services to adults with SMI and children with SED. In many states, expanded client groups such as those with intellectual and developmental disabilities also are part of the SMHA's responsibilities. Each SMHA is responsible for the creation and implementation of a comprehensive plan for community-based mental health services and for submission of this plan to SAMHSA as part of the federal MHBG requirements. In addition, every SMHA provides financial support for or directly provides community-based mental health services. Every state also operates psychiatric inpatient beds for individuals with severe mental illnesses and, in most states, the SMHA operates these psychiatric beds as part of a state psychiatric hospital system.

The organizational location of the SMHA within state government varies from state to state. SMHAs typically are located administratively within a larger umbrella agency. The SMHAs are located within the state's Department of Human Services (n=21), the state's Department of Health (n=9), or the state's Department of Health and Human Services (n=4). In 12 states, the SMHA is an independent department of mental health (see Table 1).

The SMHA director serves as a member of the Governor's cabinet in 12 states, and in 7 of these states the SMHA director reports directly to the Governor. In most states (n=23), the SMHA director reports to someone one step below the Governor. In 16 states, there are two levels of governance between the SMHA director and the state Governor.

Table 1. Organization of State Mental Health Agencies Within State Governments, FY 2015

State	Organization and Structure		
	SMHA Located in State Department	Levels Between Commissioner and Governor	Mental Health Board/Council Has Direct Oversight of SMHA
Alabama	Independent	0	Yes
Alaska	Human Services	2	No
Arizona	Health Department	1	No
Arkansas	Human Services	2	No
California	No response	No response	No response
Colorado	Human Services	1	No
Connecticut	Independent	0	Yes
Delaware	Human Services	1	No
District of Columbia	Independent	1	No
Florida	Human Services	3	No
Georgia	Independent	0	Yes
Hawaii	Health Department	1	No
Idaho	Human Services	2	No
Illinois	Human Services	2	No
Indiana	Human Services	1	No
Iowa	Human Services	2	No
Kansas	Other	2	No
Kentucky	Health Department	1	No
Louisiana	No response	No response	No response
Maine	Other	1	No
Maryland	Health Department	2	Yes
Massachusetts	Health and Human Services	1	No
Michigan	Human Services	2	No
Minnesota	Human Services	2	Yes
Mississippi	Independent	1	Yes
Missouri	Independent	0	Yes
Montana	Health and Human Services	3	Yes
Nebraska	Human Services	1	Yes
Nevada	Human Services	0	Yes
New Hampshire	Human Services	2	No
New Jersey	Human Services	2	No
New Mexico	Human Services	1	Yes
New York	Independent	2	No
North Carolina	Health and Human Services	2	Yes
North Dakota	Human Services	1	No
Ohio	Independent	0	No
Oklahoma	Independent	1	Yes
Oregon	Health Department	2	Yes

State	Organization and Structure		
	SMHA Located in State Department	Levels Between Commissioner and Governor	Mental Health Board/Council Has Direct Oversight of SMHA
Pennsylvania	Health Department	1	No
Rhode Island	Human Services	No response	No response
South Carolina	Independent	1	Yes
South Dakota	Other	1	No
Tennessee	Independent	0	Yes
Texas	Health Department	2	No
Utah	Human Services	1	No
Vermont	Human Services	1	Yes
Virginia	Independent	1	No
Washington	Human Services	1	No
West Virginia	Health and Human Services	1	No
Wisconsin	Health Department	2	No
Wyoming	Health Department	1	No
Totals	Independent=12	Direct to Governor (0)=7	Yes=17
	Health and Human Services=4	One level=23	No=31
	Human Services=21	Two levels=16	No response=3
	Health Department=9	Three levels=2	
	Other=3	No response=3	
	No response=2		

Abbreviation: SMHA, state mental health agency.

3.3 State Mental Health Agency Relationships With Other State Agencies

SMHAs collaborate with other state agencies, such as Medicaid, housing, substance use disorder services, intellectual disabilities, and public health to ensure efficient planning and delivery of needed and appropriate high quality mental health services. Some states merge responsibility for some of these programs and services within the same agency as the SMHA. However, in many states, responsibility for these other programs is located within the same larger umbrella state department as the SMHA or even in a separate state government agency (see Table 2). In states where the SMHA and other related state agencies are in different organizational locations, the state often has established interagency agreements to foster communication and service delivery between the different agencies.

Single State Agency for Substance Abuse Services

The SSA and SMHA are combined into a single state agency in 35 states and are within the same umbrella state department in 11 states. In four states, the SSA and SMHA are located in separate state departments. In three of these states, the SMHA has an interagency agreement with the SSA.

State Intellectual Disability Agency

The SMHA and state intellectual disability agency are combined into a single agency in 11 states and are within the same umbrella state department in 25 states. In 14 states, the intellectual

disability agency is located in a different state department. In 11 of these states, the SMHA has an interagency agreement with the state intellectual disability agency.

State Medicaid Agency

The SMHA is within the state Medicaid agency in one state (Pennsylvania) and is located within the same umbrella state department in 28 additional states. In 21 states, the SMHA and state Medicaid are located in different state department. In 16 of these states, the SMHA has an interagency agreement with the state Medicaid agency.

State Housing Authority

The SMHA is neither part of the state housing authority nor located in same umbrella state department as the state housing authority in any state. In almost all states (49), the state housing agency is located in a different state department. In 12 of these states, the SMHA has an interagency agreement with the state housing agency.

State Public Health Agency

In two states (Arizona and Texas), the SMHA is within the state public health agency and is in the same umbrella state department in 19 states. In 28 states, the state public health agency and the SMHA are in separate state departments. In 11 of these states, the SMHA has an interagency agreement with the state public health agency.

Table 2. State Mental Health Agency Relationships With Other State Government Agencies, FY 2015

State	SMHA Relationship With Other State Agencies				
	Substance Use Disorder	Intellectual Disabilities	Medicaid	Housing	Public Health
Alabama	Combined	Combined	Other agency	Other agency	Other agency
Alaska	Combined	Same umbrella	Same umbrella	Other agency	Same umbrella
Arizona	Combined	Other agency	Other agency	Other agency	SMHA part of public health
Arkansas	Combined	Same umbrella	Same umbrella	Other agency	Other agency
California	No response	No response	No response	No response	No response
Colorado	Combined	Other agency	Other agency	Other agency	No response
Connecticut	Combined	Other agency	Other agency	Other agency	Other agency
Delaware	Combined	Same umbrella	Same umbrella	Other agency	Same umbrella
District of Columbia	Combined	Other agency	Other agency	Other agency	Other agency
Florida	Combined	Other agency	Other agency	Other agency	Other agency
Georgia	Combined	Combined	Other agency	Other agency	Other agency
Hawaii	Same umbrella	Same umbrella	Other agency	Other agency	Same umbrella
Idaho	Combined	Same umbrella	Same umbrella	Other agency	Same umbrella
Illinois	Same umbrella	Same umbrella	Other agency	Other agency	Other agency
Indiana	Combined	Same umbrella	Same umbrella	Other agency	Other agency
Iowa	Other agency	Combined	Same umbrella	Other agency	Other agency
Kansas	Combined	Same umbrella	Other agency	Other agency	Other agency
Kentucky	Combined	Combined	Other agency	Other agency	Other agency
Louisiana	Same umbrella	Other agency	Same umbrella	Other agency	Same umbrella
Maine	Same umbrella	Same umbrella	Same umbrella	Other agency	Same umbrella
Maryland	Combined	Same umbrella	Same umbrella	Other agency	Same umbrella
Massachusetts	Same umbrella	Same umbrella	Same umbrella	Other agency	Same umbrella
Michigan	Combined	Combined	Same umbrella	Other agency	Same umbrella

State	SMHA Relationship With Other State Agencies				
	Substance Use Disorder	Intellectual Disabilities	Medicaid	Housing	Public Health
Minnesota	Same umbrella	Same umbrella	Same umbrella	Other agency	Other agency
Mississippi	Combined	Combined	Other agency	Other agency	Other agency
Missouri	Combined	Same umbrella	Other agency	Other agency	Other agency
Montana	Same umbrella	Same umbrella	Same umbrella	Other agency	Same umbrella
Nebraska	Combined	Same umbrella	Same umbrella	Other agency	Same umbrella
Nevada	Same umbrella	Same umbrella	Same umbrella	Other agency	Same umbrella
New Hampshire	Same umbrella	Same umbrella	Same umbrella	Other agency	Same umbrella
New Jersey	Combined	Same umbrella	Same umbrella	Other agency	Other agency
New Mexico	Combined	Other agency	Same umbrella	Other agency	Other agency
New York	Other agency	Other agency	Other agency	Other agency	Other agency
North Carolina	Same umbrella	Same umbrella	Same umbrella	Other agency	Other agency
North Dakota	Combined	Combined	Same umbrella	Other agency	Same umbrella
Ohio	Combined	Other agency	Other agency	Other agency	Other agency
Oklahoma	Combined	Other agency	Other agency	Other agency	Other agency
Oregon	Combined	Other agency	Same umbrella	Other agency	Same umbrella
Pennsylvania	Other agency	Same umbrella	SMHA part of Medicaid	Other agency	Other agency
Rhode Island	Combined	Combined	Same umbrella	Other agency	Other agency
South Carolina	Other agency	Other agency	Other agency	Other agency	Other agency
South Dakota	Combined	Other agency	Same umbrella	Other agency	Other agency
Tennessee	Combined	Other agency	Other agency	Other agency	Other agency
Texas	Combined	Same umbrella	Same umbrella	Other agency	SMHA part of public health
Utah	Combined	Same umbrella	Other agency	Other agency	Other agency
Vermont	Same umbrella	Same umbrella	Same umbrella	Other agency	Same umbrella
Virginia	Combined	Combined	Other agency	Other agency	Other agency
Washington	Combined	Same umbrella	Other agency	Other agency	Other agency
West Virginia	Combined	Combined	Same umbrella	Other agency	Same umbrella
Wisconsin	Combined	Same umbrella	Same umbrella	Other agency	Same umbrella
Wyoming	Combined	Combined	Same umbrella	No response	Same umbrella
Totals					
Combined	35	11	0	0	0
SMHA part of Medicaid	0	0	1	0	2
Same umbrella	11	25	28	0	19
Other agency	4	14	21	49	28
No response	1	1	1	2	2

Abbreviation: SMHA, state mental health agency.

3.4 State Mental Health Agency Service Responsibilities

SMHAs vary from state to state in the types of mental health services, treatment settings, and specific mental illnesses that each SMHA is responsible for organizing, funding, and providing. In most states, the SMHA is responsible for organizing and funding both psychiatric hospital services and community-based services for children and adults. However, in a few states, some of these responsibilities are outside the SMHA. Table 3 lists the SMHA responsibilities for specific mental health services.

State Psychiatric Hospitals

Every state government operates inpatient psychiatric beds to provide intensive treatment for individuals in a severe phase of mental illnesses. In 44 states, the SMHA is responsible for operating the state psychiatric hospital(s), but in 5 states (New Hampshire, New Mexico, North Carolina, South Dakota, and Washington) the responsibility for the operation of the state psychiatric hospital(s) is located in an agency other than the SMHA. These five states have developed policies to coordinate care between the state psychiatric hospital and the community mental health system the SMHA directed. For example, in South Dakota social workers at the state psychiatric hospital (Human Services Center) work with community mental health centers (CMHCs) and other community agencies to coordinate care for individuals discharged back to the community.

Mental Health Services for Children and Adolescents

In 25 states, the SMHAs are responsible for the provision of mental health services to children and adolescents, generally defined as those younger than 21 years; however, in 24 states, the SMHA and a separate state agency share the responsibility for children's services. In one state (Delaware), the SMHA has no responsibility for children's mental health services.

Services for Alzheimer's Disease

The SMHA and a separate state agency share the responsibility for provision of services to individuals with Alzheimer's disease in 12 states. In the majority of states (n=38), the SMHA has no responsibility for providing services to individuals with Alzheimer's disease.

Services for Organic Brain Syndrome

Two SMHAs (the District of Columbia and Wyoming) assume responsibility for the provision of services to individuals with organic brain syndrome—mental health impairments due to conditions other than psychiatric disorders. The SMHA shares the responsibility for the provision of organic brain syndrome services with a separate state agency in 12 states. In the majority of states (n=35), the SMHA has no responsibility for providing services to individuals with organic brain syndrome.

Services for Traumatic Brain Injury

The SMHA is responsible for provision of services to individuals with traumatic brain injuries in 6 states, and the SMHA and another state agency share this responsibility in 16 states. In 27 states, the SMHA was not responsible for providing services to individuals with traumatic brain injuries.

Services for Autism

The SMHA is responsible for the provision of services to individuals with autism spectrum disorders in 6 states, and the SMHA and another state agency share this responsibility in 15 states. In 26 states, the SMHA is not responsible for providing services to individuals with autism spectrum disorders.

Table 3. State Mental Health Agency Service Responsibilities, FY 2015

State	Children's Mental Health Services	Alzheimer's Disease	Organic Brain Syndrome	Traumatic Brain Injury	Autism
Alabama	Shared	Shared	Not in SMHA	Not in SMHA	Not in SMHA
Alaska	Shared	Shared	Shared	Shared	Shared
Arizona	Part of SMHA	Shared	No response	Shared	No response
Arkansas	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
California	No response	No response	No response	No response	No response
Colorado	Shared	Not in SMHA	Not in SMHA	Shared	Not in SMHA
Connecticut	Shared	Not in SMHA	Not in SMHA	Shared	Not in SMHA
Delaware	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
District of Columbia	Shared	Not in SMHA	Part of SMHA	Part of SMHA	Not in SMHA
Florida	Shared	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Georgia	Shared	Not in SMHA	Not in SMHA	Not in SMHA	No response
Hawaii	Shared	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Idaho	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Illinois	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Indiana	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Iowa	Shared	Not in SMHA	Not in SMHA	Shared	Shared
Kansas	Part of SMHA	Not in SMHA	Not in SMHA	No response	Part of SMHA
Kentucky	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Shared
Louisiana	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	No response
Maine	Part of SMHA	Not in SMHA	Not in SMHA	Part of SMHA	Shared
Maryland	Part of SMHA	Not in SMHA	Not in SMHA	Part of SMHA	Not in SMHA
Massachusetts	Shared	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Michigan	Shared	Shared	Shared	Shared	Part of SMHA
Minnesota	Shared	Not in SMHA	Shared	Shared	Shared
Mississippi	Part of SMHA	Shared	Not in SMHA	Not in SMHA	Not in SMHA
Missouri	Part of SMHA	Shared	Shared	Shared	Shared
Montana	Shared	Shared	Shared	Shared	Shared
Nebraska	Shared	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Nevada	Shared	Shared	Shared	Shared	Shared
New Hampshire	Shared	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
New Jersey	Shared	Shared	Shared	Shared	Shared
New Mexico	Shared	Not in SMHA	Not in SMHA	Not in SMHA	Shared
New York	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
North Carolina	Part of SMHA	Shared	Not in SMHA	Part of SMHA	Shared
North Dakota	Part of SMHA	Not in SMHA	Not in SMHA	Part of SMHA	Not in SMHA
Ohio	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Part of SMHA
Oklahoma	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Oregon	Part of SMHA	Not in SMHA	Shared	Shared	Not in SMHA
Pennsylvania	Part of SMHA	Shared	Shared	Shared	Shared
Rhode Island	Shared	Not in SMHA	Shared	Shared	Part of SMHA
South Carolina	Shared	Not in SMHA	Shared	Not in SMHA	Not in SMHA
South Dakota	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Tennessee	Shared	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Texas	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Utah	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Shared

State	Children's Mental Health Services	Alzheimer's Disease	Organic Brain Syndrome	Traumatic Brain Injury	Autism
Vermont	Shared	Not in SMHA	Shared	Shared	Shared
Virginia	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Part of SMHA
Washington	Part of SMHA	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
West Virginia	Shared	Shared	Not in SMHA	Shared	Shared
Wisconsin	Shared	Not in SMHA	Not in SMHA	Not in SMHA	Not in SMHA
Wyoming	Part of SMHA	Not in SMHA	Part of SMHA	Part of SMHA	Part of SMHA
Totals					
Part of SMHA	25	0	2	6	6
Shared	24	12	12	16	15
Not in SMHA	1	38	35	27	26
No response	1	1	2	2	4

Abbreviation: SMHA, state mental health agency.

SMHA Services for Individuals With Criminal Justice System Involvement

Many SMHAs have the responsibility of providing services to individuals who have a mental illness and have been arrested or convicted of crimes (see Table 4). Over half (n=32) of the SMHAs have responsibility for conducting court evaluations of mental health status, and another 11 share this responsibility with another state agency. Only four SMHAs have responsibility for administering mental health services to individuals in prisons or jails, and 34 share this responsibility with another state agency.

Table 4. State Mental Health Agency Responsibilities for Providing Mental Health Services to Individuals With Criminal Justice Involvement, FY 2015

Responsibilities	Responsibility of SMHA	Responsibility Shared With Another Agency	No SMHA Responsibility
Court evaluations of mental health status	32	11	6
Administering services to individuals with mental illness in prison or jails	4	34	12
Providing services to sex offenders	8	21	20

Abbreviation: SMHA, state mental health agency.

Forensic Service Responsibilities of the SMHA

Forensic mental health programs help care for those who are involved in the criminal justice system. In 21 states, the SMHA has statutory responsibility for forensic mental health services, whereas in 3 states, this responsibility is only with the state's Department of Corrections. In 20 states, the SMHA and the Department of Corrections share forensic service responsibilities, and three states reported that statutory responsibility for mental health forensic services is in another state agency (see Chapter 7 for additional discussion of SMHA roles in providing forensic and other involuntary treatment services).

Reorganization of SMHAs

States regularly modify the organizational structure of SMHAs and their location within the state's government. Between 2013 and 2015, the SSA and SMHA systems in the District of Columbia, Maryland, and Ohio were combined into a single behavioral health agency. In 2015,

Nevada realigned the state mental health, aging, and health programs. In Oregon, the SMHA merged with the Medical Assistance Division (Medicaid) and is now the Health Services Division. Washington restructured the Aging and Disabilities Services Administration, and the SMHA became part of the Behavioral Health and Services Integration Administration.

3.5 Eligibility for State Operated or Funded Mental Health Services

Every state has established policies and criteria to determine if an individual is eligible for SMHA-operated or SMHA-funded mental health services. States vary regarding how inclusive or restrictive their eligibility criteria are, based on decisions the state legislatures and governors make. In 26 states, mental health services funded through state general or special funds are available to all adults with any mental illness. Similarly, in 27 states, the mental health services funded through state general or special funds are available to all children with any mental illness. However, in 18 states, services funded through state general or special funds are available only to adults who meet the state's definitions of SMI; in 15 states, services funded through general or special funds are available only to children who meet the state's criteria for SED (Table 5).

Table 5. Eligibility Criteria for State Mental Health Agency Operated or Funded Mental Health Services, FY 2015

	Use of State General Funds Restricted		Use of Medicaid Restricted		Use of Other Funds Restricted	
State	**Adults**	**Children**	**Adults**	**Children**	**Adults**	**Children**
Alabama	SMI only	SED only	SMI only	SED only	SMI only	SED only
Alaska	No response	No response	No response	No response	No response	No response
Arizona	SMI only	All children	All adults	All children	No response	SED only
Arkansas	SMI only	SED only	SMI only	SED only	No response	Not applicable
California	No response	No response	No response	No response	No response	No response
Colorado	SMI only	SED only	All adults	All children	No response	Not applicable
Connecticut	SMI only	All children	All adults	All children	No response	Not applicable
Delaware	All adults	All children	SMI only	SED only	No response	Not applicable
District of Columbia	All adults	All children	All adults	All children	No response	Not applicable
Florida	All adults	All children	All adults	All children	No response	All Children
Georgia	All adults	All children	All adults	All children	SMI only	SED only
Hawaii	SMI only	SED only	SMI only	SED only	No response	Not applicable
Idaho	SMI only	SED only	SMI only	SED only	No response	Not applicable
Illinois	All adults	All children	All adults	All children	No response	Not applicable
Indiana	SMI only	SED only	All adults	All children	No response	Not applicable
Iowa	No response	No response	No response	No response	No response	No response
Kansas	SMI only	SED only	SMI only	SED only	No response	Not applicable
Kentucky	SMI only	SED only	All adults	All children	SMI only	SED only
Louisiana	No response	No response	No response	No response	No response	No response
Maine	All adults	All children	All adults	All children	All adults	All Children
Maryland	All adults	All children	All adults	All children	All adults	All Children
Massachusetts	SMI only	SED only	No response	No response	No response	No response
Michigan	SMI only	SED only	SMI only	SED only	SMI only	SED only
Minnesota	No response	No response	No response	No response	No response	No response
Mississippi	All adults	All children	SMI only	SED only	No response	Not applicable
Missouri	All adults	All children	SMI only	SED only	All adults	All Children
Montana	SMI only	SED only	SMI only	SED only	SMI only	SED only

State	Use of State General Funds Restricted		Use of Medicaid Restricted		Use of Other Funds Restricted	
	Adults	**Children**	**Adults**	**Children**	**Adults**	**Children**
Nebraska	All adults	All children	All adults	All children	No response	All Children
Nevada	All adults	All children	All adults	All children	No response	Not applicable
New Hampshire	SMI only	No response	SMI only	No response	SMI only	SED only
New Jersey	All adults	No response	All adults	No response	All adults	Not applicable
New Mexico	SMI only	SED only	All adults	All children	No response	SED only
New York	No response	No response	No response	No response	No response	No response
North Carolina	SMI only	SED only	All adults	All children	All adults	All Children
North Dakota	No response	No response	No response	No response	No response	No response
Ohio	All adults	All children	All adults	All children	All adults	All Children
Oklahoma	All adults	All children	All adults	All children	No response	Not applicable
Oregon	All adults	All children	All adults	All children	All adults	All Children
Pennsylvania	All adults	All children	All adults	All children	All adults	All Children
Rhode Island	All adults	All children	All adults	All children	All adults	All Children
South Carolina	All adults	All children	All adults	All children	All adults	All Children
South Dakota	All adults	All children	All adults	All children	No response	Not applicable
Tennessee	All adults	All children	All adults	All children	No response	Not applicable
Texas	SMI only	SED only	SMI only	SED only	No response	Not applicable
Utah	All adults	All children	All adults	All children	All adults	All Children
Vermont	All adults	All children	All adults	All children	All adults	All Children
Virginia	All adults	All children	SMI only	SED only	SMI only	SED only
Washington	SMI only	SED only	SMI only	SED only	SMI only	SED only
West Virginia	All adults	All children	All adults	All children	No response	Not applicable
Wisconsin	All adults	All children	All adults	All children	No response	Not applicable
Wyoming	All adults	All children	All adults	All children	No response	Not applicable
Totals						
All adults/children	26	27	29	28	12	13
Any with SMI/SED	18	15	14	13	8	10
No response/Not Applicable	7	9	8	10	31	288

Abbreviations: SED, serious emotional disturbance; SMI, serious mental illness; SMHA, state mental health agency.

[a] The states responded to the eligibility questions but their Other Funding questions were not completed.

In 13 states, individuals must have incomes below a state-specified level to qualify for SMHA mental health services. Twenty-five states have an illness severity requirement. Illness severity requirements vary from specified functioning levels on standardized measures to a combination of specified diagnoses along with duration of illness.

This page intentionally left blank

Chapter 4: Organization, Types, and Numbers of Mental and Substance Use Disorder Service Providers

4.1 Key Highlights

- SMHAs support mental health services in a wide range of settings, but of the total number of service providers (N=8,500), 87 percent (n=7,381) are community providers.
- In only five states, the SMHA directly operates community mental health programs with state employees. In all other states, the provider system of care is dependent on a collaborative relationship between state, county, city, or local authorities.
- Thirty-five states reported experiencing shortages of psychiatric hospital beds. This shortage led to increased waitlists for beds in the states' psychiatric hospital and in private psychiatric hospitals. In seven states, this shortage led to hospital overcrowding.
- Alabama and Georgia were the only states that closed a state psychiatric hospital in FY 2014.
- Missouri was the only state that privatized a state psychiatric hospital in FY 2014.
- In 2013, there were 14,148 specialty SUD treatment providers (also referred to as facilities). Of these, 7,802 or 55 percent receive public funding for SUD treatment (excluding Medicare or Medicaid).
- In FY 2013, 2,452 primary prevention providers were funded with SABG funds through SSAs.
- Forty-three percent of SUD treatment providers also offer mental health care, and most care is being provided in settings that are less intensive than hospitals.

4.2 Organization of Mental Health Services and Provider System

As shown in Table 6, SMHA-funded and SMHA-operated mental health services are provided in a variety of settings, including community mental health centers, nursing homes and other intermediate care facilities, state psychiatric hospitals, private psychiatric hospitals, and general hospitals with separate psychiatric units. There are 8,500 providers in 48 states, with community providers constituting 87 percent (n=7,381) of the total.

Table 6. Number of Facilities State Mental Health Agencies Operate and Fund, FY 2015

Service Setting	SMHA Operated	SMHA Funded	Total
State psychiatric hospitals	159	15	174
Community mental health providers	91	7,290	7,381
Private psychiatric hospitals	NA	69	69
General hospitals with separate psychiatric units	12	459	471
Nursing homes and other ICF-MI and SNF providers	20	34	54
Residential treatment centers	12	339	351
Total number of mental health providers	294	8,206	8,500

Abbreviations: ICF-MI, intermediate care facilities for individuals with mental illness; NA, not applicable; SMHA, state mental health agency; SNF, skilled nursing facility.

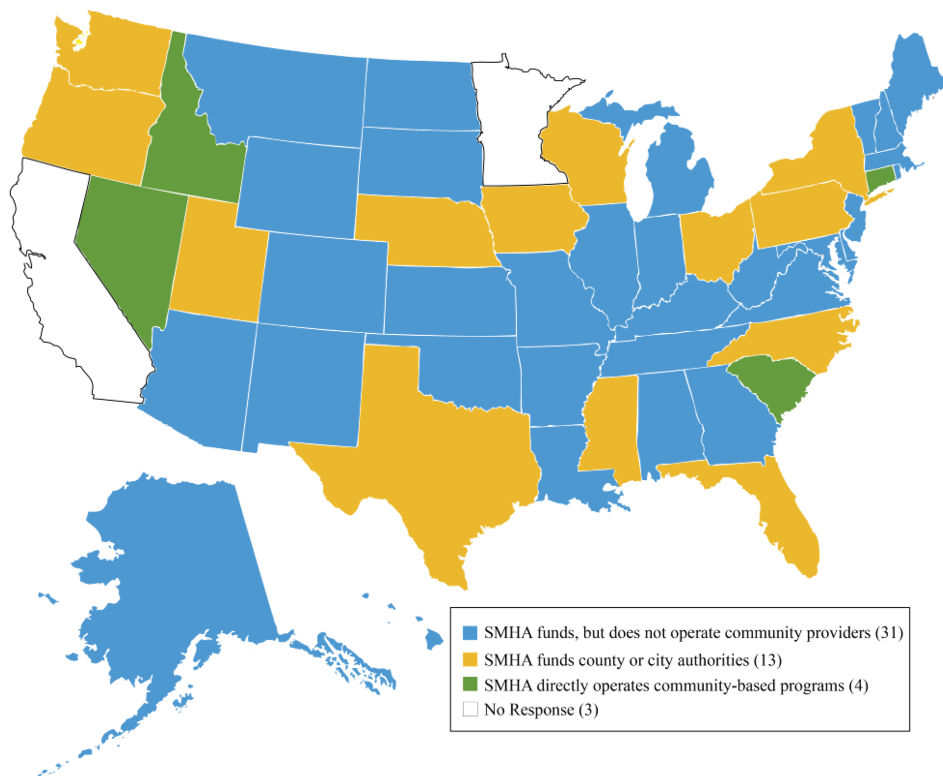
4.3 Community Mental Health Services

Community mental health systems provide a comprehensive array of mental health services and supports run by state and local governments as well as nonprofit and for-profit organizations. Community mental health systems are founded on the premise that individuals are more likely to recover from mental illness and live more productive lives if treated in the least restrictive settings possible within their community rather than in an institution. Community-based services are designed to support individuals living in their own community and include a broad array of ambulatory services, medication management, case management, crisis services, and intensive evidence-based services (see Chapter 7) as well as a variety of other services provided on a less-than-24-hour basis. Many community-based systems include the provision of short-term psychiatric inpatient care through local general hospitals (e.g., nonstate psychiatric hospitals) for individuals who experience serious psychiatric crises. Community mental health services may be provided by CMHCs, psychosocial rehabilitation programs, outpatient clinics, residential treatment programs, crisis programs, consumer-operated programs such as clubhouses or drop-in centers, and a variety of other specialty mental health providers.

Mechanisms Used to Fund and Administer Community-Based Mental Health Services

SMHAs use different mechanisms to administer SMHA-controlled funding and the delivery of community mental health services, with many states using a combination of mechanisms. SMHAs may fund and operate programs directly. Alternatively, SMHAs may fund programs directly but not operate them, contracting instead with another entity. Finally, some SMHAs fund local, county, or city authorities, who are responsible for funding service providers in their communities. Figure 1 shows the primary funding mechanism of each state. Four SMHAs directly fund and operate community mental health services. Thirty-one SMHAs fund but do not operate services. Thirteen SMHAs fund local, county, or city authorities, who in turn fund community mental health service providers.

Figure 1. Primary Mechanisms State Mental Health Agencies Use to Fund Community Mental Health Services, FY 2015



Abbreviation: SMHA, state mental health agency.

SMHAs use additional mechanisms to administer the funding and delivery of community mental health services. Of the four states in which the primary mechanism is to directly fund and operate community mental health services, one also has programs that they fund but do not operate and one also funds local authorities that in turn fund service providers. Of the 31 states in which the primary mechanism is to directly fund but not operate community mental health services, 7 also fund local authorities that in turn fund providers and five also directly fund and operate services. Finally, of the 13 states in which the primary mechanism is to fund local authorities who in turn fund mental health service providers, 9 states also directly fund but do not operate services and 2 states also directly fund and operate services.

County or city authorities administer mental health services in 25 of the 47 states reporting. In 16 of these states, county or city authorities administer mental health services throughout the state. In 9 out of the 25 states reporting, the county or city authorities administer mental health services only in parts of the state. In 21 states, local governments contribute to the funding of mental health services. This contribution is required in 13 of these 21 states.

Initiatives to Restructure Community-Based Mental Health Services

In 23 of 45 reporting states, the SMHAs were restructuring the way that they delivered community-based mental health services. For example, in Tennessee the SMHA has increased focus on crisis services as a way to stabilize individuals and prevent unnecessary hospitalization. A combination of statewide and regionally managed systems in Iowa is replacing a county-based system with emphasis on a set of core services throughout the state.

Controlling Entry to State Hospitals

Community mental health programs controlled entry into state hospitals in slightly less than half of the states. Of the 47 states reporting, 20 indicated that community mental health programs control admissions to state psychiatric hospitals. In 18 of these states, their role is to perform preadmission screenings to ensure that the state hospital is the appropriate level of care for an individual, taking into account illness severity and the individuals' potential to harm themselves or others.

Many states require general and local hospitals to be used as an initial admission site for psychiatric inpatient treatment before admission to a state psychiatric hospital. This requirement varies across states, depending on the individual's age. This requirement is present for children (0 to 12 years old) in 12 states, for adolescents (13 to 17 years old) in 11 states, for adults (18 to 64 years old) in 17 states, and for older adults (65 years and older) in 12 states.

Other mechanisms exist that affect admissions to state psychiatric hospitals in 34 of the 43 reporting states. For example, in 10 states the courts may order an individual to be admitted to the state psychiatric hospital.

Privatization of Community Mental Health Services

During FY 2014, three states privatized community mental health programs that the SMHA had operated. For example, a nonprofit now provides rural residential support in Nevada. The Nevada SMHA also is examining the conversion of state-provided outpatient services to community-based services.

4.4 State Psychiatric Hospitals

Every state operates psychiatric hospitals that provide inpatient care and treatment to individuals with SMI who are at risk to themselves and others and to those needing a level of care that exceeds what the community mental health system provides. States vary in the way they use psychiatric hospitals for different populations. As Table 7 shows, more state hospitals target adults, older adults, and forensic clients rather than children and adolescents.

Table 7. Target Population of State Psychiatric Hospitals for Acute, Intermediate, and Long-Term Inpatient Care, by Age, FY 2015

Target Population	Acute Inpatient (< 30 days)	Intermediate Inpatient (30 90 days)	Long Term Inpatient (> 90 days)
Children (0–12 years old)	12	13	9
Adolescents (13–17 years old)	16	19	13
Adults (18–64 years old)	34	37	37
Older adults (65+ years old)	31	33	35
Forensic clients	30	32	35

Reorganization of State Psychiatric Hospitals

SMHAs in 10 of the 47 reporting states are downsizing, reconfiguring, closing, or consolidating one or more state psychiatric hospitals. Alabama is closing a hospital, and Minnesota, New Hampshire, and Nevada are increasing the size of a hospital. New York is consolidating

hospitals and downsizing one or more hospitals. Alabama also is making efforts to downsize one or more hospitals. Alabama, Nevada, and New York are transferring patients from a state hospital to community inpatient facilities. Out of 42 states reporting, only Alabama and Georgia closed a state psychiatric hospital in FY 2014.

Psychiatric Inpatient Bed Availability

The SMHA has developed models estimating how many psychiatric inpatient beds are needed in 14 of the 45 reporting states. For example, in North Carolina the predicted number of beds needed is a function of historical utilization, population growth, and anticipated community development, whereas in Tennessee the need for behavioral health hospital beds is based on the calculation of 30 beds for every 100,000 population. To determine the optimum number of beds, Texas recently hired a consultant to formulate a bed model that considers current utilization and anticipated demographic change as well as predictions of unmet need.

Thirty-five of the 46 reporting states are experiencing a shortage of psychiatric hospital beds. Of these states, 17 are experiencing a shortage of acute (short-term) beds in the state psychiatric hospital, and 20 are experiencing a shortage of acute beds in private psychiatric and general hospitals. Twenty-three states are experiencing a long-term bed shortage in state psychiatric hospitals, and 12 are experiencing the shortage in private psychiatric and general hospitals. Twenty-six states are experiencing a shortage of forensic beds.

In 25 of the 35 states experiencing a shortage of psychiatric hospital beds, the shortage led to increased waiting lists for state hospital beds. In 16 states, this shortage has led to increased waiting lists for other psychiatric beds (in private psychiatric hospitals or general hospitals); in 8 states, the shortage has led to overcrowding in state hospitals; and in 9 states, the shortage has led to increased resistance to closing additional state hospital beds. In three states, the shortage of psychiatric beds has led to increased dependence on emergency departments until a bed is available. In three states, the shortage has led to a greater average distance between the individual's home community and the hospital.

The SMHA has initiatives in 36 states to ameliorate the shortage of inpatient psychiatric beds. Nine states have initiatives to expand and promote the use of crisis centers to divert individuals away from inpatient psychiatric beds. Oklahoma has created five 16-bed crisis units throughout the state and three psychiatric urgent care centers that provide counseling, case management, peer support, and physician services. The psychiatric urgent care centers are designed to help individuals remain within the community and avoid inpatient care. Five states reported having initiatives that seek to improve transition back to the community after hospitalization in order to reduce rehospitalization. For example, Missouri has increased the number of residential options for individuals with long-term care needs, such as intensive residential treatment services, clustered apartment programs, and psychiatric individual supported living. Two states indicated that they are planning to increase or already have increased bed capacity—the North Carolina State Legislature has appropriated money for an additional 59 beds, and Hawaii is considering opening a new facility.

Privatization of State Psychiatric Hospitals

Only one state (Missouri) reported privatizing a state psychiatric hospital. Missouri privatized the Southwest Missouri Psychiatric Rehabilitation Center, which a CHMS took over. However, West Virginia reported that there is an ongoing legislative study examining the public-private partnership model for the operation and maintenance of some or all of its state hospitals and nursing facilities.

4.5 Forensic Mental Health Services

In 36 states, the SMHA has initiatives to improve mental health services in correctional settings. For example, in seven states the SMHA supports transitional services to ensure that people with mental health issues do not experience a drop in care that could lead to reincarceration. Hawaii and New York provide training to corrections staff to improve interactions with incarcerated individuals with mental health issues. Connecticut and Michigan are working with other agencies and state government to improve sentencing statutes for people with mental illness.

4.6 Public Substance Use Disorder Prevention and Treatment Systems

States have developed substantial networks of primary prevention and treatment and other prevention providers over the years. These service delivery systems, created in the 1970s, continue to exist primarily through federal and state funding. There are 2,452 primary prevention providers funded with SABG funds through SSAs. In addition, 7,802 providers of specialty SUD treatment are owned by nonprofit organizations or state or local government and largely provide care for people who are underinsured or have low incomes.

The best data about prevention providers are in a national roster of 2,452 primary prevention organizations that are funded with SABG dollars; SSA submit these data in required BG Reports (Table 8). Funded providers are required to compile and report data about the numbers and characteristics of individuals served and the general nature of preventive services delivered. These statistics are tabulated and reported elsewhere in this document.

A review of selected State Entity Inventories (in the annual BG Reports) shows that the vast majority of primary prevention providers are nonprofit, nongovernmental organizations, and a minority of prevention providers are government units, such as local health departments or school districts. Four states with small populations (e.g., Delaware, Montana, Wyoming, Rhode Island) have five or fewer funded entities, whereas more populated states such as California and Illinois fund several hundred organizations. A number of states manage via county, municipality, or regional systems, and the entities receiving funds are city or county agencies (e.g., in Ohio and Pennsylvania) or multicounty entities (either quasi-governmental regional entities or nonprofit organizations) such as in Arizona, Colorado, and North Carolina.

The national and public SUD treatment system is profiled through the National Survey of Substance Abuse Treatment Services (N-SSATS), which performs an inventory each year. The primary objective of N-SSATS is to update and maintain a comprehensive and current SUD treatment locator to help patients readily find SUD treatment. In addition, the survey obtains extensive data about the characteristics of care as well as basic data about the clients being treated. The N-SSATS is an inventory of specialty SUD service delivery facilities. *Specialty*

SUD providers are facilities that have qualified SUD treatment practitioners on staff, meaning that these individuals have a SUD-specific license, certificate, or credential. Additionally, the facility is generally licensed or certified by the state SUD facility credentialing agency. Private practitioners such as doctors, counselors, and clinical social workers are not listed in N-SSATS unless they are staff members at or are affiliated with a facility.

Published data from N-SSATS indicates that in 2013 there were 14,148 specialty SUD treatment providers; of these, about 7,800, or 55 percent, receive public funding for SUD treatment, either from state or county funds or from the federal SABG (excluding Medicare or Medicaid).

Given that SUDs and mental illnesses present in about one-third of individuals seeking SUD treatment (based on the 2012 TEDS), integration of SUD with mental health care has been a growing theme. Looking at the entire specialty SUD treatment system (the universe of 14,148 SUD facilities from N-SSATS), 43 percent of facilities offer both SUD and mental health care, versus 57 percent of providers that offer only SUD care. There is substantial variation across states in the degree to which SUD facilities offer only SUD services or also offer mental health care. In Connecticut, Delaware, and the District of Columbia, in excess of 60 percent of specialty SUD providers also have mental health services, whereas in six states more than 70 percent deliver SUD services but must refer individuals to obtain mental health services.

Increasingly, the treatment system is designed around a continuum of care, ranging from very high acuity services or hospital inpatient services (very high intensity) to nonhospital residential care, followed by intensive outpatient care and then regular outpatient care (very low intensity). Recovery support services intended to assist patients during and beyond the termination of formal treatment services also exist; however, this emerging segment of providers has not yet been studied and profiled. Nationally, only 5.3 percent of the 14,148 SUD providers (as counted in N-SSATS) are hospitals that offer SUD inpatient care (data not shown). Moreover, the SABG does not permit funding of hospital inpatient care—a prohibition in federal funding that goes back to the inception of federal grant support of drug treatment in the early 1970s. Progressively larger shares of the 14,148 specialty SUD treatment providers deliver lower intensity services, with 24 percent (about 3,400 facilities) offering some type of nonhospital residential care, 45 percent offering intensive outpatient care, and 76 percent (10,400 facilities) offering regular outpatient care. About seven percent of providers (about 1,000 facilities) provide opioid outpatient treatment with methadone or buprenorphine. Table 8 contains data on the configuration of the respective state treatment systems.

Table 8. Single State Agency Supported Providers of Primary Prevention and Treatment, by State, FY 2013

Area	SABG Funded Prevention Providers, n	Publicly Funded Treatment Providers, n	Types of Treatment Offered by SUD Treatment Providers*, %					
			SUD Only	SUD and Mental Health	Residential	Intensive Outpatient	Regular Outpatient	Opioid Outpatient
Total U.S.	2,452	7,802	57	43	24	45	76	**7**
Alabama	29	87	73	27	22	50	62	16
Alaska	10	66	54	46	28	52	85	8
Arizona	7	51	56	44	24	51	73	13
Arkansas	30	63	73	27	30	54	89	9
California	284	899	54	46	36	39	64	12
Colorado	35	229	49	51	14	49	89	5
Connecticut	36	154	32	68	28	43	64	19

Area	SABG Funded Prevention Providers, n	Publicly Funded Treatment Providers, n	Types of Treatment Offered by SUD Treatment Providers*, %					
			SUD Only	SUD and Mental Health	Residential	Intensive Outpatient	Regular Outpatient	Opioid Outpatient
Delaware	3	27	38	62	19	38	74	29
District of Columbia	3	26	27	73	30	49	65	24
Florida	58	299	58	42	30	38	76	10
Georgia	36	125	54	46	22	35	77	16
Hawaii	15	106	82	18	10	37	95	7
Idaho	66	70	47	53	12	84	92	6
Illinois	263	332	72	28	17	62	88	13
Indiana	25	168	70	30	11	55	90	7
Iowa	21	91	54	47	22	59	85	4
Kansas	13	120	71	29	13	48	94	6
Kentucky	17	157	69	31	16	31	82	8
Louisiana	51	103	62	38	31	51	71	9
Maine	40	72	64	36	11	22	87	10
Maryland	24	167	50	50	19	46	78	29
Massachusetts	49	218	51	49	38	19	56	23
Michigan	140	277	56	44	18	36	88	10
Minnesota	26	178	57	44	37	59	69	7
Mississippi	29	71	58	42	36	38	66	5
Missouri	22	201	66	34	23	62	90	12
Montana	1	56	57	43	25	58	83	14
Nebraska	33	90	69	31	31	41	83	4
Nevada	28	48	59	41	25	46	73	20
New Hampshire	16	36	55	46	31	35	71	22
New Jersey	35	214	50	51	15	59	83	14
New Mexico	23	109	52	48	17	45	81	10
New York	120	513	47	53	27	27	61	23
North Carolina	20	179	59	41	19	41	77	17
North Dakota	18	22	62	39	31	46	89	2
Ohio	138	274	57	43	23	52	83	15
Oklahoma	16	127	51	49	22	35	85	6
Oregon	44	151	50	50	20	71	87	7
Pennsylvania	51	276	53	47	27	46	72	19
Rhode Island	5	43	45	55	24	45	81	31
South Carolina	33	60	69	32	14	43	78	18
South Dakota	23	47	54	46	30	59	78	2
Tennessee	85	155	53	47	34	45	68	5
Texas	91	253	64	36	28	49	66	17
Utah	16	84	46	54	28	53	79	13
Vermont	47	35	50	50	21	36	80	25
Virginia	40	137	54	46	19	38	76	17
Washington	135	252	67	34	14	77	88	9
West Virginia	12	73	60	40	25	34	77	25
Wisconsin	88	166	70	30	18	34	82	12
Wyoming	33	45	60	40	23	70	83	6

* Percentage of the total 14, 148 Substance Use Disorder providers from the N-SSATS

Abbreviations: SABG, Substance Abuse Block Grant; SSA, single state agency; SUD, substance use disorder.

This page intentionally left blank

Chapter 5: Characteristics of Individuals the State Mental Health Agency and Single State Agency Systems Serve

5.1 Key Highlights

- In FY 2014, SMHAs served 7.3 million individuals and SSAs treated 2.3 million individuals.
- The majority (98 percent) of individuals the SMHAs served received community mental health services.
- Within the SSA system, 57 percent of admissions misused alcohol (as their primary or secondary substance) and 76 percent misused some other type of drug (as their primary or secondary substance).
- At discharge, the treatment provider reported that 82.5 percent of clients were alcohol abstinent compared with 57 percent who misused alcohol at the time of entry into treatment.
- SSAs reported that 17.5 million people received individual-based SUD prevention services in FY 2014, and population-based prevention strategies produced an estimated 484 million person-exposures.

5.2 Individuals State Mental Health Agencies Served, FY 2014

In 2014, the 50 states, the District of Columbia, and U.S. territories and associated states served 7.3 million individuals (2.3 percent of the U.S. population). The total number of individuals each SMHA served ranged from 60 in the Republic of Marshall Islands to 729,421 in New York. Of all SMHAs reporting data, individuals served in the Republic of Marshall Islands had the lowest utilization rate[9] (85 per 100,000 population), and individuals served in Maine had the highest utilization rate (5,128 per 100,000 population). Of the individuals an SMHA served, 70 percent of all children younger than 18 years had an SED, and 68 percent of all adults aged 18 years and older had an SMI.

Demographic Characteristics of Individuals Served

Fifty-two percent of individuals were female (with a utilization rate of 23.2 per 1,000), and 48 percent were male (with a utilization rate of 22.3 per 1,000). Adults between ages 25 and 44 years made up the highest percentage (31 percent), and adults aged 75 years and older made up the lowest percentage (1 percent) of individuals the SMHA systems served (Figure 2). The

[9] *Utilization rate* refers to the number of individuals of a particular age, sex, or race and ethnicity divided by that group's population in a state

majority of clients served were White (62 percent), whereas African Americans represented 20 percent of individuals served (Figure 3).

Figure 2. Percentage Distribution of Consumers Served, by Age (in Years), FY 2014

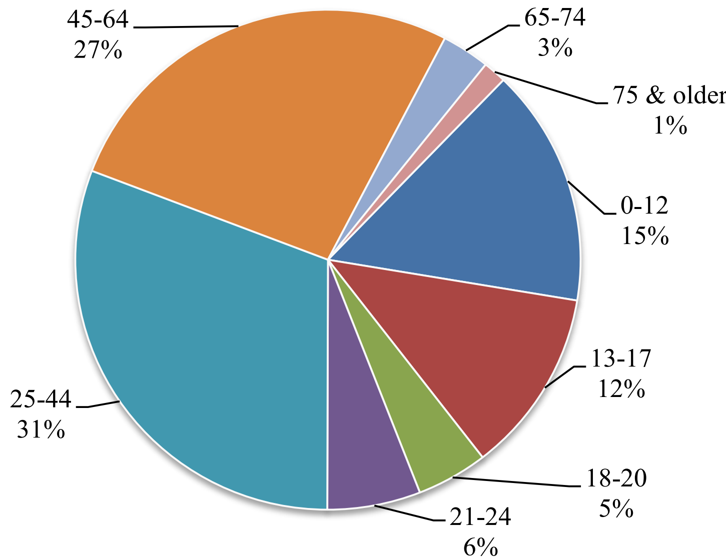
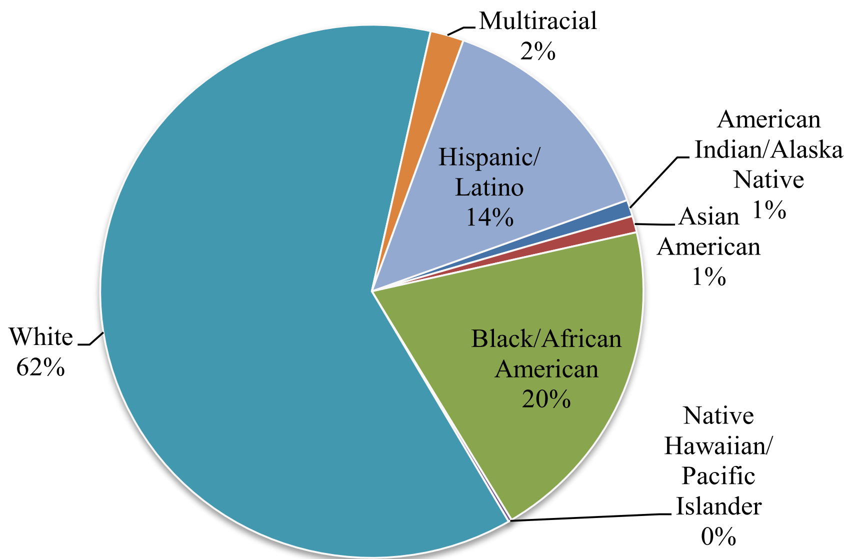


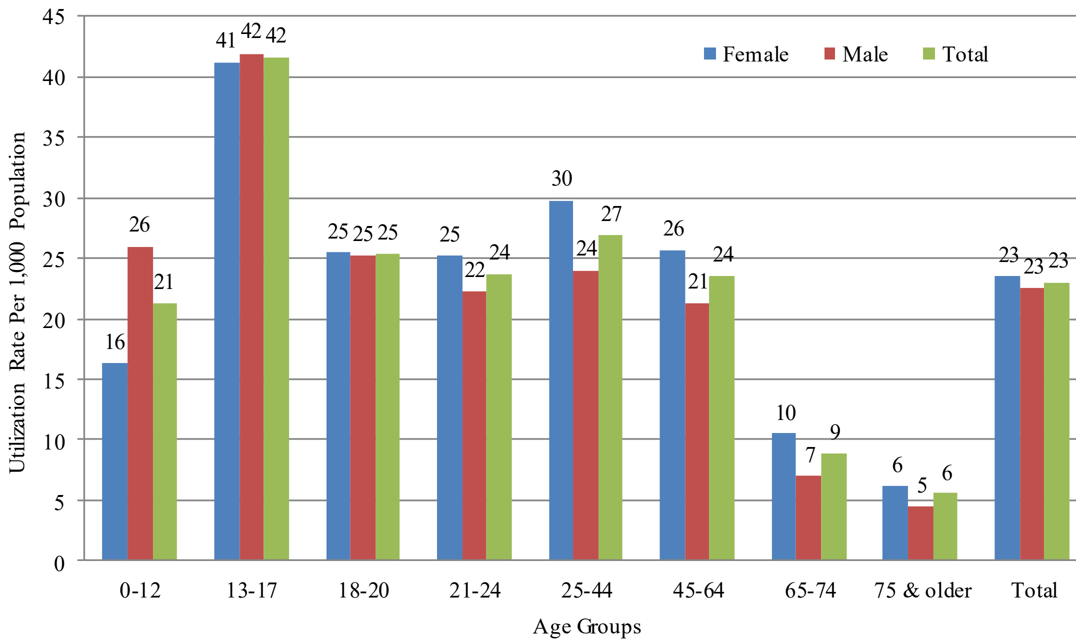
Figure 3. Percentage of Consumers Served, by Race and Ethnicity, FY 2014



Utilization Rates of Individuals Served, by Age and Sex

Although adolescents 13 through 17 years of age represented only 12 percent of the total population served, they used services at a much higher rate (42 per 1,000) than any other age group (Figure 4). Females aged 21 years and older used services at a higher rate than males, whereas females younger than 13 years used services at a lower rate than their male counterparts.

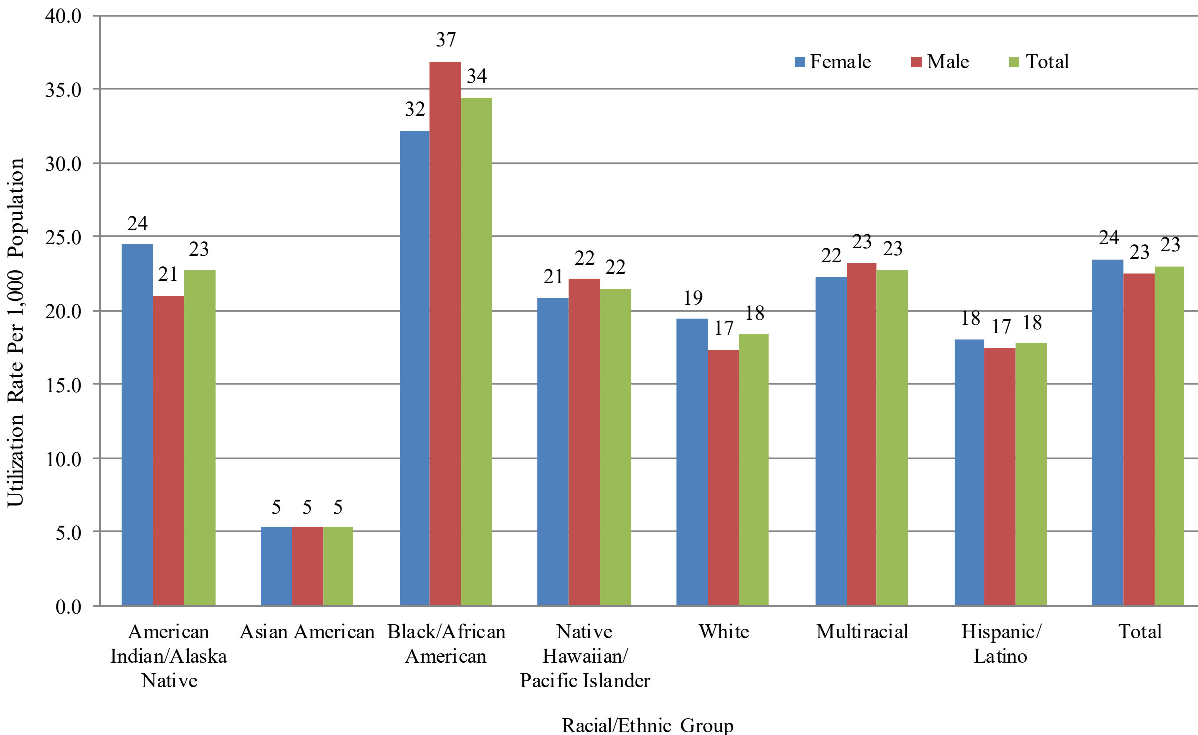
Figure 4. Utilization Rates of Individuals Served, by Age (in Years) and Sex, FY 2014



Utilization Rates of Individuals Served, by Race and Ethnicity and by Sex

Although White individuals made up the largest percent of clients served, they used services at a lower rate (18 per 1,000 population) than did African Americans (34 per 1,000), American Indian/Alaska Native individuals (23 per 1,000), multiracial individuals (23 per 1,000), and Native Hawaiian/Pacific Islanders (22 per 1,000) (Figure 5). African Americans used SMHA-funded and operated services at a higher rate (34 per 1,000 population) than any other racial group, whereas Asian Americans had the lowest utilization rates (5 per 1,000 population).

Figure 5. Utilization Rates of Individuals Served, by Race and Ethnicity and by Sex, FY 2014



Individuals Served, by Service Setting

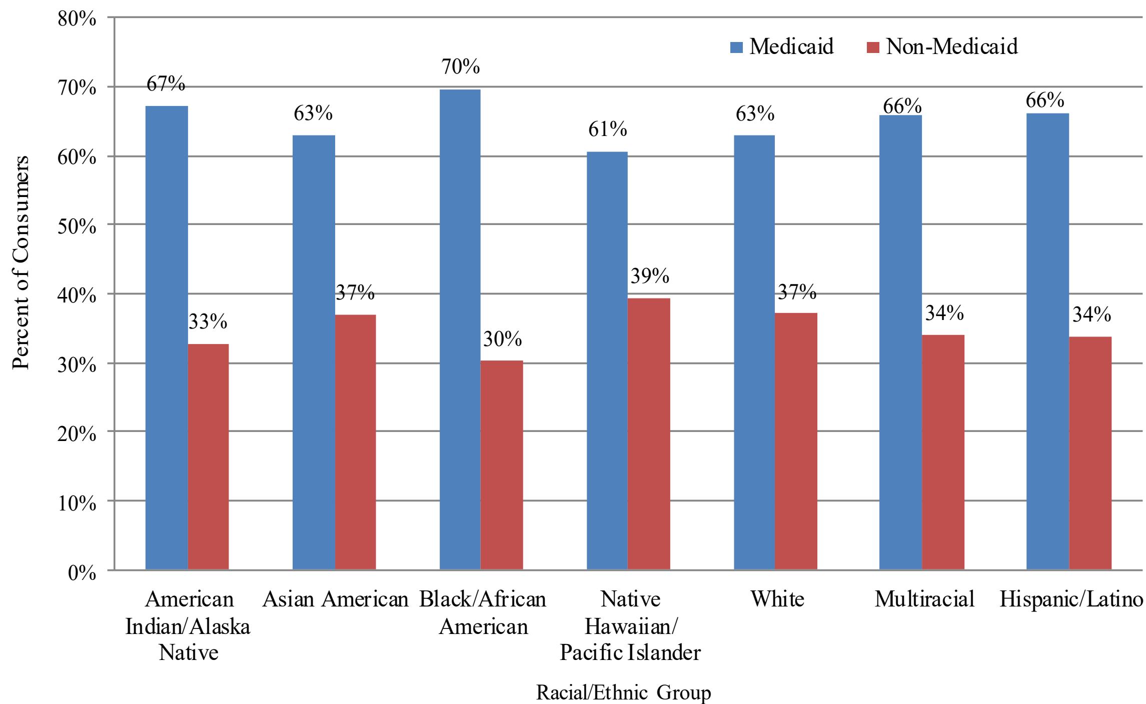
SMHAs fund and operate mental health services in a variety of service settings including community settings, state psychiatric hospitals, other psychiatric inpatient settings,[10] and residential treatment centers. In 2014, 98 percent of the 7.3 million individuals received mental health services in community settings, with a utilization rate of 22.3 per 1,000 of the population. Six percent of individuals received services in other psychiatric inpatient settings (with a utilization rate of 1.3 per 1,000), whereas only 2 percent and 1 percent of individuals received services in state psychiatric hospitals (with a utilization rate of 0.5 per 1,000) and residential treatment centers (with a utilization rate of 0.2 per 1,000), respectively.

Individuals Served Through Medicaid and Other Funding Sources

Medicaid funds were used to pay for at least some of the mental health services that 64 percent of individuals received, whereas only non-Medicaid funds were used for 36 percent of individuals. As depicted in Figure 6, African Americans used the highest percentage of Medicaid services, with 70 percent using Medicaid to pay for mental health services, whereas Native Hawaiian/Pacific Islanders had the lowest percentage of Medicaid service use, with 61 percent.

[10] Inpatient psychiatric care through a private provider or medical provider licensed and contracted through the SMHA.

Figure 6. Percentage of Individuals by Medicaid and Funding Sources and by Race/Ethnicity, FY 2014



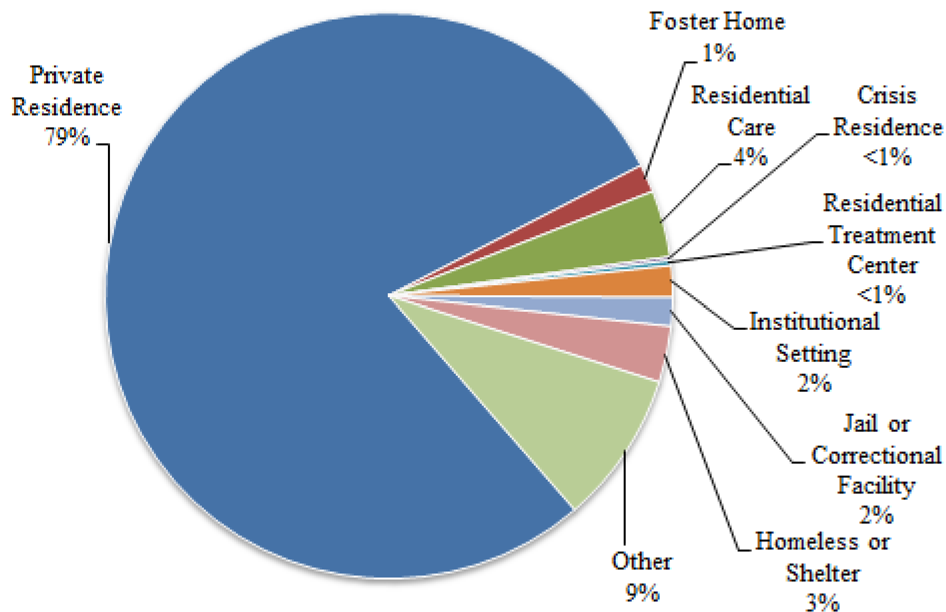
Employment Status of Individuals Served

The vast majority of adult individuals served in community settings either were not in the labor force (54 percent) or were unemployed (28 percent). Only 18 percent were competitively employed. In 48 SMHAs, individuals diagnosed with schizophrenia and related disorders had the lowest employment rate (six percent), followed closely by individuals diagnosed with other psychoses (seven percent). In these SMHAs, individuals diagnosed with bipolar and mood disorders had a relatively higher employment rate (14 percent).

Residential Settings of Individuals Served

Seventy-nine percent of individuals served lived in private residences (Figure **7**). The remaining individuals lived in a variety of settings, including residential care facilities (four percent), foster homes (one percent), jail or correctional facilities (two percent), or institutional settings (two percent). Three percent of individuals were homeless or in shelters of which the majority (61 percent) were male.

Figure 7.Percentage of Individuals by Residential Setting, FY 2014



5.3 Individuals for Whom Single State Agencies Provided Substance Use Disorder Services, FY 2013–2014

The SSA-supported SUD treatment system delivers a majority of the specialty SUD treatment in the nation. Reports from SSAs (annual reports for the SABG) show that they served 2.3 million individuals from July 2013 through June 2014.[11] About 1.46 million of these individuals were new admissions in FY 2013–2014 (Table 9). An additional 668,491 initiated their treatment in a prior year—these individuals started treatment before July 1, 2013, but continued treatment for some months into the FY 2013–2014 reporting year. SSAs also report that they funded recovery support services (but no treatment) to 188,919 individuals. These individuals often are receiving recovery support following treatment in previous years, or individuals who used support or recovery services such as those provided through the Access to Recovery (ATR) initiative but never accessed formal treatment services. Most states do not track information on individuals receiving only recovery services. Fewer than half of SSAs report this information, possibly due to reporting challenges because individuals who receive support or recovery services often do so in conjunction with or following episodes of SUD treatment.

The distribution of SSA services by state can be found in Table 9. California served the most people from FY 2013 through 2014 (237,352). The states serving the fewest number of individuals were Hawaii (5,231), North Dakota (5,061), and New Mexico (2,239). Nationally, about 0.8 percent of the total population received SSA-supported treatment. The percentage served by states ranged from 0.1 percent for New Mexico to 3.0 percent for South Dakota).

Data on treatment admissions also are provided in Table 9. SSAs supported about 1.89 million treatment admissions during FY 2013–2014. The total number of admissions was higher than

[11] The data in this section include the most recent values that states submitted to SAMHSA. For most states, it is the 2013–2014 reporting year; however, for several states, the data are for the 2012–2013 reporting year.

the number of individuals' first initiating treatment in the same year, because up to a third of those who began treatment dropped out and then re-entered treatment in the same year. When individuals change from one type of treatment to another, it is generally counted as a transfer rather than as a new admission. However, in a few states, new admissions actually may include some transfers because of data reporting issues.

There were nearly 1.18 million SSA-supported admissions to outpatient treatment; of these total admissions, almost 1 million were to standard outpatient care compared with 200,000 SSA-supported admissions to intensive outpatient care (not shown here). SSAs supported 100,658 admissions to opioid replacement treatment, which was predominantly methadone; however, buprenorphine is being used more frequently than in the past. Note that the SABG and TEDS reporting systems count individuals who transferred to opioid treatment after residential (detox or rehabilitation) treatment. Residential treatment made up about one-third of admissions, and this was split almost equally between detoxification and care oriented toward rehabilitation. Again, these values only represent individuals whose care was supported in some degree by SSAs; those whose care was reimbursed by insurance or out-of-pocket are outside of these figures.

Various types of information about individuals admitted to SSA-supported treatment can be acquired by abstracting the intake assessment from the clinical records in the TEDS. SSAs operate the TEDS under agreements with SAMHSA. Analysis of the most recent (2012) TEDS shows that slightly more admissions were from individual self-referrals (36 percent) than from courts and other criminal justice (34 percent). Referrals from all other sources made up 28 percent (e.g., health care, social service, or other SUD providers).

Table 9. Number of Individuals Receiving Single State Agency-Supported Substance Use Disorder Treatment or Support Services, by Nation and State, FY 2013–2014

	Persons Provided Treatment or Recovery Services					SSA Supported Admissions in 2013 2014			
		Treatment							
State	Total, Any Service	Admitted 2013 2014	Admitted Prior Year	Other Recovery	Total, as Share of Population*, %	Total	Residential Detox or Rehab	Outpatient	Opioid Replacement
U.S.	**2,316,247**	**1,458,837**	**668,491**	**188,919**	**0.8**	**1,890,279**	**614,084**	**1,176,258**	**100,658**
Alabama	18,792	16,182	2,610	0	0.4	20,767	5,180	13,665	1922
Alaska	7,512	5,073	1,109	1330	1.0	6,437	2,496	3,903	38
Arizona	128,392	78,485	49,907	0	1.9	75,775	8,551	62,229	4,995
Arkansas	15,177	12,265	2912	0	0.5	14,268	5,155	8,227	886
California	237,352	138,076	99,276	0	0.6	167,148	56,911	93,147	17,090
Colorado	128,249	83,298	44,951	0	2.4	102,680	63,852	36,784	2,044
Connecticut	56,991	26,100	13,282	17,609	1.6	37,303	15,993	15,947	5,363
Delaware	9,744	4,884	4,159	701	1.0	7,641	2,065	4,797	779
District of Columbia	10,204	5,468	1,521	3,215	1.5	6,226	3,068	2,752	406
Florida	117,216	76,573	40,643	0	2.5	150,534	35,844	109,383	5,307
Georgia	35,634	14,841	20,793	0	0.4	59,242	13,435	45,585	222
Hawaii	5,231	3,888	913	430	0.4	4,664	959	3,695	10
Idaho	8,100	8,100	0	0	0.5	4,833	297	4,536	0
Illinois	71,499	23,419	24,710	23,370	0.6	73,006	27,146	43,761	2,099
Indiana	47,397	24,060	23,337	0	0.7	25,717	2,191	23,170	356
Iowa	53,848	43,380	10,468	0	1.7	18,042	3,804	14,112	126
Kansas	18,872	14,153	4,719	0	0.6	10,034	4,547	5,487	0
Kentucky	17,920	14,784	3,136	0	0.4	16,956	7,407	9,549	0
Louisiana	15,208	12,674	2,534	0	0.3	13,991	8,744	5,247	0
Maine	15,654	12,960	240	2,454	1.2	14,203	2,446	8,118	3,639
Maryland	70,365	52,506	17,859	0	1.2	49,768	16,541	29,097	4,130
Massachusetts	68,328	52,362	15,913	53	1.0	105,860	69,092	28,465	8,303
Michigan	73,983	59,026	8,245	6,712	0.7	70,088	23,663	42,904	3,521
Minnesota	30,578	24,311	6,267	0	0.6	33,235	15,764	16,060	1,411
Mississippi	7,874	7,325	549	0	0.3	6,767	2,963	3,779	25
Missouri	53,870	30,980	11,611	11,279	0.9	49,587	14,702	34,269	616
Montana	7,072	5,422	1,650	0	0.7	6,534	1,349	5,185	0
Nebraska	17,642	13,518	4,124	0	0.9	14,317	2,363	10,616	1338
Nevada	11,164	7,513	2,494	1157	0.4	7,215	1,632	5,505	78
New Hampshire	18,078	6,356	2,157	9565	1.4	7,337	1,753	5,584	0
New Jersey	49,785	27,236	21,488	1,061	0.6	34,862	15,999	18,642	221
New Mexico	2,239	2,133	106	0	0.1	2,255	483	1,767	5
New York	131,173	92,754	38,419	0	0.7	105,400	43,014	54,948	7,438
North Carolina	75,387	47,053	12,352	15,982	0.8	59,852	10,477	49,067	308

State	Persons Provided Treatment or Recovery Services					SSA Supported Admissions in 2013 2014			
		Treatment							
	Total, Any Service	Admitted 2013 2014	Admitted Prior Year	Other Recovery	Total, as Share of Population*, %	Total	Residential Detox or Rehab	Outpatient	Opioid Replacement
North Dakota	5,061	3,917	1140	4	0.7	3,857	728	3,129	0
Ohio	108,282	49,578	7,748	50,956	0.9	53,585	7,260	40,780	5,545
Oklahoma	22,571	17,811	4,760	0	0.6	20,741	5,906	14,822	13
Oregon	113,313	73,706	26,957	12,650	2.9	73,619	8,656	56,531	8,432
Pennsylvania	72,920	39,016	33,904	0	0.6	55,594	19,724	30,850	5,020
Rhode Island	9,980	5,052	4,928	0	0.9	7,425	3,190	2,628	1607
South Carolina	44,769	33,838	10,931	0	0.9	39,776	3,122	36,654	0
South Dakota	25,596	11,597	13,999	0	3.0	14,004	8,260	5,744	0
Tennessee	18,605	13,872	2,010	2,723	0.3	20,045	11,540	8,505	0
Texas	43,775	37,473	6,302	0	0.2	52,754	23,051	27,624	2,079
Utah	16,219	10,976	5,243	0	0.6	17,272	5,787	11,082	403
Vermont	16,719	8,197	2,489	6,033	2.7	12,295	4,475	6,124	1696
Virginia	33,035	21,408	11,627	0	0.4	32,534	4,843	27,691	0
Washington	69,432	34,716	34,716	0	1.0	41,647	9,868	28,813	2,966
West Virginia	28,066	20,615	2,825	4626	1.5	30,136	537	29,599	0
Wisconsin	42,522	22,427	3,086	17,009	0.7	30,294	6,502	23,571	221
Wyoming	8,852	7,480	1,372	0	1.5	2,878	749	2,129	0

*Share of population in U.S. as a whole and by each individual state, as applicable

Abbreviation: SUD, substance use disorder.

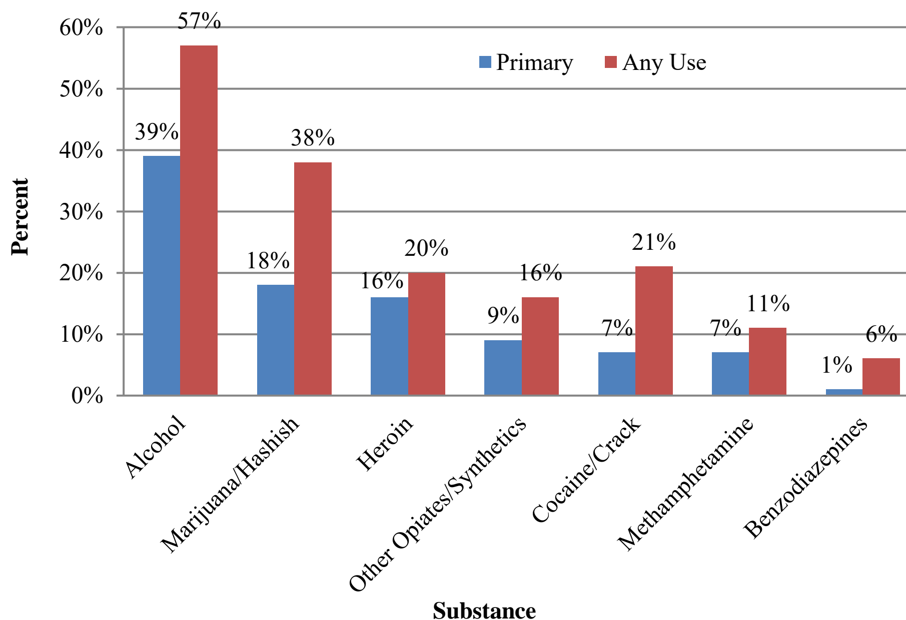
Characteristics of Individuals Admitted to Publicly Supported Treatment for Substance Use Disorders

The TEDS also includes the primary and additional substances that the client uses. Knowledge of the substances being abused has important implications for the nature and course of care given to the patient. For example, there are effective medications to treat abuse of alcohol, heroin, or other opiates, and various therapeutic approaches may be better suited for certain substances.

The primary substances reported for admissions in the FY 2012 TEDS online public use file were alcohol (39 percent) and illicit drugs of different types (61 percent) (Figure 8). In total, 57 percent of admissions misused alcohol (as their primary or secondary substance) versus 76 percent that abused some other type of drug (as their primary or secondary substance). Only 21 percent of admissions misused only alcohol versus 42 percent that only used illicit drugs; 35 percent had problems with both alcohol and illicit drugs.

Marijuana was the primary drug reported for 18 percent of admissions, followed by heroin (16 percent), other opiates (9 percent), cocaine or crack (7 percent), methamphetamines (7 percent), and benzodiazepines (1 percent). For 1 percent of admissions, there was no primary drug reported.

Figure 8. Primary and Other Substances Abused at Admission to Publicly Supported Substance Use Disorder Treatment, FY 2012



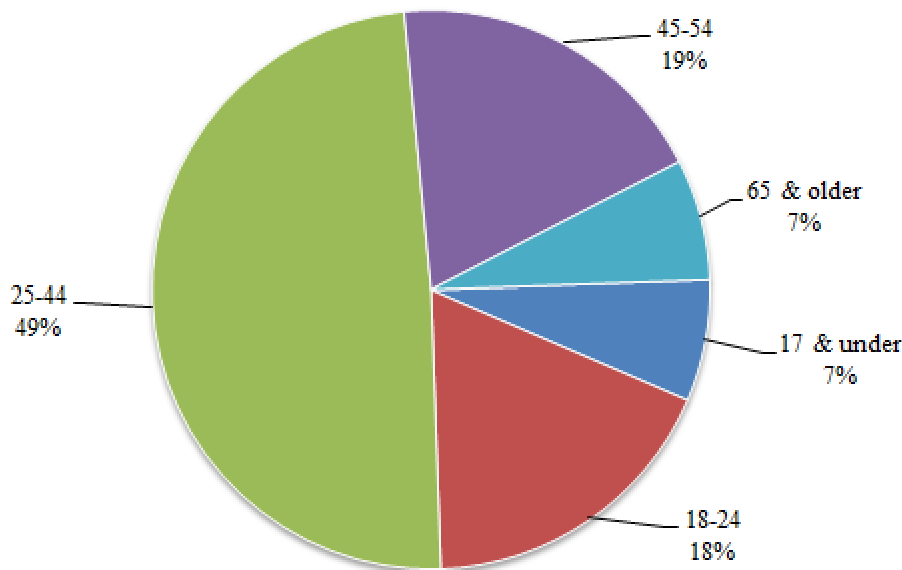
Note: Two percent of admissions were for substances reported in an 'other' category and no primary drug was reported for 1 percent of admissions. Hence, the percentages in the figure sum only to 97 percent. Admissions could be associated with more than one drug in the any use category, so these percentages sum to more than 100 percent.

Individuals Entering Into Substance Use Disorder Treatment, by Age and Sex

As depicted in Figure 9, a large majority (68 percent) of people entering SSA-supported treatment were between the ages of 25 and 54 years. Adults aged 18 through 24 years

constituted another 18 percent. Individuals aged 17 years and younger and adults aged 65 years and older represented only 7 percent.

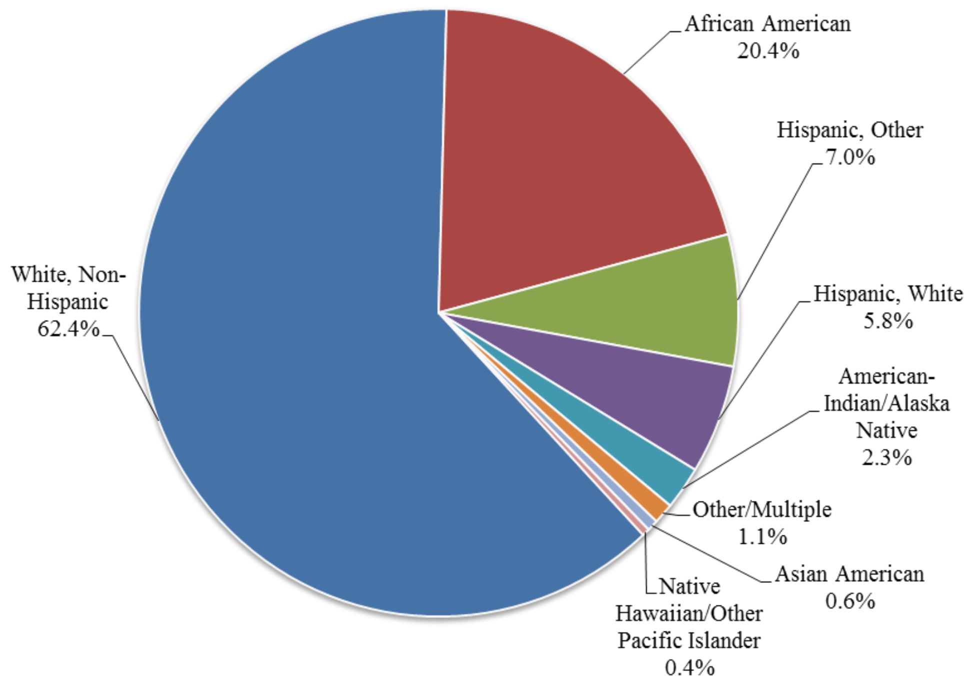
Figure 9. Age Distribution (in Years) of Individuals Entering Single State Agency Supported Treatment, FY 2012



Individuals Admitted to Substance Use Disorder Treatment, by Race and Ethnicity

Racial/ethnic characteristics are tracked in the TEDS. Figure 10 displays the racial/ethnic distribution of individuals admitted to SSA-supported SUD treatment in 2012 (from the 2012 TEDS). In total, individuals who were Hispanic or Latino represented 12.8 percent of SSA-supported admissions. Individuals who were White (non-Hispanic) made up 62.4 percent of admissions, followed by those who were African American (non-Hispanic, 20.4 percent), American Indian and Alaska Native (2.3 percent), other/multiple race (1.1 percent), and Asian American (0.6 percent).

Figure 10. Racial Distribution of Individuals Admitted to Single State Agency Supported Substance Use Disorder Treatment, FY 2012



Outcomes of Treatment

SAMHSA and states collaborated to develop the 10 domains for the National Outcome Measures (NOMs). The NOMs provides state-level data about SUD treatment and SUD prevention services. That effort resulted in a national system that tracks and periodically publishes the results through the state SABG Annual Reports. A few key results from the extensive and comprehensive system are presented below.

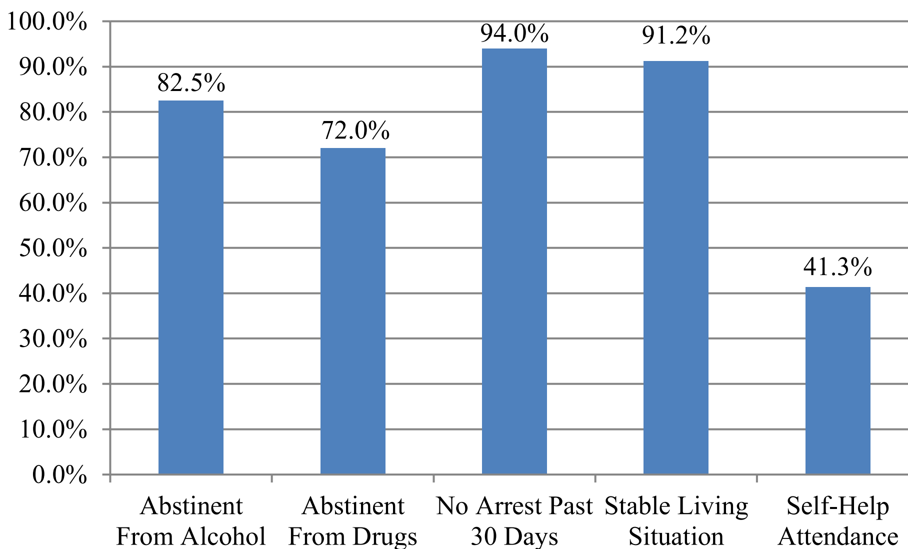
In this section, results are presented for standard outpatient treatment providers that receive support from SSAs, although similar data exist for other types of treatment. Outcomes from this level of care are highlighted because standard outpatient treatment is expected to be the final formal phase of a treatment episode that has prepared an individual to pursue recovery.

Abstinence from (or at least reduced use of) alcohol and illicit drugs are considered to be the most important outcomes of SUD treatment. At discharge, the treatment providers reported clients' abstinence rates as 82.5 percent for alcohol and 72.0 percent for drugs (Figure 11) compared with 57 percent who misused alcohol at the time of entry into treatment and 76 percent who misused drugs in the month prior to treatment entry (Figure 8).

Two other important measures distinctly improved following treatment. Ninety-one percent (data not shown) of individuals were free of arrests at admission; this number rose to 94.0 percent who were free for the past 30 days during the first month before discharge. Similarly, 86.4 percent (data not shown) reported being in a stable living situation at admission, but 91.2 percent reported housing stability at discharge.

The final outcome measure is attendance at self-help groups such as Alcoholics Anonymous during the last 30 days of treatment; 41.3 percent of individuals participated in these groups. Although this participation is not a direct outcome, it is an indicator of prospects for sustained recovery. A minority of clients explore self-help groups on their own or at the suggestion of providers while waiting for admission. Self-help groups generally are the most important at the conclusion of treatment, when the patient needs support to achieve and sustain recovery. Moreover, states increasingly are funding recovery support services intended to assist clients to re-establish equilibrium in their lives. No data are collected yet on how many individuals access recovery support services during and following SUD treatment.

Figure 11. Primary Outcomes at Discharge From Standard Outpatient Treatment, FY 2011–2012



Prevention: Population Served and Services Provided

SSAs report in their annual block grant reports that they funded about 2,452 prevention providers from 2013 through 2014. These agencies collectively serve tens of millions of individuals each year, reaching some individuals with direct services and many more though community policies or mass media messages and contacts. SAMHSA broadly differentiates these as *individual-based* and *population-based* prevention strategies. *Individual-based programs or strategies* are provided to identifiable individuals who are provided education about SUD harms and skills to resist or avoid risky substance use situations. The service may occur in a planned sequence that is designed to inform, educate, develop skills, and alter risk behaviors; most often, it is delivered in small groups (e.g., parent education groups). *Population-based programs or strategies* include initiatives aimed at influencing communities or large groups of people through changing laws or policies or educating via public service campaigns or events such as a health fair or distribution of leaflets.

SSAs reported that 17.5 million people received individual-based SUD prevention services from 2013 through 2014. Although it is possible that some individuals engaged in more than one service (e.g., a student who had a health class and went to after-school, drug-free activities), it is believed that the amount of overlap is small.

In contrast, SSA-supported population-based prevention strategies produced an estimated 483.6 million person exposures. This count is larger than the total U.S. population, and it reflects the fact that public service campaigns with mass media messages reach people multiple times. Environmental strategies encompass the entire community and include activities such as building community coalitions, restricting alcohol advertisements, training alcohol servers, and restricting the hours or density of alcohol served. As a result, multiple strategies may affect the same community, and each strategy results in its own person exposure count.

The total number of individuals served by population-based strategies often includes multiple counts of the same person. For example, a number of states reported the number of individuals served in excess of their state population (see Table 10). In these states, *individuals served* may be defined as person exposures, where it is hypothesized that a given person benefited from multiple substance abuse prevention services, messages, and strategies.

A caveat must be noted regarding the state-by-state data on prevention. The tendency is to expect that more is better; unfortunately, there is little basis on which to assess the differences across states in the patterns and levels of individual versus population services. These data on the number of individuals reached or person exposures by a prevention strategy are an important but limited metric of the reach of strategies. Information about intensity or type of prevention strategies and the success of the strategies in reducing SUDs is not available.

Table 10. Number of Individuals/Person Exposures Served by Single State Agency Sponsored Substance Abuse Prevention Strategies in FY 2013–2014, by State

State	Number of Individuals/Person Exposures	
	Individual Prevention Strategy	Population Prevention Strategy
U.S.	17,538,773	483,595,707
Alabama	89,974	708,491
Alaska	10,818	5,043
Arizona	29,333	2,405,938
Arkansas	90,187	116,830
California	386,489	4,810,807
Colorado	198,382	1,717,506
Connecticut	4,281,660	14,887,432
Delaware	9,457	197,719
District of Columbia	567	3,925
Florida	6,511	6,858,965
Georgia	103,838	1,061,186
Hawaii	12,214	97,136
Idaho	12,082	5,627,680
Illinois	36,281	51,443
Indiana	30,909	39,654
Iowa	167,998	32,475
Kansas	11,433	48,295
Kentucky	421,210	113,728,194
Louisiana	83,694	253,177
Maine	761	1,329,192
Maryland	7,971	312,591

State	Number of Individuals/Person Exposures	
	Individual Prevention Strategy	Population Prevention Strategy
Massachusetts	0	56,664,162
Michigan	147,376	350,302
Minnesota	45,016	155,412
Mississippi	141,459	675,745
Missouri	270,233	4,619,924
Montana	5,310	421,990
Nebraska	115,268	624,484
Nevada	5,445	635,726
New Hampshire	30,613	352,053
New Jersey	63,393	164,075
New Mexico	1,045	1,583,920
New York	95,098	4,273,392
North Carolina	103,346	51,644
North Dakota	236,111	8,164,526
Ohio	280,383	2,410,780
Oklahoma	6,446,322	9,482,592
Oregon	55,295	78,514
Pennsylvania	220,926	8,008,348
Rhode Island	13,355	691
South Carolina	102,870	6,432,981
South Dakota	98,865	118,691
Tennessee	16,614	183,521,236
Texas	130,124	15,338,880
Utah	2,372,370	12,315,662
Vermont	1,276	423,348
Virginia	46,997	679,839
Washington	40,157	55,313
West Virginia	9,731	1,259,487
Wisconsin	448,161	2,430,723
Wyoming	3,845	8,007,588

Individual and Population Prevention Service Recipients, by Age

SUD prevention services are intended to reach all ages in a community. It is often thought that SUD prevention is especially important for adolescents (ages 12–20 years), when SUD has the highest rates of onset and incidence. Other studies have shown that preadolescents are also responsive to preventive messages. For this reason, state prevention strategies are designed to reach across the lifespan. This is readily seen in the data on the ages of individuals prevention services reach.

Figure 12 shows service recipients for whom age was reported. Only 29 percent of individual prevention recipients were aged 12–20 years, and 17 percent were younger than 12 years. More than 50 percent of individuals served were aged 21 years or older, and 9 percent were aged 65 years and older. Figure 13 shows population prevention strategies, which are somewhat more focused on adolescents. Forty-four percent of person exposures were among adolescents (aged 12–20 years), with only 3 percent directed at younger children and 53 percent reaching adults aged 21 years and older.

Figure 12. Age Distribution (in Years) of Individual Prevention Service Recipients, FY 2013–2014

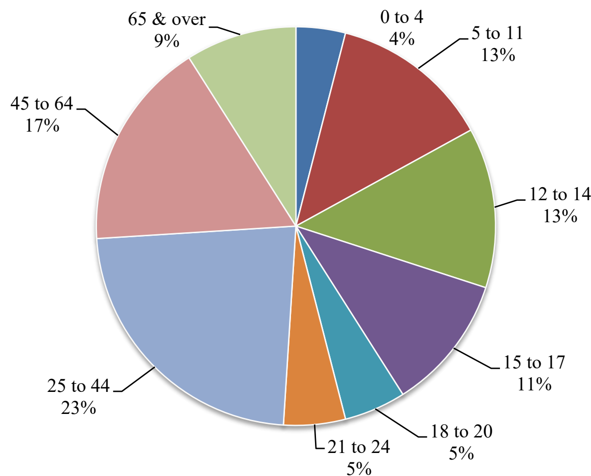


Figure 13. Age Distribution of Population Prevention Service Recipients, FY 2013–2014

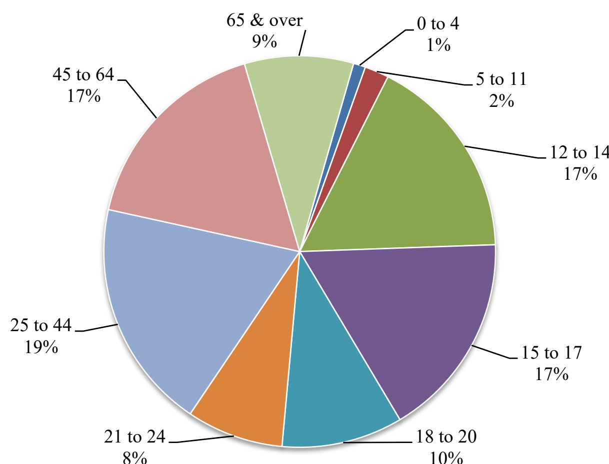
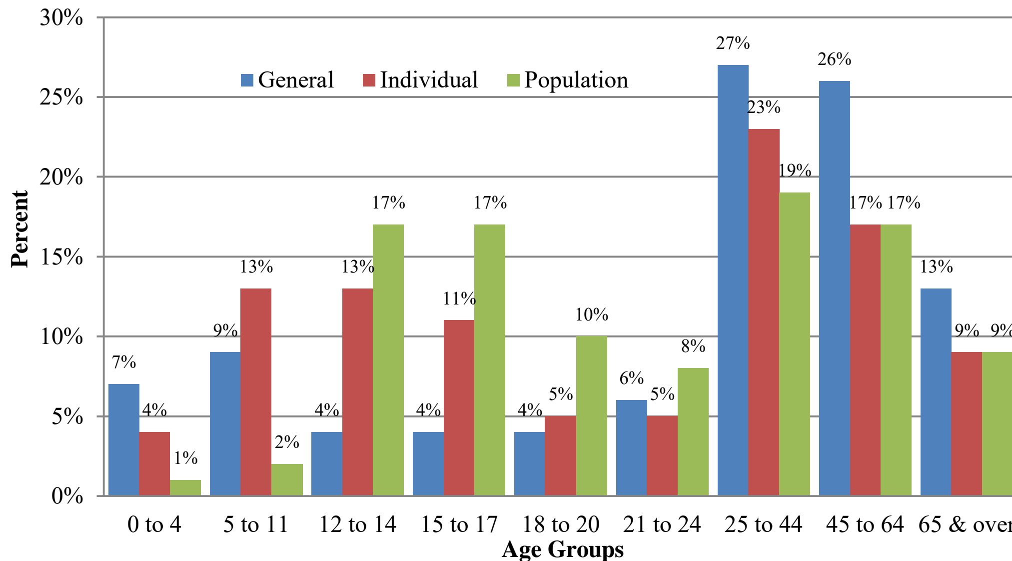


Figure 14 compares the distribution of individuals from various age groups in the general population and those who received individual and population prevention services.[12] Adolescents aged 12 through 20 years, who receive a disproportionately large share of primary prevention services, typically initiate alcohol and drug misuse. Individuals aged 12 through 14 years make up only 4 percent of the U.S. population, but they constitute 13 percent of those reached by individual prevention and 17 percent of those reached by population prevention efforts. Very similar ratios apply to those aged 15 through 17 years. Adults aged 25 through 64 years receive a disproportionately lower share of prevention services, representing about 35 to 40 percent of prevention service exposures, although they constitute 53 percent of the total population. About 51 percent of all individuals reached by SUD prevention services were female.

---

[12] Data on the general population were obtained from the Census Bureau's website http://www.census.gov/

Figure 14. Age Distribution of Individual and Population Prevention Recipients Versus the General Population, FY 2013–2014

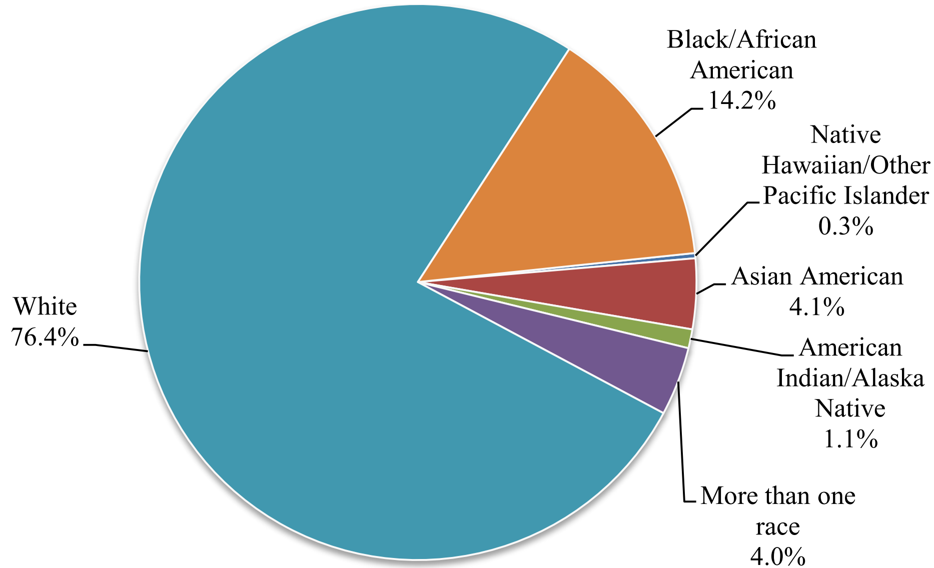


Individual and Population Prevention Service Recipients, by Race and Ethnicity

Figures 15 and 16 show the racial distributions of individual and population prevention services, respectively. These figures indicate that 76.4 percent of people receiving individual and 76.7 percent receiving population prevention services were identified as White. Although data are available by Hispanic ethnicity, the states did not disaggregate Hispanic ethnicity by race. Census Bureau data show that individuals who are White make up 74 percent of the general population.

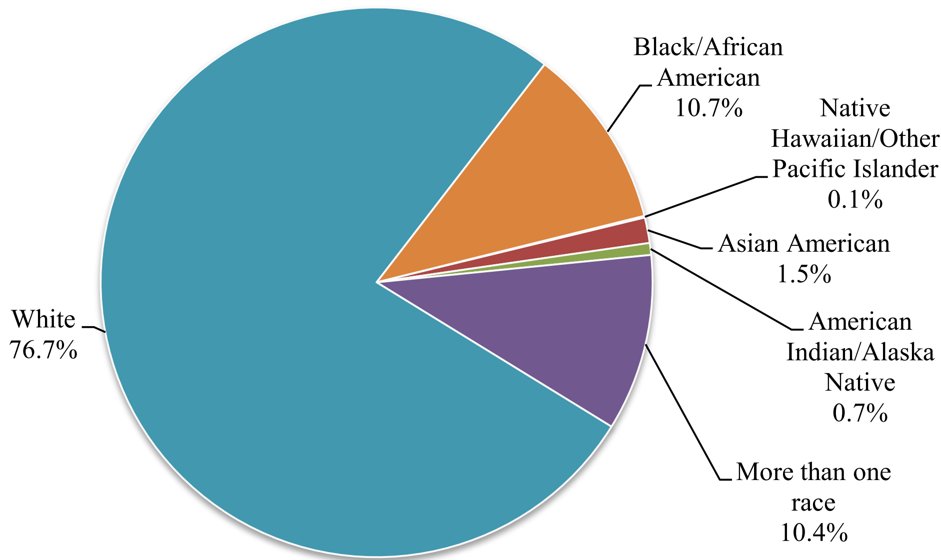
Individuals identified as Hispanic and Latino received 8.3 percent of individual prevention services and 4.5 percent of population prevention-based exposures. Hispanics constitute 16 percent of the total population. Individuals identified as African American made up 14.2 percent of the individual prevention recipients and 10.7 percent of population prevention exposures, and they constitute 12.5 percent of the general population. Data from SSAs show that people who identify as being of more than one race made up 4.0 percent and 10.4 percent of individual and population prevention exposure recipients, respectively. Individuals who identify as being of more than one race constitute 2.5 percent of the general population. Finally, individuals identified as American Indian and Alaska Native made up 1.1 percent and 0.7 percent of the individual and population prevention service recipients, respectively, compared with the 0.8 percent share in the general population.

Figure 15. Racial Distribution of Individual Prevention Services Recipients, FY 2013–2014



Note: Percentages may not total 100 percent because of rounding.

Figure 16. Racial Distribution of Population Prevention Services Recipients, FY 2013–2014



Note: Percentages may not total 100 percent because of rounding.

This page intentionally left blank

Chapter 6: State Mental Health Agency Efforts to Address Health-Mental Health Integration

6.1 Key Highlights

- Forty-two states currently have initiatives to improve the integration of mental health with primary care.
- Thirty-seven states screen or assess individuals with mental health issues for physical health issues in community mental health settings.
- Forty states have initiatives with mental health providers to offer targeted services to people with co-occurring M/SUDs.
- Information management for mental health functions is combined with SUD funds in 22 states, combined with both SUD functions and intellectual disability functions in 10 states, and operates independently in 11 states.
- The median amount spent in each state on information management for mental health functions is $847,489.
- A total of 534 CMHCs and 92 state hospitals throughout the country implement EHRs.
- Only six states have implemented personal health records.
- More than half of states (23 out of 44) have rules in place that provide more stringent privacy protections than those provided under the Health Insurance Portability and Accountability Act (HIPAA).

6.2 Integration, Colocation, and Other Initiatives to Integrate Physical and Behavioral Health

Integration of Mental Health and Primary Care

The integration of mental health with primary care has been linked to cost savings, better treatment outcomes, and lower rates of mortality.[13] Most states (42 out of 48 reporting) reported that their SMHA has initiatives under way to improve the integration of mental health with primary care. Fifteen SMHAs indicated that they are pursuing integration through health homes. For example, in Massachusetts, the Department of Mental Health's Massachusetts Mental Health Center has begun transforming the Wellness and Recovery Medicine Center into a health home

[13] Wotmann, E., Grogan-Kaylor, A., Perron B., Georges, H., Kilbourne, A.M., Bauer, M.S. (2012). *Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis*. American Journal of Psychiatry, *169*(8), 790-804.

that will include a full-service, on-site primary care clinic with two full-time primary care providers (PCPs), in-house phlebotomy services, and referrals to vision, dental, and specialty medical services. In Nevada, the SMHA partners through the Rural Community Health Service with PCPs in rural Nevada to integrate mental health care by collocating services or providing telehealth options.

States may opt to integrate mental health services into FQHCs to reach underserved populations in a setting that receives enhanced Medicare and Medicaid funding. The SMHA works with FQHCs to provide mental health services in 26 of the 39 reporting states, although SMHA integration efforts with FQHCs exist at different levels of implementation. For example, SMHAs in North Carolina, New Jersey, and Nevada are just initiating work with FQHCs. Missouri, however, has had partnerships in place between CMHCs and FQHCs since 2008. In Hawaii, FQHCs can be contracted service providers of the SMHA.

In 20 of 38 states reporting, the SMHA works with other federal agencies to integrate mental health and primary health services. For example, Texas works with CMS on demonstrations of the Money Follows the Person and Medicaid Incentives for the Prevention of Chronic Diseases innovation models. Vermont has an epidemiologist from the Centers for Disease Control and Prevention (CDC) working on children's mental health issues. Twenty-four states have received Certified Community Behavioral Health Clinic (CCBHC) planning grants under the § 223 CCBHC demonstration project.[14]

Colocation of Mental Health and Primary Care

One of the methods to integrate mental health and primary care is to collocate care in a single facility. When modifying existing, nonintegrated programs, colocation can be accomplished by providing primary care in mental health facilities or by providing mental health care in a primary care facility. States often pursue colocation of care in FQHCs.

Of 45 states reporting, in 39 states the SMHA supports the colocation of primary care in mental health programs. For example, in Mississippi the Department of Mental Health is working with CMHCs to integrate primary care clinics into their programs after the state government recently passed a law that allows CMHCs to open primary care clinics. Of 46 states reporting, 39 states report that their SMHA supports the colocation of mental health providers in primary care. For example, in Texas, some Local Mental Health Agencies locate staff in FQHCs to provide mental health assessments, case management, and treatment services.

Altogether, 41 states indicated that their SMHA supports either the colocation of primary care in mental health programs or the colocation of mental health providers in primary care settings. Thirty-six states reported that their SMHA supports both types of colocation. Three states indicated that their SMHA supports the colocation of primary care in mental health programs but not the colocation of mental health providers in primary care settings. Two states reported that their SMHA supports the colocation of mental health providers in primary care settings, but not

---

[14]Substance Abuse and Mental Health Services Administration. (2015). *HHS awards up to $22.9 million in planning grants for certified community behavioral health clinics*. Retrieved from http://www.samhsa.gov/newsroom/press-announcements/201510191200.

the colocation of primary care in mental health programs. Finally, four states indicated that their SMHA currently does not support either type of colocation.

Physical Health Screening

A first step in incorporating primary care into mental health care is implementation of health screenings. Forty (out of 49) states reporting indicated that the SMHA screens or assesses individuals for physical health issues in community mental health settings.

Sixteen of these states screen or assess *all* individuals served in *all* community mental health programs that SMHAs fund or operate. For example, in Utah physical health issues are a component of the assessment battery that all providers are required to perform, but providers also are required to perform additional screenings if patients are prescribed certain medications; for example, patients prescribed clozapine receive regular blood testing to screen for neutropenia. Twelve states screen or assess *some* individuals served in *all* community mental health programs that SMHAs fund or operate. For example, in Florida, all individuals who are in crisis stabilization units or residential settings who receive treatment services or who are under case management are screened for physical health issues. Only individuals receiving supports, such as intervention services that do not require a full evaluation, are not screened for physical health issues.

Only one state screens or assesses *all* individuals served in *some* community mental health programs that SMHAs fund or operate. Ten states screen or assess *some* individuals served in *some* community mental health programs that SMHAs fund or operate. For example, Massachusetts requires a physical health screen in community-based flexible support and ACT programs, which together serve over 75 percent of individuals served in the community.

Among all states that perform physical health screenings in some or all mental health programs, SMHAs require the screening in 23 states. The screening is funded by state general funds in 28 states, by Medicaid in 30, by Medicare in 7, with local funds in 1, and by the CMHS block grant in 1.

Selection criteria varied among states indicating that they perform physical health screenings only for some patients. Some states, such as Ohio, perform physical health screenings in certain settings, such as residential treatment facilities and health homes, but only for clients with serious and persistent mental illness. Vermont screens all clients who enter the program designated for adults with severe and persistent mental illness. In Alabama, the decision to screen patients is made at the provider level. Missouri indicated that all members of a health care home receive health screenings and a metabolic syndrome screening. Additionally, in Missouri, all individuals receiving antipsychotic medications receive a yearly metabolic syndrome screening.

Substance Use Treatment and Trauma Initiatives

In addition to the integration of mental health with primary care, SMHAs also have initiatives to integrate screening and treatment of other behavioral health issues into mental health settings. In a majority of the reporting states (43 out of 48), the SMHA supports or requires mental health providers to screen for histories of trauma in people the public health system serves. Three states reported that they do not require trauma screenings but that several providers do administer

them. Other states, such as Tennessee, Wisconsin, and Colorado, reported that their SMHA provides technical assistance and training to providers wishing to implement trauma screenings and trauma-informed treatment. Ten states said that they include a trauma screening in the battery of assessments administered to every client on intake. Five states reported that their SMHA does not require or work with mental health providers to screen individuals for trauma.

A similar majority of states (44 out of 48 reporting) said that their SMHA has initiatives with mental health providers to provide targeted services to people with co-occurring mental and substance use disorders. Five states have combined mental health and substance use treatment facilities. Wyoming's SMHA also operates a co-occurring residential treatment facility. Twelve states reported that their SMHA provides support in the form of technical assistance, training, or grant money to treatment and service providers to implement co-occurring treatment models. Texas has made available a web-based training on co-occurring M/SUDs to all treatment and service providers. In 20 of the 48 reporting states, the SMHA has an office or coordinator position dedicated to co-occurring mental health and substance use treatment services.

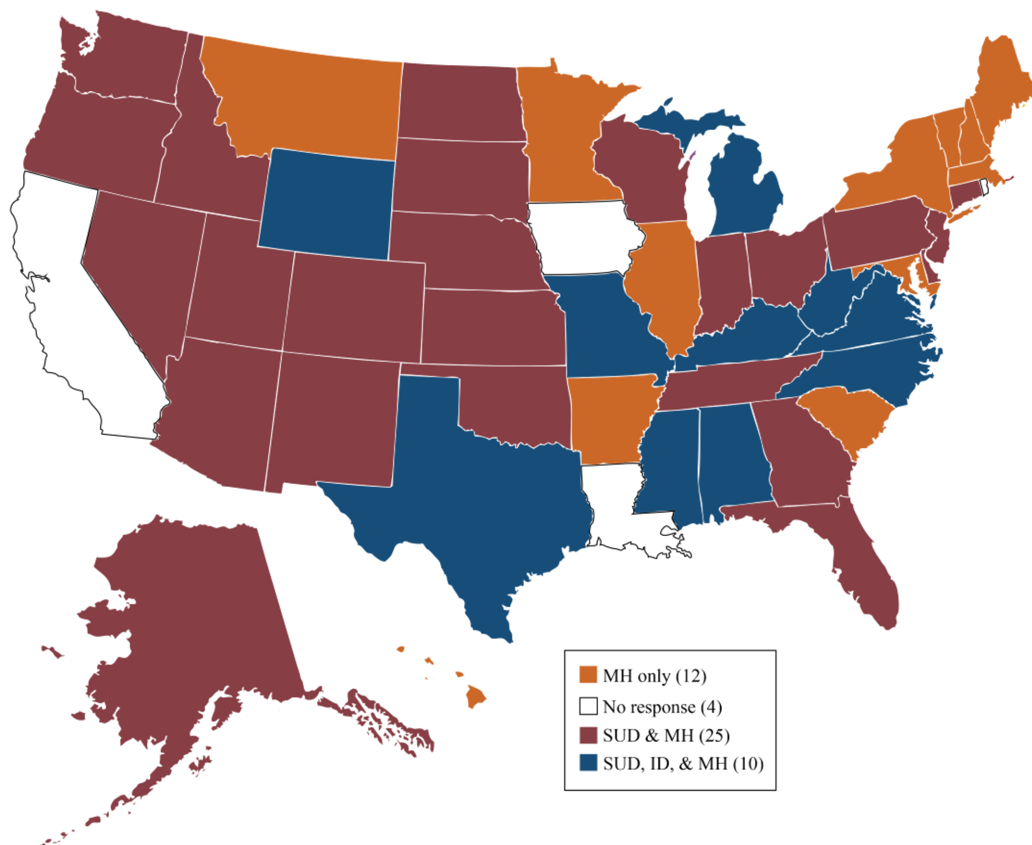
6.3 Implementation of Electronic Health Records and Sharing Electronic Health Information

Organization and Funding of Information Management Functions

Information management systems are an increasingly important functional component of SMHA core infrastructure and necessary for the effective integration of care across different systems. The cost and technical knowledge required to implement and maintain information management systems is significant. Some states use combined systems in partnership with other state agencies, such as substance use treatment and intellectual disability agencies.

As shown in Figure 17, the SMHA's information management is not combined with any other disability services information management in 12 of the 47 reporting states. In 25 states, the SMHA's information management is combined with the substance use treatment services information management system. In 10 states, the SMHA's information management is combined with the substance use disorder and intellectual disability systems. In Maine, the SMHA's information management is not combined with the system for any other disability services, but they are developing an information data model that can be used for both mental and substance use disorders.

Figure 17. Mental Health Information Management Systems, Stand-Alone and in Combination With Other Information Management Systems, by State, FY 2015



Abbreviations: ID, intellectual disability; MH, mental health; SUD, substance use disorder.

In addition to investment in the technical infrastructure, significant staff effort is needed to implement and maintain information management systems. In the 43 states reporting that their SMHA has employees dedicated to information management functions for mental health, the SMHA has an average of 15 dedicated full-time equivalent (FTE) employees. Among the 29 states reporting staffing data in which information management infrastructure is shared with or located in another agency, an average of 10 FTEs are located in another agency but dedicated to mental health information management functions. In 26 states, contractors support SMHA information management functions for mental health and have an average of 116 dedicated FTEs. Across 42 states reporting, an average total of 1,023 FTEs (in the SMHA, other agencies, or contractors) are dedicated to information management functions for mental health.

According to data 36 states reported in 2015, the average total budget per state for information management functions for mental health was $3,558,072, with a median of $847,489 (Table 11). These 36 states also reported that the average budget for information management personnel was $1,750,523, with a median of $509,175. Thirty states reported spending on other information management functions, with an average amount spent of $2,169,058 and a median of $407,042. Some of these other functions included software and technology purchasing costs, training expenses, contracting expenses, rent, utilities and maintenance, and undifferentiated support costs.

Table 11. Budget for Information Management for Each State, FY 2015

State	Budget for Personnel	Budget for All Other Items	Total Budget for Information Management
Alabama	1,453,000	1,349,418	2,802,418
Alaska	530,000	35,000	565,000
Arizona	– [a]	– [a]	– [a]
Arkansas	333,650	381,620	715,271
California	– [a]	– [a]	– [a]
Colorado	– [a]	– [a]	– [a]
Connecticut	2,800,000	4,000,000	6,800,000
Delaware	3,013,000	3,500,000	6,513,000
District of Columbia	488,349	75,000	563,349
Florida	454,113	536,693	990,806
Georgia	– [a]	– [a]	– [a]
Hawaii	417,986	– [a]	417,986
Idaho	735,952	– [a]	735,952
Illinois	234,000	0	234,000
Indiana	252,000	0	252,000
Iowa	– [a]	– [a]	– [a]
Kansas	74,091	147,135	221,226
Kentucky	– [a]	– [a]	– [a]
Louisiana	– [a]	– [a]	– [a]
Maine	205,900	593,638	799,538
Maryland	394,600	– [a]	394,600
Massachusetts	– [a]	– [a]	– [a]
Michigan	1,250,000	75,000	1,325,000
Minnesota	366,008	– [a]	366,008
Mississippi	1,876,000	1,400,000	3,276,000
Missouri	3,859,542	– [a]	3,859,542
Montana	– [a]	– [a]	– [a]
Nebraska	– [a]	– [a]	– [a]
Nevada	1,340,470	1,174,965	2,515,435
New Hampshire	81,737	–	81,737
New Jersey	1,438,242	2,114,852	3,553,094
New Mexico	– [b]	– [b]	– [b]
New York	23,200,000	30,400,000	53,600,000
North Carolina	– [a]	– [a]	– [a]
North Dakota	69,614	432,464	502,078
Ohio	6,520,978	9,758,000	16,278,978
Oklahoma	1,412,708	2,034,536	3,447,245
Oregon	900,000	200,000	1,100,000
Pennsylvania	– [c]	– [c]	– [c]
Rhode Island	– [a]	– [a]	– [a]
South Carolina	3,447,707	2,742,645	6,190,352
South Dakota	– [a]	– [a]	– [a]
Tennessee	2,506,327	2,681,583	5,187,911
Texas	885,145	10,294	895,439
Utah	100,000	265,400	365,400
Vermont	396,000	4,260	400,260

State	Budget for Personnel	Budget for All Other Items	Total Budget for Information Management
Virginia	198,352	76,851	275,203
Washington	762,000	250,000	1,012,000
West Virginia	145,994	149,900	295,894
Wisconsin	420,000	682,500	1,102,500
Wyoming	455,371	0	455,371
Total	63,018,836	65,071,754	128,090,593
Average	$1,787,528	$2,243,854	$3,646,721
Median	509,175	407,042	847,489
Number of states reporting	36	30	36

[a] No response.

[b] Behavioral health is carved into the operations of four managed care organizations under Medicaid, one administrative services organization (ASO) under fee-for-service Medicaid, and one ASO for non-Medicaid. Reporting is from the respective claims systems within each entity and therefore is not a state budget item.

[c] Unknown.

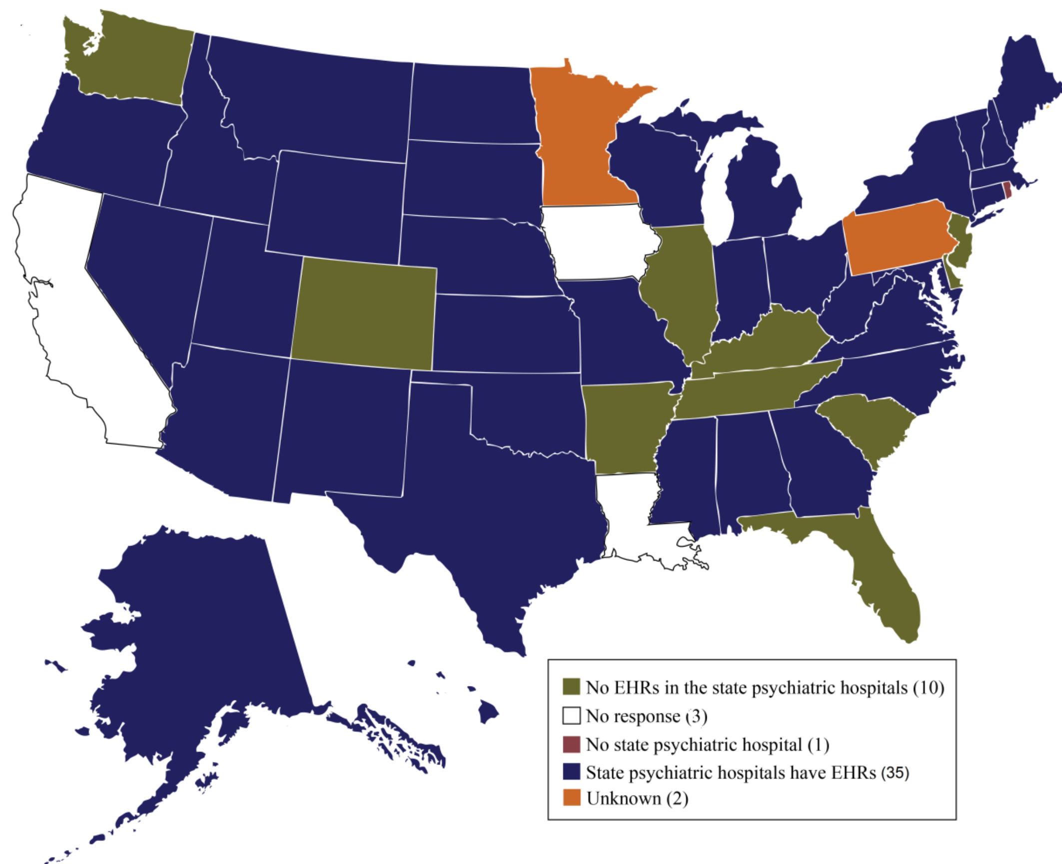
According to data 40 states reported in 2015, the average funding per state from all sources dedicated to information management functions for mental health was $5,064,054, with a median of $895,439. Of 35 states reporting, the average funding amount for information management functions coming from the SMHA operating budget was $5,191,329, with a median of $767,953. Of 34 states responding, the average funding amount coming from federal funds through the SMHA was $354,240, with a median of $137,363. Of 18 states responding that other funding sources were used, the average amount of funding from other sources was $549,182, with a median of $137,400.

Electronic Health Records

Electronic health records allow SMHAs to track clients across services within the agency and potentially across services in other agencies. They form a critical component of an integrated health care system.

Across all 47 states reporting, 626 CMHCs in 37 states have implemented EHRs, with an average of 18 CMHCs in each state. Across 48 states reporting, 93 state psychiatric hospitals in 35 states and, on average, two state psychiatric hospitals in each state have implemented EHRs. Figure 18 shows the presence of EHRs in state hospitals across the states. The majority of states that have not implemented EHR systems in their state hospitals are in the Southeast region.

Figure 18. State Psychiatric Hospital Electronic Health Record Systems, FY 2015



Abbreviation: EHR, electronic health record.

Twenty-nine of the 38 states reporting have a single EHR system for all state psychiatric hospitals. One state has a single EHR system for all CMHCs and eight states have a single EHR system for both state psychiatric hospitals and CMHCs.

In 14 of the 45 reporting states, the SMHA sets standards for EHRs in state psychiatric hospitals, CMHCs, or both. For example, in Connecticut, all state-operated CMHCs must adhere to the same EHR format, whereas in South Carolina all CMHCs must use the same state-developed EHR format. All state psychiatric hospitals in New York must use the same EHR system, and the state is switching them to a modified version of the Veterans Administration's open source EHR format, VistA.

Electronic Health Records in the State Psychiatric Hospital

The functionality of EHRs in state psychiatric hospitals differs widely between states. Table 12 shows EHR functions and the number of states whose state psychiatric hospital EHR system implements each of those functions. Michigan reports that their state hospital EHR also functions to maintain an inventory of controlled and noncontrolled drugs.

Table 12. Number of States Implementing Electronic Health Record Functions in State Psychiatric Hospitals, by Function, FY 2015

EHR Function	Number of States
Scheduling	17
Physician order entry	24
Treatment/recovery planning	29
Progress/case documentation	30
Clinical assessments	30
External consultation	12
Exchanging client info with providers	13
Billing	25
Pharmacy	32
Dietary	23
Patient admission, discharge, transfer	35
Medication algorithms	13
Reporting	32
Patient trust/representative payee	16
Other	3

Abbreviation: EHR, electronic health record.

Thirteen of 41 states reported that the EHR used in state psychiatric hospitals is hosted locally by the state hospital. Eleven states reported that it is hosted centrally by the SMHA, 7 reported that it is hosted by a vendor, and 10 reported that it hosted in a different fashion. Colorado, North Dakota, Nevada, Oregon, South Dakota, and Vermont indicated that psychiatric hospital EHRs are hosted by state information technology departments.

A total of 25 of 38 states reported that all state psychiatric hospital EHR systems met the meaningful use requirements[15] specified in the Health Information Technology for Economic and Clinical Health (HITECH) Act portions of the American Recovery and Reinvestment Act. Two states reported that only some state psychiatric hospital EHR systems met the meaningful use requirements. Eleven states reported that no state psychiatric hospital EHR systems met these requirements; in order to bring state psychiatric hospital EHR systems into compliance with the meaningful use requirements, Colorado, Massachusetts, Maine, Mississippi, and Ohio are upgrading their EHR systems in 2015 and 2016. Mississippi includes information required for meaningful use reporting in its state hospital EHR.

The average cost of EHR software (including required customization) for state psychiatric hospitals was $3,629,684, with a median of $900,000 (21 states reporting). The average cost of annual maintenance fees for EHR technology was $492,430, with a median of $245,407 (26 states reporting). The average cost of staff training was $426,214, with a median of $10,125 (19

[15] The HITECH Act was enacted to promote the adoption and meaningful use of health information technology. This Act provided financial incentives for health care professionals and hospitals to implement and meaningfully use EHRs. According to CMS, meaningful use requirements are being rolled out in three stages; see https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html. Stage 1 began in 2011. It requires programs to demonstrate that their EHR systems are able to collect clinical data and electronically share health information with patients. Stage 2 began in 2014. It requires programs to demonstrate the ability to exchange data with other health care providers electronically. Stage 3 is scheduled to being in 2017. As currently proposed, it will require programs to report on the quality of care provided.

states reporting). In addition, 12 states reported an average "other" EHR implementation (such as device and equipment charges) cost of $328,867, with a median cost of $309,833. Note, a few states are installing EHRs in multiple state psychiatric hospitals and thus have very high costs that skew the average costs above the median costs. For example, New York's costs for EHR software for their multi-hospital system were $36 million.

Electronic Health Records in Community Mental Health Settings

A total of 17 of 34 states reported that all community mental health EHR systems meet the meaningful use requirements specified in the HITECH Act. These requirements are met by some community mental health EHR systems in 13 states and by no community mental health EHR systems in 4 states. In nine states, the SMHAs are not involved in the meaningful use certification process for community mental health providers and therefore are not aware of provider meaningful use certification plans. In Oklahoma, all of the state's CMHCs are behavioral health homes and therefore are required to have certified EHR systems within 18 months of opening.

Health Data Sharing, Privacy and Access

In 23 of the 44 reporting states, the SMHA has agreements in place allowing state hospitals within the state to share EHR data. In only 12 of the 44 reporting states, the SMHA has agreements in place to share EHR data between state hospitals and community providers. In 6 of the 44 reporting states, there are agreements in place to share data between managed care firms and the SMHA. In 11 of the 42 reporting states, there are agreements in place to share EHR data between community providers, and 10 states have agreements in place to share EHR data through a health information exchange (HIE). HIEs allow health professionals to share patient information (in accordance with legal and regulatory requirements) in a secure and efficient manner.[16]

Although HIPAA requires privacy protections for personal health information, over half (24 out of 45) of states reported that they have rules in place that provide more stringent privacy protections than those required under HIPAA.

One of the ways that states address concerns regarding the privacy of patient data is through individual authorizations. In 20 of the 45 states reporting, the SMHA has individual authorizations in place for sharing EHR data between providers or with the HIE. Of these states, 16 states have authorizations that follow the opt-in model, in which individuals agree to share their EHR data, whereas 7 states have authorizations that follow the opt-out model, in which EHR data are shared unless the individual elects to opt out. Nebraska reported that it uses both opt-in and opt-out authorization models. Hawaii does not use individual authorizations in its Adult Mental Health Division, but the Child/Adolescent Mental Health Division uses an opt-out model for information sharing between providers. Kentucky and Massachusetts require consent for sharing EHR data.

Clients have access to their EHR data via the SMHA in 6 of the 38 reporting states. Eighteen of these states have clients access their EHR data via the providers. In three states, clients have

[16] HealthIT.gov. (2014, June). Health Information Exchange (HIE). [Web page]. Retrieved from https://www.healthit.gov/HIE

access to their EHR data via the HIE. In four states, clients have access to EHR data via the SMHA as well as the providers. In one state, clients have access to EHR data via the SMHA and a HIE. In two states, clients have access to EHR data via the providers and an HIE. In Oregon, clients have access to EHR data via the SMHA, providers, and an HIE. Finally, 13 states reported the SMHA is not involved in client access to EHR information, but instead EHR access is handled directly by providers who maintain the EHR systems.

Personal Health Records

Personal health records (PHRs) are designed to help individual track their health care services, medications, and medical history. An individual also can elect to share these records with providers and others to facilitate communication.

In 6 of the 43 states reporting, the SMHA has implemented a PHR for individuals. In addition, one state is currently designing a PHR, and three are working with other providers to support a PHR. For example, Connecticut, Hawaii, Maryland, Nebraska, and Ohio use the Network of Care website[17] as the repository for patients' PHRs. In Missouri, the State Medicaid Agency operates and maintains a PHR repository, which is available for the SMHA client population on Medicaid in that state—which is approximately 80 percent of their SMHA population. SMHAs in 33 states are not currently working on or supporting the development of a PHR.

[17] Network of Care. (n.d.). [Website]. http://www.networkofcare.org/splash.aspx

Page intentionally left blank

Chapter 7: Major Policies of State Mental Health Agencies and Single State Agencies

7.1 Key Highlights

- SMHAs provide EBPs for children, adolescents, and adults, but states are not consistently monitoring for fidelity.
- SMHAs work with universities to implement and evaluate the implementation of EBPs.
- States fund the implementation of EBPs using state general funds, Medicaid, and funds from the MHBG.
- Most states have an involuntary treatment law, and most commonly can hold an individual for 72 hours.
- The majority of individuals being held involuntarily in FY 2014 were in psychiatric inpatient facilities other than state psychiatric inpatient facilities.
- Most SMHAs collaborate with other entities or stakeholder groups on initiatives to prevent risk factors for mental health problems.
- Most SMHAs promote health and recovery-oriented services for individuals in recovery from mental illness and co-occurring disorders.
- Mobile crisis teams, 24-hour hotlines, and crisis stabilization beds are the most common types of crisis intervention services that SMHAs provide.
- In the past 3 years, 80 percent of states have passed legislation addressing prescription drug abuse, heroin abuse, or both.
- When asked about the most important issue for their SSAs, 43 percent responded that it was the prevention, identification, and treatment of prescription drug abuse; 51 percent of SSAs considered this topic very important.
    - In the past year, 43 percent of states have seen an increase in reports of prescription drug overdose.
    - Ninety percent of states currently have a task force addressing prescription drug abuse.
- Thirty-five percent of SSAs consider services related to prevention, identification, and treatment of heroin abuse to be the most important issue; another 43 percent consider heroin abuse services to be very important.
    - In the past year, 76 percent of states have seen an increase in reports of heroin overdose.

- Forty-six percent of states have had a task force addressing heroin abuse in the past year.

- Eighty-three percent of states have taken steps to educate the general public on prescription drug abuse issues, and 52 percent have made efforts to educate the public on heroin abuse issues.
- In the past year, 26 percent of states have distributed naloxone kits, and 21 percent have made plans to distribute naloxone kits.
- Fifty-two percent of states have legislation requiring opioid prescribers to report to prescription drug monitoring programs (PDMPs).

7.2 Evidence-Based Practices

Evidence-Based Practices for Mental Health

SAMHSA supports the development and implementation of EBPs for behavioral health by identifying EBPs and publishing implementation toolkits and resource guides. SAMHSA's goal is to ensure that individuals receive services that provide proven, positive results. SMHAs have implemented or are planning to implement a variety of mental health EBPs. Table 13 shows the EBPs most commonly implemented.

Table 13. Number of State Mental Health Agencies Implementing or Planning to Implement Evidence-Based Practices, FY 2015

Evidence Based Practice	Implementing Statewide	Implementing in Parts of State	Piloting	Planning to Implement
Adults				
Assertive Community Treatment	21	21	0	0
Supported Employment	20	22	4	1
Family Psychoeducation	9	15	0	0
Integrated Dual Diagnosis Treatment (M/SUD)	16	12	1	2
Illness Self-Management and Recovery	10	18	1	0
Supportive Housing	22	18	0	0
Consumer-Operated Services	9	27	0	0
Children and Adolescents				
Multisystemic Therapy	5	14	0	2
Therapeutic Foster Care	12	9	1	0
Functional Family Therapy	3	12	0	4
Incredible Years	0	10	2	2
Parent-Child Interaction Therapy	3	14	1	2
Cognitive Behavior Therapy for Depression	3	8	0	1
Cognitive Behavior Therapy for Anxiety	4	6	0	1
Trauma-Focused Cognitive Behavior Therapy	10	17	0	2
Triple P (Level 4): Positive Parenting Program	1	6	3	1

Abbreviation: M/SUD, mental and substance use disorder.

Other adult-focused EBPs that SMHAs implemented include the following:

- Medication Algorithms for Schizophrenia

- Wellness Recovery Action Plan (WRAP)
- International Center for Clubhouse Development (ICCD) Certified Clubhouse Model

Other child and adolescent-oriented EBPs implemented include the following:

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Second Step
- Parent Management Training–Oregon
- Brief Strategic Family Therapy
- Problem Solving Skills Training, Interpersonal Therapy for Depression
- Modular Approach to Therapy for Children (MATCH)
- Managing and Adapting Practice, Prolonged Exposure Therapy for Adolescents
- Multidimensional Treatment Foster Care (MTFC)
- Wraparound Services
- Parenting with Love and Limits
- Nurturing Families
- Trauma Informed Child Parent Psychotherapy
- Motivational Interviewing
- Seeking Safety
- Dialectical Behavioral Therapy

Table 14 shows the number of programs and the number of individuals receiving the most commonly provided EBPs. The most widely used EBPs for adults were illness self-management, which is a broad set of methods that teach individuals to collaborate actively with mental health professionals on their treatment and recovery, and integrated dual diagnosis treatment for co-occurring M/SUD. The EBPs provided to the largest number of children and adolescents were functional family therapy, which is a phasic program to enhance protective factors and reduce risk, and Multisystemic Therapy, in which the goal is to facilitate change in an individual's natural environment to promote individual change.

Table 14. Number of Evidence-Based Practice Programs in States and Number of Individuals Receiving These Programs, FY 2015

Evidence Based Practice	Number of Programs	Number of SMHAs Reporting	Number of People Served	Number of SMHAs Reporting
Adults				
Assertive Community Treatment	839	37	61,445	38
Supported Employment	616	37	61,511	41
Family Psychoeducation	437	16	23,224	15
Integrated Dual Diagnosis Treatment (M/SUD)	354	25	205,694	24
Illness Self-Management and Recovery	293	18	242,609	19
Supportive Housing	821	27	81,422	36
Consumer-Operated Services	381	28	28,593	9
Children and Adolescents				

Evidence Based Practice	Number of Programs	Number of SMHAs Reporting	Number of People Served	Number of SMHAs Reporting
Multisystemic Therapy	143	14	17,988	16
Therapeutic Foster Care	419	15	8,859	24
Functional Family Therapy	66	10	20,996	13
Incredible Years	23	6	164	3
Parent-Child Interaction Therapy	197	12	629	4
Cognitive Behavior Therapy for Depression	72	6	1,624	3
Cognitive Behavior Therapy for Anxiety	76	6	1,624	13
Trauma-Focused Cognitive Behavior Therapy	280	15	11,670	7
Triple P (Level 4): Positive Parenting Program	38	6	3,496	3

Abbreviation: M/SUD, mental and substance use disorder; SMHAs, state mental health agencies.

Implementation of Evidence-Based Practices

SMHAs rated whether a variety of factors were barriers to the implementation of EBPs. Possible responses were never, rarely, occasionally, sometimes, frequently, regularly, or always. Forty-seven SMHAs rated the following as sometimes to always a barrier: provider readiness (96 percent), financing EBPs (96 percent), a shortage of an appropriately trained workforce (91 percent), and attaining or maintaining EBP model fidelity (83 percent). Resistance from providers and clinicians to EBP implementation was only occasionally or sometimes a barrier for 68 percent of the 47 SMHAs reporting. A mismatch of EBP models to the specific needs of communities was a barrier only occasionally or sometimes for 57 percent of the 47 SMHAs reporting.

Most SMHAs (37 of 47 reporting), work with academic or university partners to implement or evaluate EBPs or promising practices, and six states have partnered with the Dartmouth Psychiatric Research Center of the Dartmouth Medical School. The most commonly used mechanisms the 49 SMHAs used to promote the adoption of EBPs were the following:

- Awareness and training (n=35)
- Incorporating EBPs in contracts with providers (n=33)
- Consensus building among stakeholders (n=27)
- Monitoring of fidelity (n=29)
- Budget requests specific to EBPs (n=22)
- Modification of information systems and data reports (n=22)
- Financial incentives (n=12)

SMHAs use multiple funding sources to pay for the provision of EBP services, as seen in Table 15. State general funds and Medicaid are the most commonly used, followed by MHBG funds. Some EBP services cannot be covered under Medicaid's base section 1905(a) authority, but by adopting a variety of Medicaid options and waivers, states are able to use Medicaid to reimburse these EBP services. A lesser number of SMHAs use local government funding or a variety of other funds. Some states use just one of these sources, but many use multiple sources.

Table 15. Number of States Reporting Funding Sources of Evidence-Based Practices, FY 2015

Evidence Based Practice	State General Funds	Medicaid	Mental Health Block Grants	Local Funds	Other Funds
Adults					
Assertive Community Treatment	35	38	16	6	3
Supported Employment	34	20	19	4	12
Family Psychoeducation	17	14	9	4	4
Integrated Dual Diagnosis Treatment (M/SUD)	18	20	12	5	6
Illness Self-Management and Recovery	20	19	10	3	3
Supportive Housing	33	12	13	6	9
Consumer-Operated Services	28	9	17	7	5
Children and Adolescents					
Multisystemic Therapy	14	16	7	4	5
Therapeutic Foster Care	14	14	2	0	3
Functional Family Therapy	10	10	1	3	2
Incredible Years	4	4	2	6	2
Parent-Child Interaction Therapy	12	10	4	4	4
Cognitive Behavior Therapy for Depression	4	8	4	2	2
Cognitive Behavior Therapy for Anxiety	4	8	3	2	1
Trauma-Focused Cognitive Behavior Therapy	16	21	10	3	8
Triple P (Level 4): Positive Parenting Program	5	4	2	1	4

Abbreviation: M/SUD, mental or substance use disorder.

Most SMHAs (34 of 39 reporting) provide workforce training for child and adolescent EBPs, with 15 providing training to individuals served and 18 providing training for family members. Most SMHAs (35 of 44), provide workforce training for adult EBPs, with 26 providing training to individuals served and 10 providing training for family members. Few SMHAs (11 of 36), provide workforce training for older adult EBPs, with 2 providing training to individuals served.

The most commonly used mechanisms the 48 reporting SMHAs used to provide ongoing EBP training for providers were the following:

- Use of expert consultants (n=37)
- Internal staff providing training (n=37)
- Collaboration with universities (n=32)
- Provider-to-provider training (n=25)
- Establishing research and training institute(s) (n=11)
- Outside accreditation (n=7)

EBPs are programs with specified practices and procedures. Although it is sometimes important to adapt successful models to better fit the needs of specific communities and populations, in general the closer an evidence-based model is followed, the more successful the program may be in practice—a concept referred to as *fidelity*. States were best at monitoring the fidelity of their

ACT and Multisystemic Therapy programs. As Table 16 shows, states were better at implementing EBPs than at assessing or monitoring them.

Table 16. Number of States Assessing or Monitoring Fidelity of Evidence-Based Practices, FY 2015

Evidence Based Practice	Number of States
Adults	
Assertive Community Treatment	31 of 42
Supported Employment	27 of 47
Family Psychoeducation	8 of 24
Integrated Dual Diagnosis Treatment - Mental and Substance Use Disorder	10 of 31
Illness Self-Management and Recovery	6 of 29
Supportive Housing	13 of 40
Consumer-Operated Services	7 of 36
Children and Adolescents	
Multisystemic Therapy	14 of 21
Therapeutic Foster Care	5 of 22
Functional Family Therapy	8 of 19
Incredible Years	3 of 14
Parent-Child Interaction Therapy	7 of 20
Cognitive Behavior Therapy for Depression	1 of 12
Cognitive Behavior Therapy for Anxiety	1 of 11
Trauma-Focused Cognitive Behavior Therapy	9 of 29
Triple P (Level 4): Positive Parenting Program	4 of 11

7.3 Involuntary Mental Health Treatment

Mental health is the largest area of medicine in which state laws can authorize treatment without the patient's consent. States have public health safety laws that permit the involuntary assessment and treatment of individuals with a mental illness if they are at risk of harming themselves or others. Although these laws vary by state, the SMHA's usually have the responsibility for the assessment and involuntary treatment.

The provision of involuntary treatment typically requires review and approval by a court, but it also can involve short-term emergency inpatient stays, also called *holds*, for a psychiatric evaluation prior to a court hearing. Every state allows for *involuntary civil status commitments*, which is when a court considers individuals to be dangerous to themselves or others, and *forensic commitment*, which is the same as involuntary civil commitment except that the individuals also have been charged with a crime. Every state has psychiatric inpatient beds that are used to treat individuals with a mental illness—usually those who are experiencing a psychiatric crisis and therefore need a high-intensity level of treatment. Involuntary treatment traditionally is conducted in inpatient psychiatric facilities; however, most states (41 of 47 reporting) now have an outpatient civil commitment law mandating that these individuals receive treatment in their own community.

Involuntary Patient Treatment

Prior to a formal commitment hearing, state laws allow law enforcement or a physician to take individuals involuntarily to a psychiatric hospital for an evaluation of their mental health and to be treated, if necessary. State statues vary regarding how long an individual may be held involuntarily before a court hearing must be held to determine whether involuntary treatment should continue. The following are the maximum periods for which an individual can be held for observation or emergency evaluation under an involuntary hold status for issues related to mental illness:

- 72 hours in 25 states
- 48 hours in three states
- 24 hours in two states
- Other durations in 16 states, including the absence of any maximum duration

SMHA Access to Information About Involuntary Commitments

Most SMHAs (40 of 43 reporting) have access to information about involuntary commitments. State psychiatric hospitals are the best source of information about involuntary treatment, followed by other state-funded psychiatric inpatient facilities and private psychiatric facilities, as seen in Table 17.

Table 17. Number of State Mental Health Agencies Able to Access Information About Involuntary Treatment (N=43 States), FY 2015

Legal Status	State Psychiatric Hospitals	Other State Funded Psychiatric Inpatient	Private Psychiatric Inpatient Care
Involuntary holds and evaluation	35	15	9
Involuntary civil status (excluding sex offenders)	41	19	10
Involuntary forensic (criminal status)	41	13	5
Sex offender status	26	8	4
Other legal status	12	4	3

The majority of individuals with involuntary holds in FY 2014 were in psychiatric inpatient facilities other than state psychiatric inpatient facilities. Twenty-two SMHAs reported that there were 19,511 individuals with involuntary holds in state psychiatric inpatient facilities. Thirteen SMHAs reported that there were 208,073 individuals with involuntary holds in other psychiatric inpatient facilities.

In FY 2014, the majority of individuals with involuntary civil holds were in state psychiatric inpatient facilities. Thirty-seven SMHAs reported that there were 47,551 individuals with involuntary civil holds in state psychiatric inpatient facilities, and 17 SMHAs reported that there were 14,969 individuals with involuntary civil holds in other psychiatric inpatient facilities.

In FY 2014, nearly all individuals with involuntary criminal holds were in state psychiatric inpatient facilities. Thirty-six SMHAs reported that there were 17,024 individuals with involuntary criminal holds in state psychiatric inpatient facilities. Twelve SMHAs reported that there were 665 individuals with involuntary criminal holds in other psychiatric inpatient facilities.

In FY 2014, nearly all individuals with sex offender status were in state psychiatric inpatient facilities. Eighteen SMHAs reported that there were 1,931 individuals with sex offender status in state psychiatric inpatient facilities, and 8 SMHAs reported that there were 285 individuals with sex offender status in other psychiatric inpatient facilities.

Not all individuals with holds were included in the counts reported above. In some states particular categories of individuals are not included in state's counts. These categories can include the following:

- Individuals with holds when the SMHA was not party to the hold
- Sexually violent predators
- Developmentally delayed adults
- Children
- Individuals in detention centers or jails
- Other psychiatric inpatient settings with which the SMHA does not have a contract
- Voluntary patients and patients sent from state-supported living centers on 30-day consignments for psychiatric stabilization

Many states (26 of 43 SMHAs reporting) have restrictions on the use and reporting of involuntary treatment data, whereas 17 states have no restrictions. In states with restrictions, permissions vary. Some states permit reporting only if statutory, regulatory, or certification requirements mandate it, whereas others permit reporting only for gun purchases. In still others, patient consent forms must be signed for the release of information other than for treatment, payment, or operations, whereas some states permit only state police queries for individuals admitted to state psychiatric facilities with stays longer than 30 days. Finally, data regarding involuntary commitment are confidential in many states and may be reported only in the aggregate.

Delivery Settings for Forensic Clients and Sex Offenders

The 46 SMHAs that responded use a variety of delivery settings to treat forensic clients and sex offenders, with Alabama, Arizona, Hawaii, and Minnesota illustrative of the several different settings. The most common setting used was a state psychiatric hospital that treats forensic clients and sex offenders as well as other patients (n=36). Less common was the use of freestanding facilities that serve only forensic clients (n=6), only clients who are sex offenders (n=5), and only clients with forensic and sex offender status (n=3). In Kentucky, state psychiatric facilities do not treat sex offenders.

Forensic Bed Availability

On the first day of FY 2014, there were 14,624 forensic patients in 36 states, of whom 112 were juveniles. Of these forensic patients, 4,562 in 33 states were incompetent to stand trial, 3,806 in 35 states were not guilty by reason of insanity (NGRI), 3,375 in 30 states were in the hospital for a pretrial psychiatric evaluation, and 2,741 in 26 states had been committed under a sex offender commitment statute. The remainder were guilty by reason of insanity or were state prisoners or jail detainees transferred to mental health facilities.

Responsibility for Providing Mental Health Services in Correctional Settings

SMHAs and local mental health agencies—including city, county, and regional agencies—often are responsible for providing mental health services to adults and to children and adolescents in correctional settings. In some cases, these responsibilities overlap, perhaps because local mental health agencies often are the providers of services for the SMHAs. Among community correction populations—including individuals on probation, parole, and alternatives to incarceration—the provision of services to adults was the responsibility of local mental health agencies in 19 states and the SMHAs in 11 states. In local jails or detention centers, the provision of services to adults was the responsibility of local mental health agencies in 21 states reporting and none of the SMHAs. The provision of services to children and adolescents in local juvenile halls or detention centers was the responsibility of local mental health agencies in 13 states and the SMHAs in 4 states.

In prisons, the provision of services to adults was the responsibility of local mental health agencies in only eight states and the SMHAs in three. The provision of services to children or adolescents in prisons was the responsibility of local mental health agencies in nine states and the SMHAs in four states.

Sex Offenders

Some states (18 of 46 reporting), have a state law mandating the hospitalization or commitment of sex offenders, including sexually violent predators and sexually dangerous individuals. In FY 2014 in 12 of these states, 483 individuals were committed under the sex offender statute, and in 11 of the states, 153 individuals who were sex offenders were released from state hospitals.

Legal Status of Patients in State Psychiatric Hospitals

State psychiatric hospitals are part of the states' safety-net systems that provide intensive services to individuals deemed dangerous to themselves or others. There was great variability among states related to the legal status of individuals admitted to and residing in state psychiatric hospitals.

Voluntary admissions (including readmissions) to state psychiatric hospitals ranged from 0 percent to 95 percent among the 41 SMHAs reporting. Involuntary admissions (including readmissions) ranged from 1 percent to 98 percent among the 42 SMHAs reporting. Involuntary civil admissions (including readmissions) ranged from 0 percent to 100 percent with 41 SMHAs reporting. In one state, pretrial forensic evaluations and emergency involuntary holds constituted 91 percent of admissions (including readmissions).

Individuals voluntarily admitted to state psychiatric hospitals ranged from 0 percent to 82 percent of hospital residents among the 39 SMHAs reporting. Individuals involuntarily civilly committed to state psychiatric hospitals ranged from 1 percent to 90 percent of state psychiatric hospital residents among the 40 SMHAs reporting. Individuals involuntarily criminally committed to state psychiatric hospitals ranged from 0 percent to 100 percent of state psychiatric hospital residents among the 43 SMHAs reporting. Involuntary holds (e.g., civil, forensic) and conditional voluntary holds were 65 percent of state psychiatric hospital residents.

Outpatient Commitment

The mental health code in 41 states (out of 47 reporting) allows the use of outpatient civil commitment for mental illness. Of these 41 states, the SMHA is responsible for maintaining information about individuals with this status in 14 states; in 12 states, it is maintained at county or local provider levels, whereas in 10 states, other entities maintain this information—primarily the courts. Few SMHAs (5 of 36 reporting), received dedicated funding for services for individuals under outpatient commitment and, of these, 5 received a total of $6,125,000.

Many states were unable to report the number of new outpatient commitments or the number of individuals under an outpatient commitment during FY 2014. In 12 states, a total of 12,412 individuals with mental illness were added to outpatient commitment during FY 2014. A total of 16,902 individuals were under an outpatient commitment throughout FY 2014 in 13 states.

Not Guilty by Reason of Insanity and Guilty but Mentally Ill

Most states (39 of 45 reporting), had a NGRI statute or case law. In FY 2014, 1,057 individuals in 30 states had been found NGRI. In FY 2014, 1,139 patients with NGRI status in 29 states were released from state psychiatric hospitals, not counting conditional releases of individuals who were still in a hospital's census.

Few states (14 of 45 reporting) had a guilty but mentally ill (GBMI) statute or equivalent. In FY 2014, 180 individuals in seven reporting states had been found GBMI.

7.4 Other Major SMHA Policy Initiatives

Prevention Initiatives

Most SMHAs (37 of 47 reporting) collaborate with other systems or stakeholder groups on initiatives to prevent risk factors for mental health problems. Many SMHAs (30 of 47 reporting) offer family-based or parental support services as a preventive measure to support the healthy emotional development of children and adult individuals the SMHA serves. Many SMHAs (29 of 47 reporting) provide evidence-based interventions to prevent the onset of mental health problems, including working with and supporting families.

Preventing suicides is a common activity of SMHAs. Of the 47 SMHAs reporting, the following were the most common suicide prevention initiatives:

- Crisis hotlines (n=38)
- Training mental health professionals in evidence-based treatments to reduce suicidality (n=35)
- Continuity of care following discharge from emergency departments and inpatient psychiatric hospitalization (n=33)
- Post-suicide support for families (n=29)
- Reducing access to lethal means for suicide (n=19)

The following population groups were the most common targets of these suicide prevention initiatives:

- Adolescents (n=43)
- Adults (n=41)
- Children (n=39)
- Older adults (n=32)
- Veterans and military personnel (n=32)
- Lesbian, gay, bisexual and transgender (LGBT) individuals (n=28)

Recovery Support

Recovery from mental illness is part of a process of change whereby individuals with a mental illness improve their overall health and wellness and live their lives more independently with the goal of achieving more of their potential. Most of the 48 SMHAs reporting said that they promote health and recovery-oriented services for individuals in recovery from mental illness and co-occurring disorders by offering the following:

- Promoting recovery-oriented service systems (n=46)
- Engaging individuals in recovery and their families in self-directed care, shared decision-making, and person-centered treatment planning (n=46)
- Promoting health, wellness, and resilience (n=45)
- Promoting self-care and alternatives to traditional care (n=42)

As shown below, most SMHAs also ensure that permanent housing and supportive services are available for individuals in recovery from mental and substance use disorders by offering the following:

- Building leadership, promoting collaborations with other state agencies, and supporting the use of EBPs related to permanent supportive housing for individuals and families who are homeless or at risk of homelessness and have mental illness or SUDs (n=43)
- Improving access to mainstream benefits (benefits not specific to people with a mental illness), housing assistance, and supportive behavioral health services (n=41)
- Increasing the knowledge of the behavioral health field about homelessness among people with mental illness, SUDs, or both (n=38)

Crisis Intervention

Individuals with an SMI or SED sometime experience crises that may be brought about by their mental illness and may be triggered by lack of access to mental health services, poverty, homelessness, SUDs, underlying health problems, and other stress factors such as traumatic events or disruptions in personal relationships. Individuals in crisis may be a danger to themselves or others, have intense distress, and exhibit significant change in hygiene and behavior. The 48 reporting SMHAs provided the following types of crisis intervention services:

- Mobile crisis teams (n=35)
- 24-hour hotlines (n=35)
- Crisis stabilization beds (n=35)
- Crisis clinics (n=19)

- Psychiatric emergency rooms (n=16)

Most of these SMHAs (n=39) also work with law enforcement to train crisis intervention teams (CITs), with the Memphis CIT model the most popular among those used (n=12). Most (n=35) work with general hospital emergency departments to improve their mental health crisis services. In 28 states, individuals remain in emergency departments when they are ready to be discharged because there are no suitable placements, such as hospital or residential beds. Most states (n=43) are developing or supporting alternative forms of mental health services designed to reduce the need for hospitalizations.

Only 31 SMHAs reported funding for crisis services. These SMHAs reported more than $517 million of state general revenue funds, $238 million from Medicaid funds, and $57 million from some other funding source.

7.5 State Initiatives to Address the Opioid Epidemic

Overview

SSAs consider prescription drug and heroin abuse to be an important—if not "the most important"—issue that they currently face. States have conducted and continue to conduct multiple efforts to address this problem, including convening task forces, enacting legislation, and providing education to prescribers, pharmacists, individuals served, and the general public, among other strategies. To better understand the scope of the problem and how SSAs are addressing the issue, NASADAD conducted an inquiry with its members.

These findings are from a series of NASADAD membership inquiries done in 2012 (period covering March 2011 through March 2012), 2014 (period covering March 2013 through March 2014), and 2015 (period covering May 2014 through May 2015) undertaken at the direction of the NASADAD Board of Directors. The inquiry drew input from SSA managers and staff, as well SAMHSA and members of the CFRI contract team (for the 2015 edition).

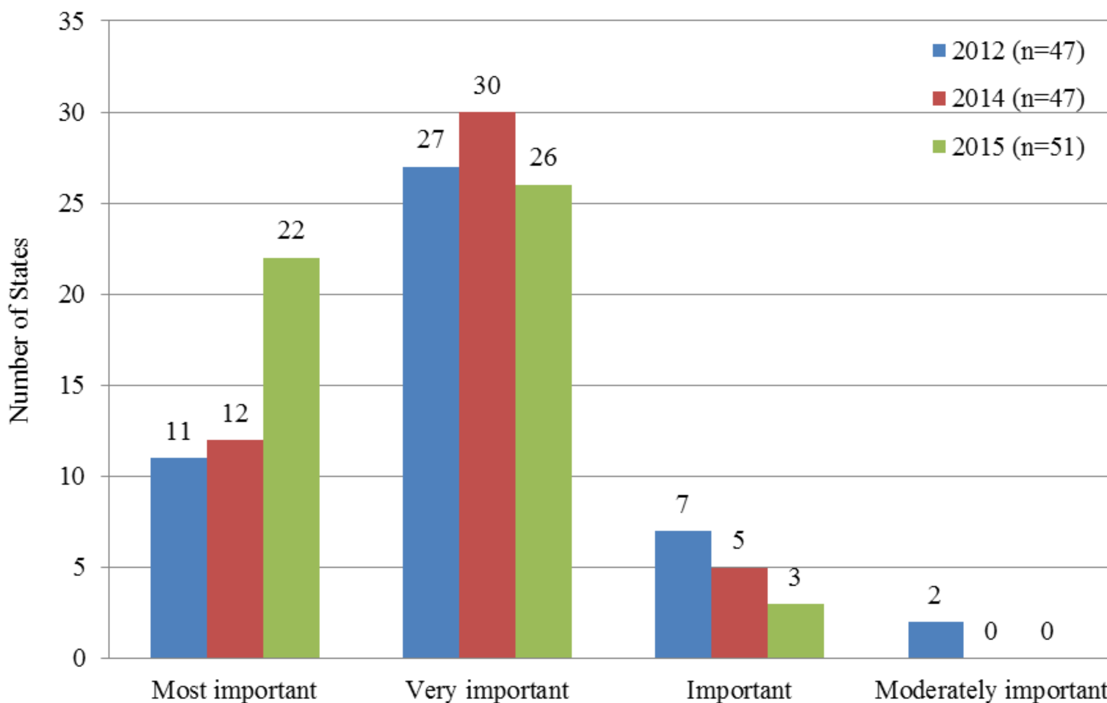
The inquiries examined state priorities, policies and initiatives directed at prescription medication misuse, and the linkage to heroin misuse. A web-enabled instrument was used to collect the responses from SSAs. States had the option of submitting a single unified response on behalf of the SSA or submitting multiple responses, from different staff perspectives. In total, 83 respondents completed the inquiry, representing 50 states, the District of Columbia, and 1 territory. Responses from 50 states and the District of Columbia, heretofore referred to as the *states*, were included in the analysis (N=51). A few states did not respond to some items, and the graphic and text indicate the number of states that provided the information. In addition to the SSA directors, treatment leads, prevention leads, and opioid leads, a handful of states designated other staff to complete the inquiry, including SSA deputy directors and a media liaison. When a state provided multiple responses, we reviewed the responses to ensure that there was consistency. There was a very high level of correspondence. In the few instances in which there were discrepancies across state respondents, the SSA director's response was used to represent the state. We summarized open-ended responses from all respondents within a state.

State Prioritization of the Current Opioid Problem

The Urgency of Prescription Drug and Heroin Abuse

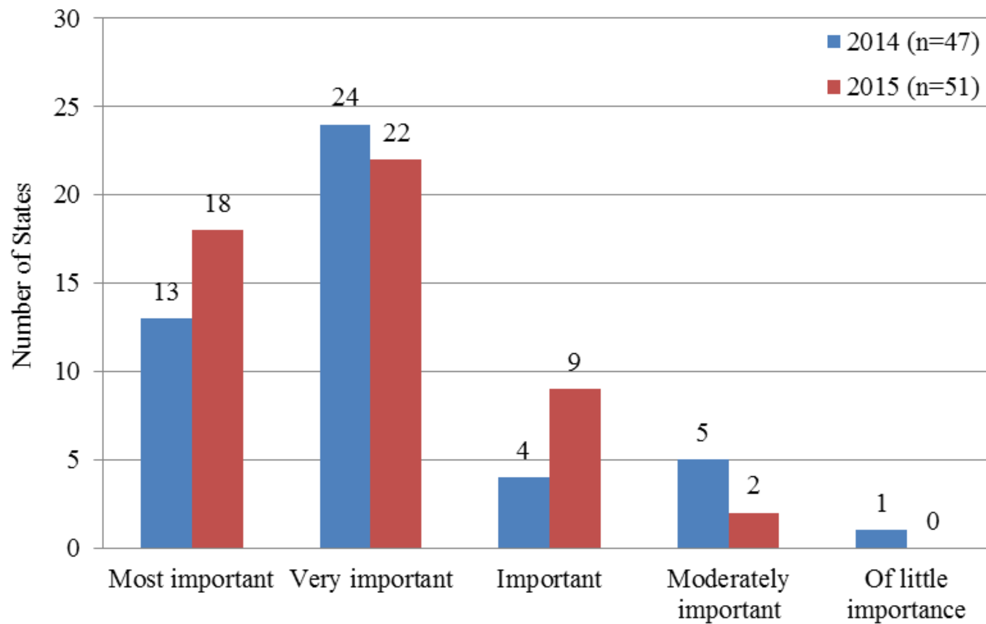
Although SSAs face many issues related to substance abuse from marijuana legalization to underage drinking, all states specified that prescription drug abuse was a high priority issue for their agency. In 2015, 43 percent of SSAs (n=22) indicated that prescription drug abuse was the most important issue for the agency, another 51 percent (n=26) indicated this was very important, and only 3 states indicated it was just important (Figure 19). No states labeled prescription drug abuse as being of moderate, little, or no importance. Compared with 2012 and 2014, approximately twice as many SSAs considered prescription drug abuse the most important issue to their agencies in 2015.

Figure 19. States' Ratings of the Importance of Prescription Drug Abuse to Single State Agencies, 2012–2015



Similarly, almost all states specified that heroin abuse was a high priority issue for their agency. In 2015, 35 percent of SSAs (n=18) said that heroin abuse was the most important issue for the agency, and another 43 percent (n=22) indicated that it was very important; 18 percent (n=9) indicated it was important, and 4 percent (n=2) indicated that it was moderately important (Figure 20). No states considered heroin abuse to be of little or no importance. Compared with 2014 when 13 states considered heroin abuse to be the most important issue, in 2015 18 states rated it as most important, and fewer states consider it to be of little or moderate importance (six percent to two percent).

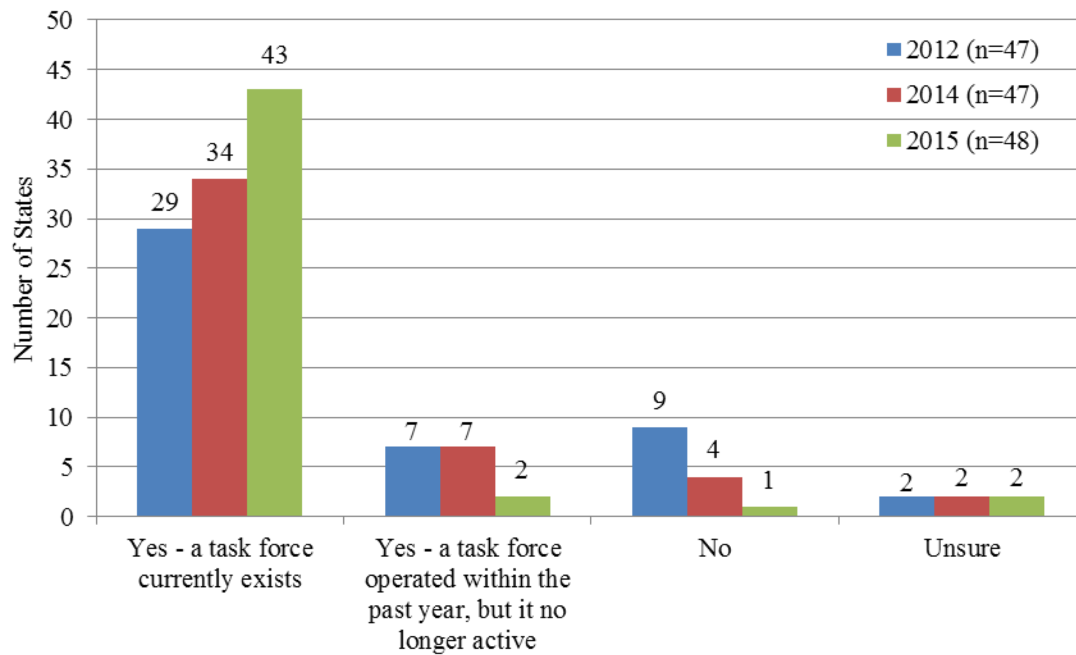
Figure 20. States' Ratings of Importance of Heroin Abuse to Single State Agencies, 2014–2015



State Task Forces

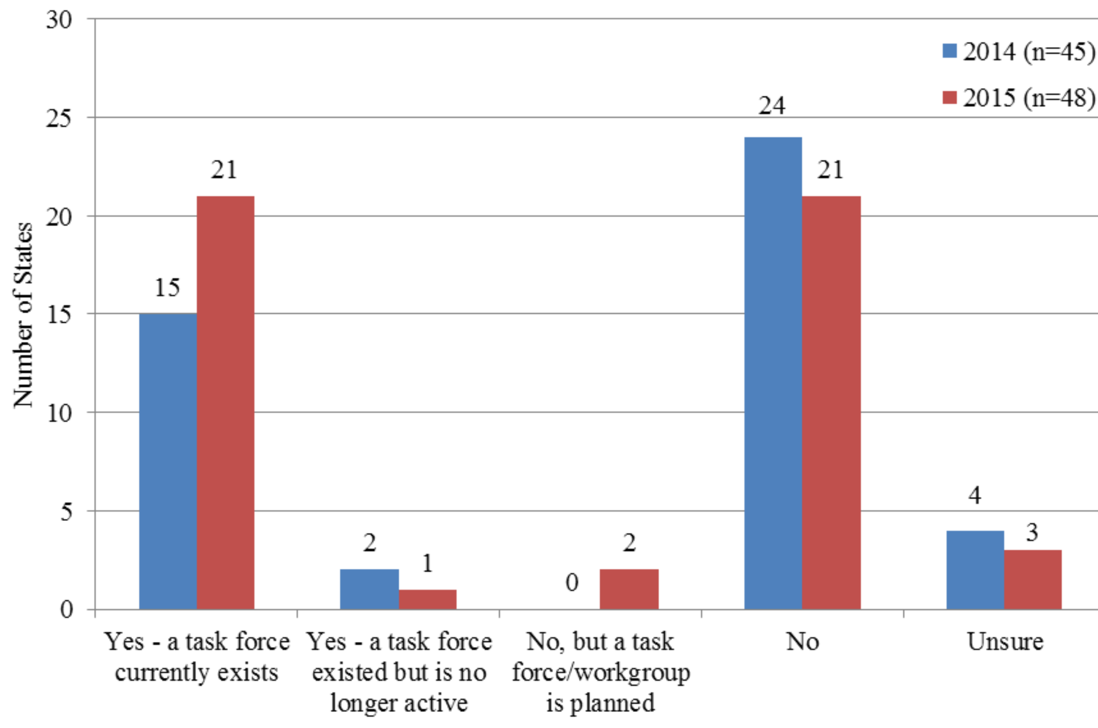
State Task Forces allow for stakeholders from different arenas to address an issue collaboratively and holistically. Ninety percent of respondents (n=43) reported that their state currently has a task force or workgroup to address prescription drug abuse (Figure 21). This was an increase from 2014, when 34 states indicated that they had an active prescription drug task force, and from 2012, when a slightly smaller number (n=29) reported that they had an active task force. Another two states noted that a task force existed over the past year but is no longer active. Of those states with an active task force in 2015, 47 percent of SSAs participate as members, 31 percent are coordinators, 4 percent are observers, and 6 percent indicated that they have a role such as co-chairperson.

Figure 21. States With Prescription Drug Abuse Task Force, 2012–2015



Heroin abuse task forces are not quite as common as prescription drug task forces, with only 44 percent of states (n=21) having a task force in existence (Figure 22). One state noted that a task force functioned over the past year but is no longer active. Forty-four percent (n=21) reported that no task force exists or had recently existed; 2 states indicated that a task force or workgroup is planned; and 3 states were unsure. Reflecting growing attention to the heroin abuse issue, an increasing number of states have active task forces to address heroin abuse in 2015 (44 percent) compared with 2014, when only 33 percent (n=15) indicated that they had such a group. However, despite the increase in heroin task forces, there are still twice as many task forces for prescription drug abuse than for heroin abuse.

Figure 22. States With Heroin Abuse Task Force, 2014–2015

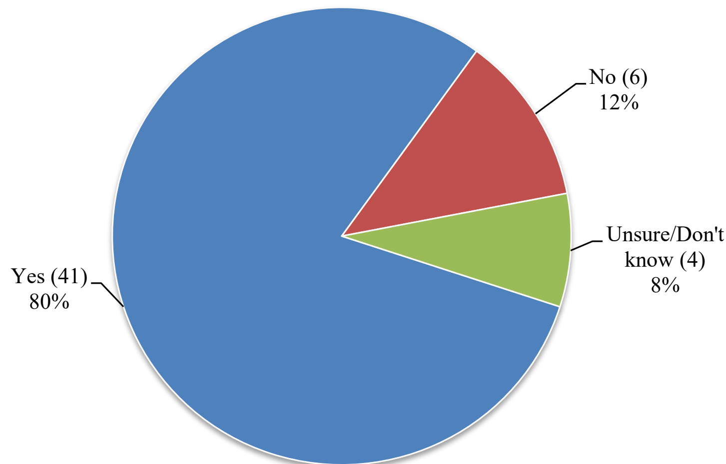


Passage of Prescription Drug and Heroin Abuse Legislation

Legislation related to opioids can vary in scope, addressing issues such as prescription monitoring, naloxone access, and 911 Good Samaritan laws.[18] The past several years have seen most states pass legislation of one type or another: 80 percent of respondents (n=41) indicated that their state has passed some type of legislation to address prescription drug abuse, heroin abuse, or both in the past 3 years, whereas 12 percent (n=6) have not (Figure 23). More detail about the nature of legislation is presented later in this section.

[18] Davis, C (2013). *Legal interventions to reduce overdose mortality: Naloxone access and overdose Good Samaritan laws*. The Network for Public Health Law. Retrieved from https://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf

Figure 23. Number of States That Enacted Prescription Drug or Heroin Abuse Legislation



Trends in State Data on Prescription Drugs and Heroin Abuse

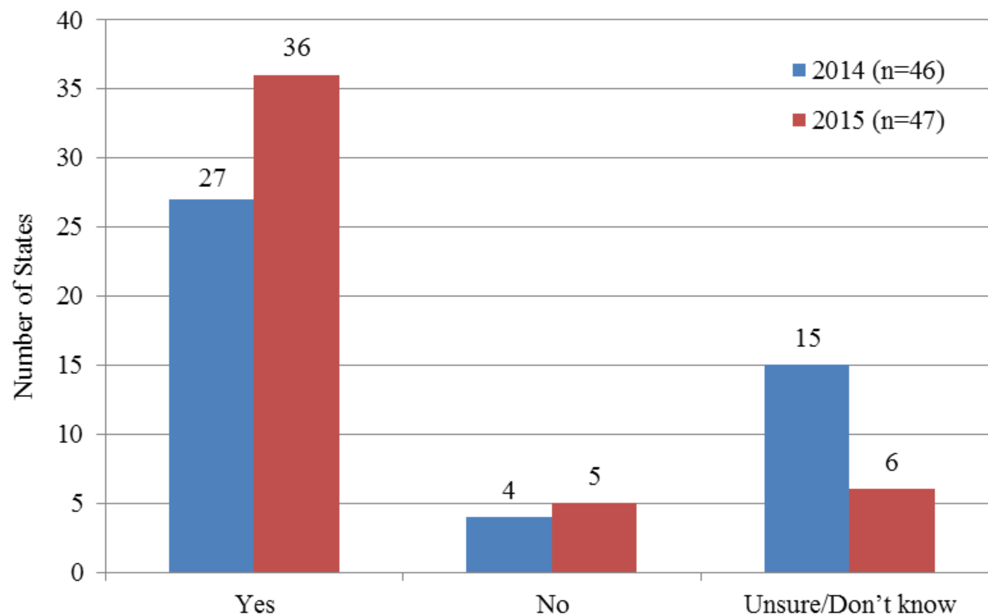
According to the CDC, individuals who abuse prescription opioid painkillers are 40 times more likely to be addicted to heroin.[19] In 2014, 59 percent of states (n=27) reported that patterns in their treatment admissions data in the past year show evidence that users are shifting from prescription drug abuse to heroin abuse (Figure 24). According to the National Institute on Drug Abuse, the shift from prescription drug abuse to heroin abuse can be attributed to the affordability and accessibility of heroin.[20] In 2015, 76 percent of SSAs (n=36) reported an increase in heroin overdoses over the past year, and 11 percent (n=5) reported no increase. This represents a higher proportion than in 2014.

---

[19] Centers for Disease Control and Prevention. (2015). Today's heroin epidemic. [Web page]. Retrieved from http://www.cdc.gov/vitalsigns/heroin/

[20] National Institute on Drug Abuse. (2014). *What is heroin and how is it used?* (NIH Publication Number 15-0165). Retrieved from http://www.drugabuse.gov/publications/research-reports/heroin/what-can-be-done-for-heroin-overdose

Figure 24. Number of States Reporting Increases in Heroin Overdose, 2014–2015



With regard to prescription drug overdose, over the past year, 43 percent of states (20 states) have seen an increase in reports of overdose.

Preventing Prescription Drug and Heroin Abuse

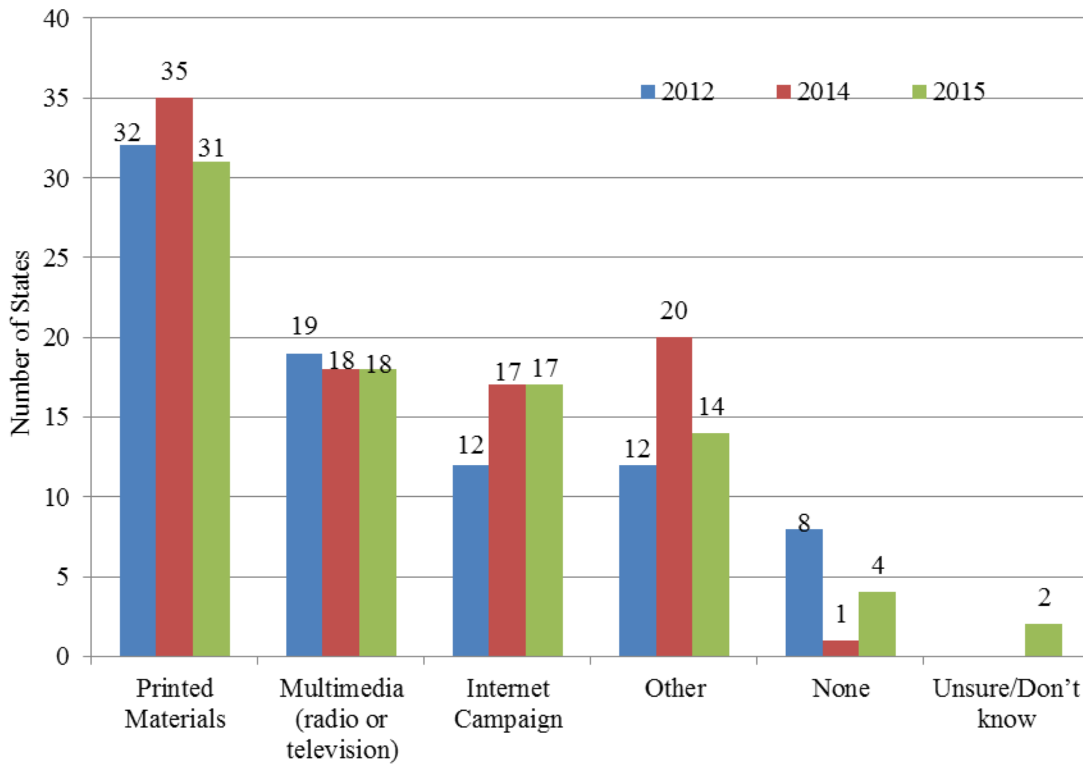
Educating the General Public

Education about the risks of opioids can be effective in preventing prescription drug and heroin abuse. Research has shown that individuals who perceive drugs to constitute great risks are much less likely to abuse them.[21]

Eighty-eight percent of states have recently taken specific steps to better educate the general public about the risks of prescription drug abuse. In 2015, 65 percent of the 47 respondents (n=31) indicated the use of printed materials as a method of education, 38 percent (n=18) used radio or television, 35 percent (n=17) used Internet campaigns, and 29 percent (n=14) used other means of educating the general public (e.g., speakers at health fairs, civic groups, schools, and billboards) (Figure 25). Eight percent (n=4) did not take steps to educate the public, and four percent (n=2) were unsure. Compared with 2012 and 2014, states took fewer or the same number of steps to educate the general public on prescription drug abuse in 2015.

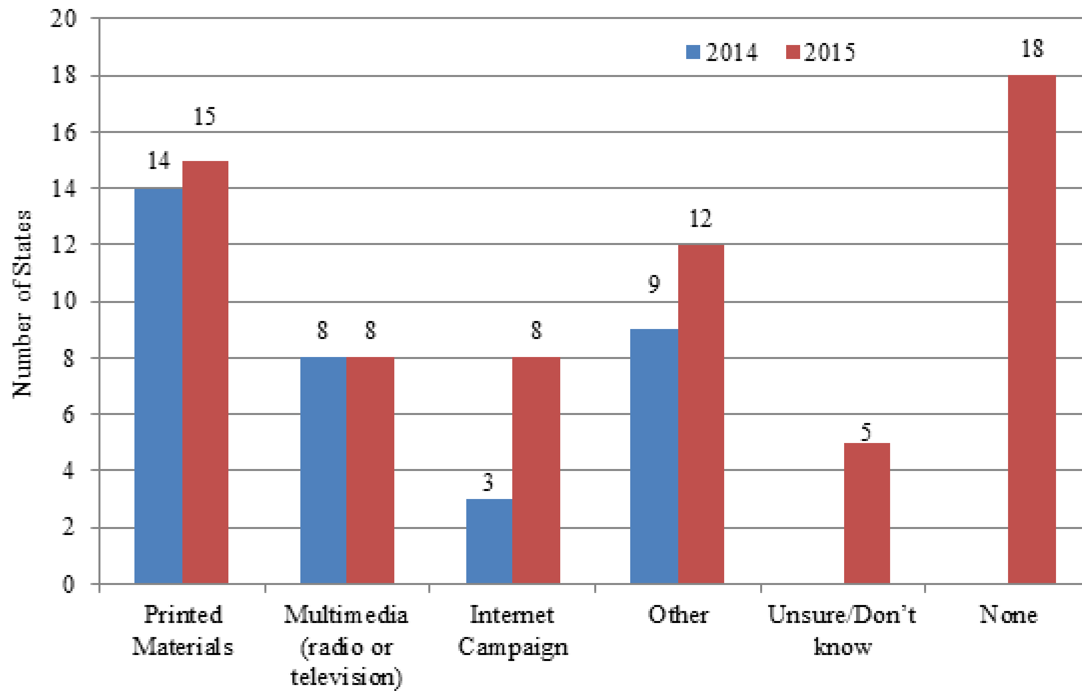
[21] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2013). *The NSDUH report: Trends in adolescent substance use and perception of risk from substance use.* Rockville, MD: Author.

Figure 25. Educational Campaigns and Strategies for the General Public, 2012–2015



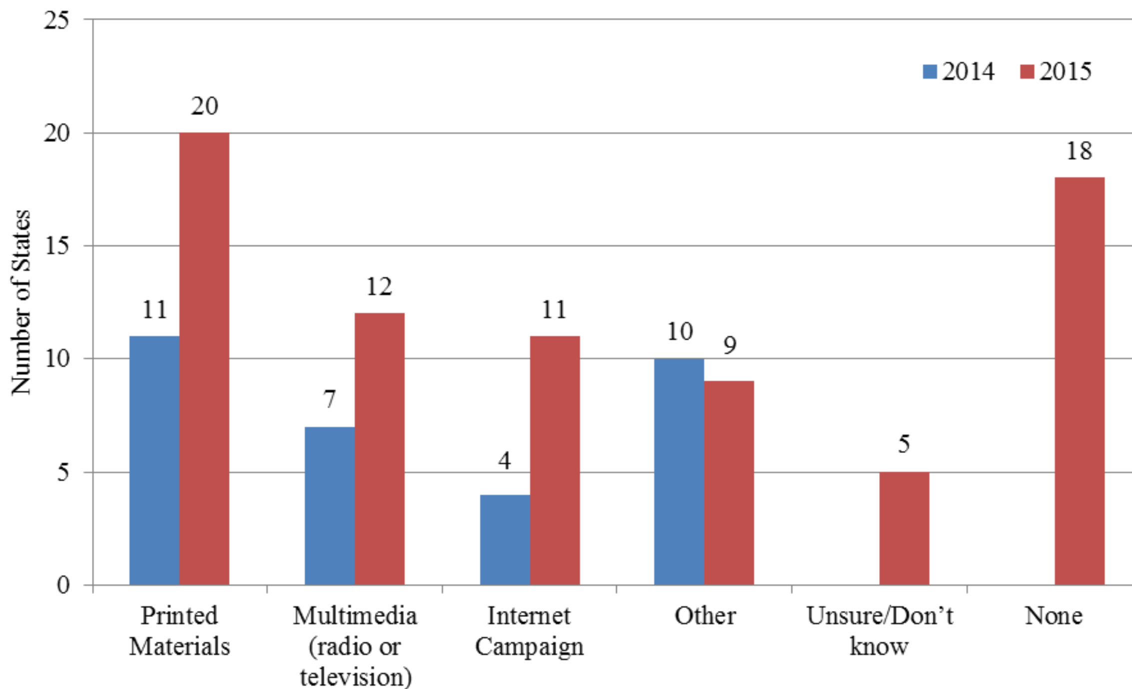
Fewer states—52 percent of the 48 respondents (n=25)—have taken steps to educate the general public about the shift from prescription drug abuse to heroin abuse. Thirty-one percent of respondents (n=15) used printed materials, 17 percent (n=8) used radio or television, another 17 percent (n=8) used Internet campaigns, and 25 percent (n=12) of respondents used other means of educating the general public (Figure 26). Thirty-eight percent (n=18) did not take steps to educate the public, and 10 percent (n=5) were unsure. Unlike the recent trend of decreased education provided on prescription drug abuse, more states have taken steps to educate the public on the shift to heroin abuse in 2015 than in 2014.

Figure 26. Educational Campaigns About Shift From Prescription Drug Abuse to Heroin, 2014–2015



Twenty-five states—52 percent of the 48 respondents—indicated that they have taken distinct steps in the past year to educate the public about heroin abuse. Forty-two percent of respondents (n=20) used printed materials to educate the public, 25 percent (n=12) used radio or television, 23 percent (n=11) used Internet campaigns, and 19 percent (n=9) of respondents used other means of educating the general public (Figure 27). Thirty-eight percent (n=18) did not take steps to educate the public, and 10 percent (n=5) were unsure. Compared with 2014, states took more steps to provide education on heroin abuse with printed materials, multimedia, and Internet campaigns.

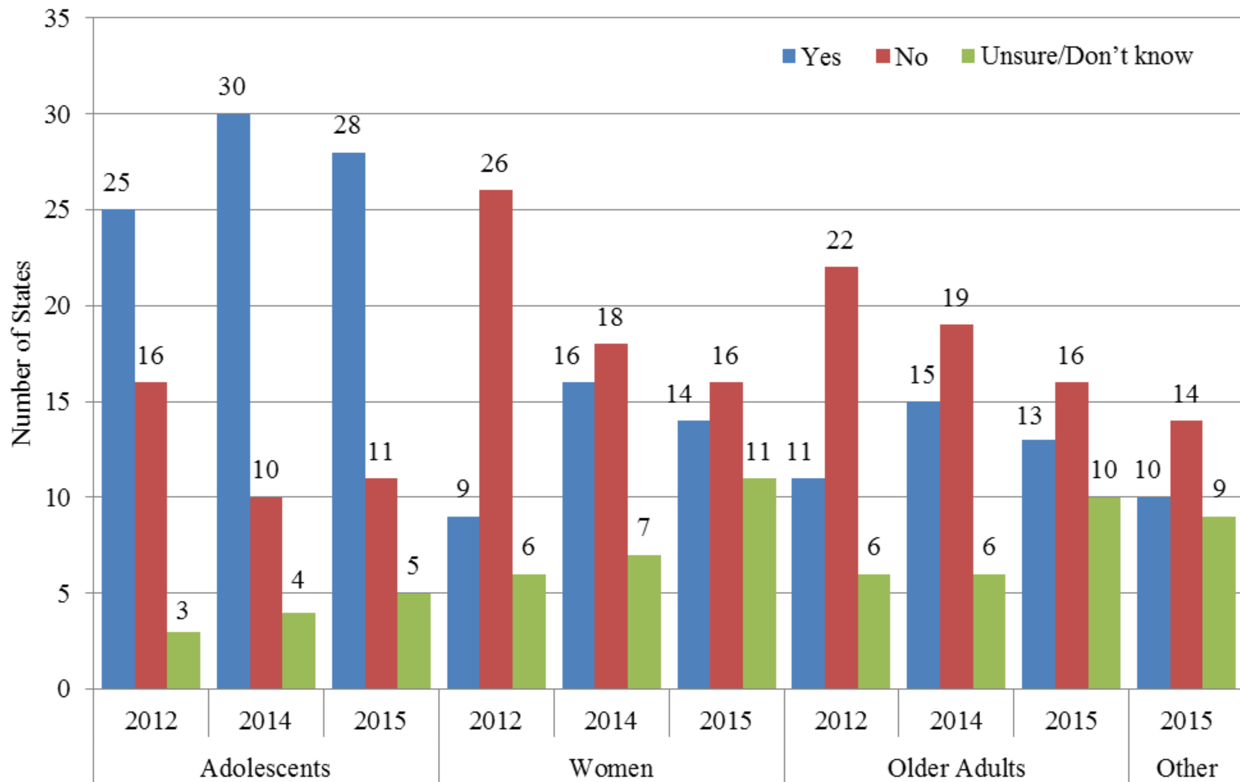
Figure 27. Educational Campaigns About Heroin Abuse, 2014–2015



Prevention for High-Risk Populations

Special populations such as women, adolescents, and older adults have unique needs with respect to the prevention and treatment of opioid use disorders. Many states sponsor programs or initiatives to prevent prescription drug abuse in these specific populations. In 2015, 33 percent of SSAs (n=13 out of 39 responding) indicated that they have programs targeting older adults, 34 percent (n=14 out of 41 responding) have programs for women, and 64 percent (n=28 out of 44 responding) target youths (Figure 28). Only10 states reported initiatives targeting other specific populations, such as Native Americans or pregnant women. The number of states targeting their prevention initiatives at each of these special populations is higher than in 2012 but slightly lower than in 2014.

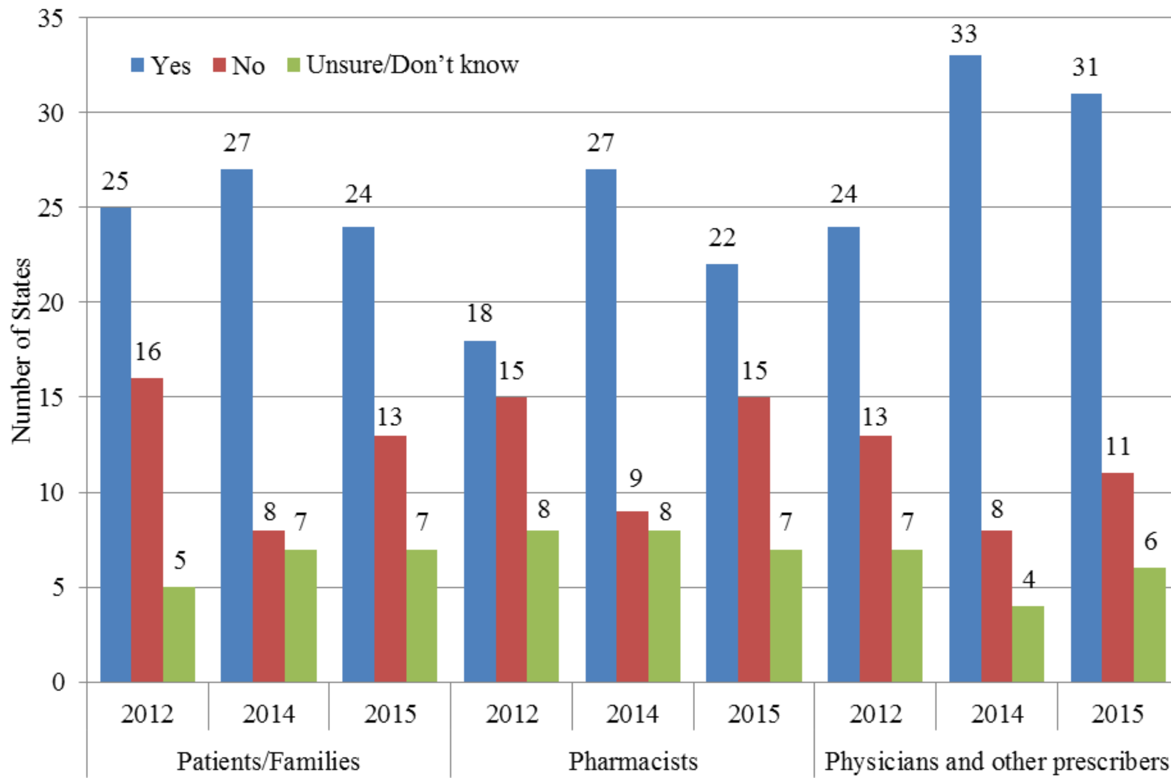
Figure 28. States With Prescription Drug Abuse Prevention Initiatives for Special Populations, 2012–2015



Education for Prescribers, Pharmacists, and Patients and Families

Educational initiatives play an important role in the prevention of drug abuse for individuals, the promotion of responsible prescribing among physicians, and the identification of "doctor shopping" by pharmacists. Overall, 71 percent of SSAs (n=34) reported undertaking educational activities related to prescribing and prescription drugs for specific groups. Specifically, 65 percent (n=31 out of 48 responding) began educating physicians and other prescribers, 50 percent (n=22 out of 44 responding) started implementing educational activities for pharmacists, and 55 percent (n=24 out of 44 responding) focused on education of patients and families (Figure 29). The number of educational activities for specific groups has increased since 2012, but it is slightly lower than in 2014 for each population group.

Figure 29. States With Education for Prescribers, Pharmacists, and Patients and Families, 2012–2015

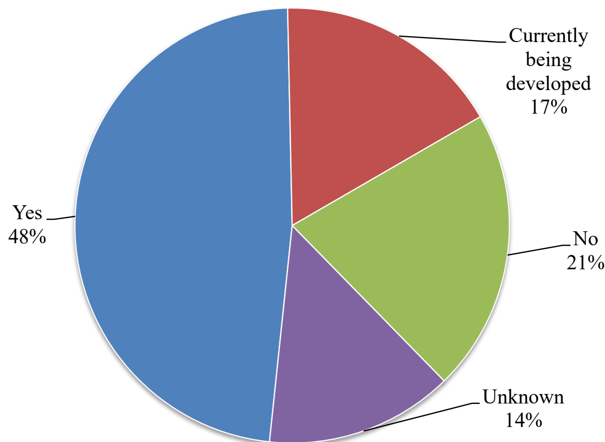


Medication Prescribing Guidelines

According to the CDC, prescribing guidelines for providers ensure that patients have access to safe, effective treatment while reducing the number of people who abuse prescription drugs.[22] Forty-eight percent of state agencies or professional agencies (n=23 out of 48 responding) have issued opioid prescribing guidelines for providers, and 17 percent (n=8) indicated that they are currently developing prescribing guidelines (Figure 30). Twenty-one percent of states (n=10) did not have such guidelines, and 14 percent (n=7) did now know. The agencies that have issued guidance include states' Department of Health (nine states), Medical Board (seven states), and Department of Behavioral Health (two states).

[22] Centers for Disease Control and Prevention (2015). Injury prevention & control: Prescription drug overdose. [Web page]. Retrieved from http://www.cdc.gov/drugoverdose/prescribing/common-elements.html

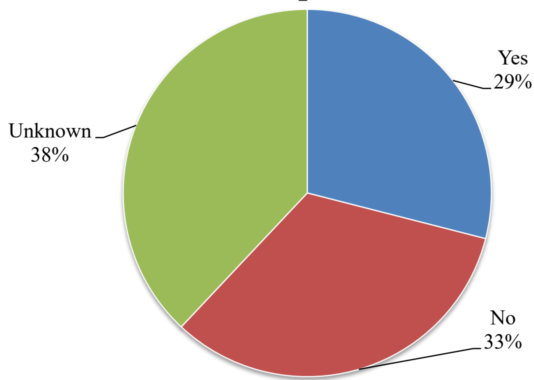
Figure 30. States Issuing Prescribing Guidelines for Providers



The aspects of prescribing addressed in the 23 states issuing guidelines include dosing (74 percent, n=17); screening (65 percent, n=15); information about patient education resources (61 percent, n=14); urine drug testing to ensure medication compliance (57 percent, n=13); doctor-patient agreements for opioid use (57 percent, n=13); and emergency department coordination with primary care (44 percent, n=10).

Another approach to curbing the overprescribing of opioids is requiring pain clinics to register with the state.[23] Twenty-nine percent of states (n=14) have enacted such laws, whereas 33 percent (n=16) have not, and 38 percent (n=18) of respondents did not know (Figure 31).

Figure 31. States With a Requirement for Pain Clinics to Register With State



Addressing the Discrimination Associated With Drug Abuse

Initiatives to Address Discrimination

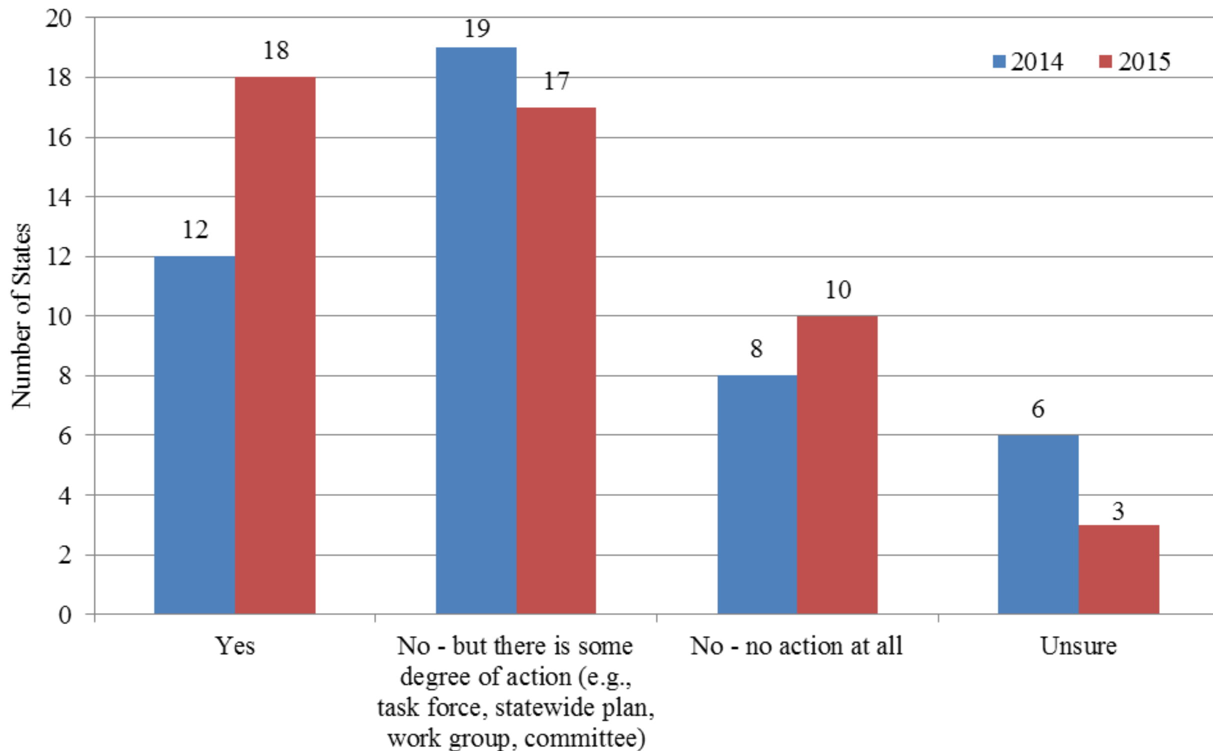
Individuals who receive MAT for their prescription drug or heroin abuse problem often face discrimination, because MAT can be viewed as merely replacing one drug addiction for

---

[23] Centers for Disease Control and Prevention. (2012). *Menu of pain management clinic regulation*. Retrieved from http://www.cdc.gov/phlp/docs/menu-pmcr.pdf

another.[24] In 2015, 38 percent of 47 states (n=18 out of 48 responding) have initiatives addressing discrimination associated with receiving treatment for opioid use disorders (Figure 32). Thirty-five percent (n=17 out of 48 responding) reported that their state does not have such initiatives but there is some degree of action (e.g., task force, statewide plan, work group, committee), whereas 21 percent (n=10) reported no action at all. Six percent of respondents (n=3) were unsure. Compared with 2014, there was a distinct increase in stigma reduction initiatives in 2015.

Figure 32. States With Initiatives to Address Discrimination, 2014–2015

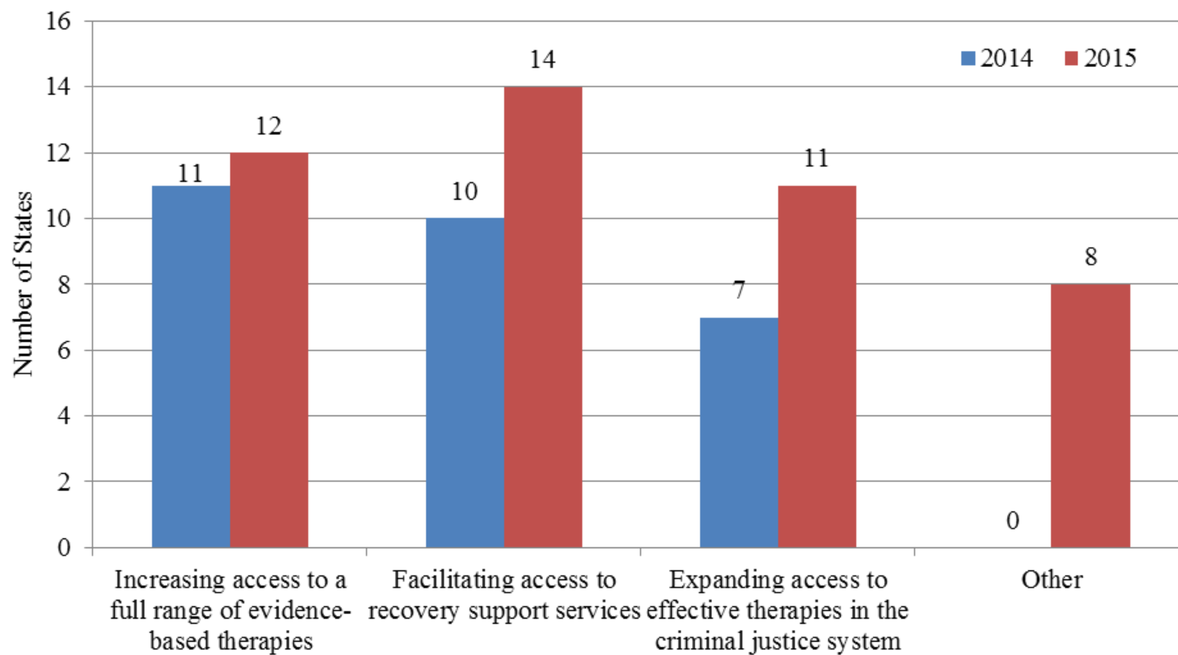


Types of Initiatives to Address Discrimination

The types of initiatives that address discrimination associated with receiving MAT vary. In 2015, 78 percent of the 18 states with initiatives (n=14) indicated efforts to facilitate access to recovery support services, which was higher than in 2014 when 10 states reported such initiatives (Figure 33). Sixty-seven percent (n=12) of 18 states reporting initiatives increased access to a full range of evidence-based therapies, and 61 percent (n=11) expanded access to effective therapies in the criminal justice system in 2015, compared with 7 states in 2014. Forty-four percent (n=8) reported other types of initiatives such as training providers or changing the language used in discussing opioid abuse in order to reduce discrimination.

[24] Substance Abuse and Mental Health Services Administration. (2009). *Medication-assisted treatment for opioid addiction* (HHS Publication Number (SMA) 09-4443). Retrieved from https://store.samhsa.gov/shin/content/SMA09-4443/SMA09-4443.pdf

Figure 33. Types of Initiatives to Address Discrimination, 2014–2015



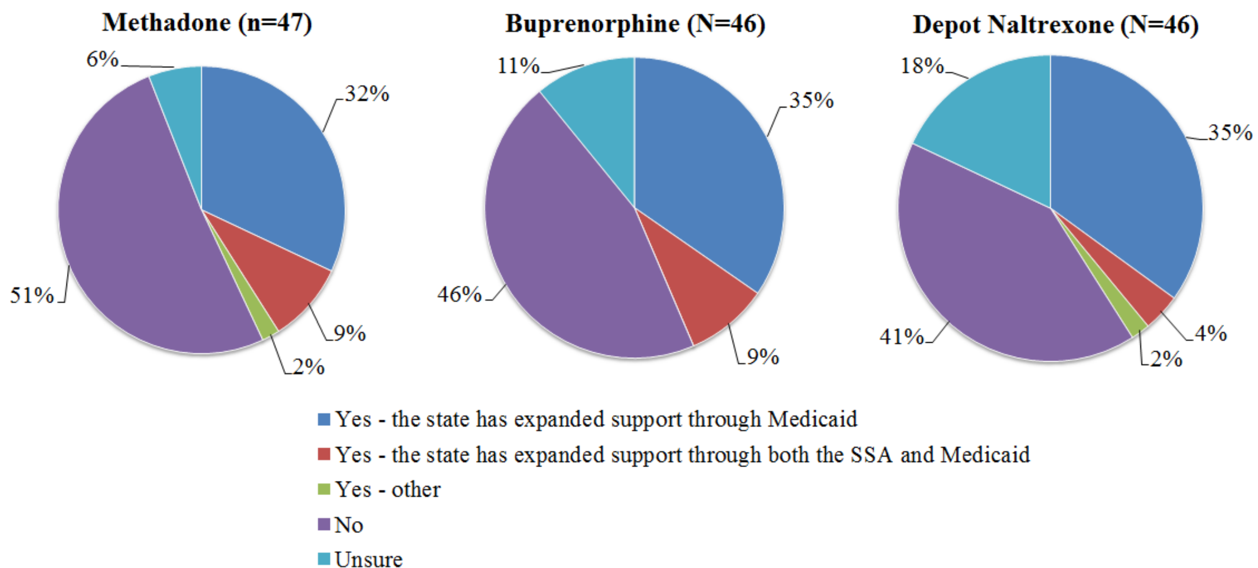
Medication-Assisted Treatment and Naloxone

Expanded Financial Access for Medication-Assisted Treatment

The use of medication (e.g., methadone, buprenorphine, and depot naltrexone) in the treatment of opioid use disorders can be an important recovery tool for some individuals.[25] However, only 32 percent of SSAs (n=15) indicated that their state has expanded financial support for the use of methadone in the treatment of opioid or heroin dependence through Medicaid (Figure 34). Similarly, only 35 percent (n=16) have expanded support for buprenorphine and depot naltrexone through Medicaid. Nine percent (n=4) have expanded support of methadone and buprenorphine through both the SSA and Medicaid, and four percent (n=2) expanded support of depot naltrexone through both the SSA and Medicaid.

[25] National Institute on Drug Abuse (2012). Principles of drug addiction treatment: A research-based guide (3rd ed., NIH Publication Number 12–4180). Retrieved from https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/acknowledgments.

Figure 34. Proportion of States With Expanded Financial Support for Medication-Assisted Treatment



Note: Percentages may not total 100 percent because of rounding.

Naloxone: Expanded Financial Support, Distribution, Training, and Legislation

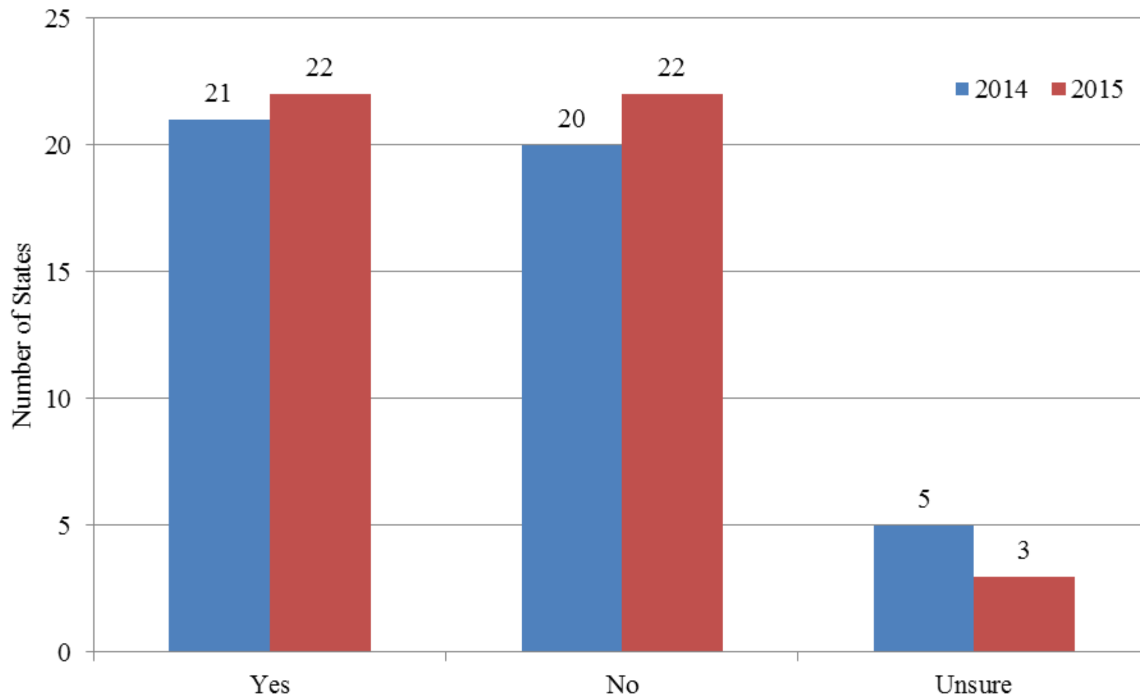
Naloxone reverses opioid overdose and reduces fatalities.[26] Twenty-six percent of states (n=12 of 46 responding) expanded financial support for the use of naloxone in the reversal of opioid or heroin overdose through the SSA; 24 percent (n=11) went through the Department of Health; 22 percent (n=10) went through the Medicaid agency; 9 percent (n=4) went through law enforcement; 7 percent (n=3) went through another state agency; 13 percent (n=6) went through some other entity, such as a private opioid treatment programs (OTP) or the Department of Public Safety; and 13 percent (n=6) were unsure. Thirty-seven percent of states (n=16 of 43 responding) indicated that no entities within their state had expanded financial support for the use of naloxone.

In addition to providing financial support, some state agencies (47 percent; n=22 of the 47 responding states) have distributed or have made plans to distribute naloxone overdose reversal kits to clients or families (Figure 35). Forty-seven percent of SSAs (n=22) indicated that they have not distributed kits. These results are comparable to those of 2014.

---

[26] Substance Abuse and Mental Health Services Administration. (2013). SAMHSA Opioid Overdose Prevention Toolkit (HHS Publication No. (SMA) 13-4742). Retrieved from https://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf

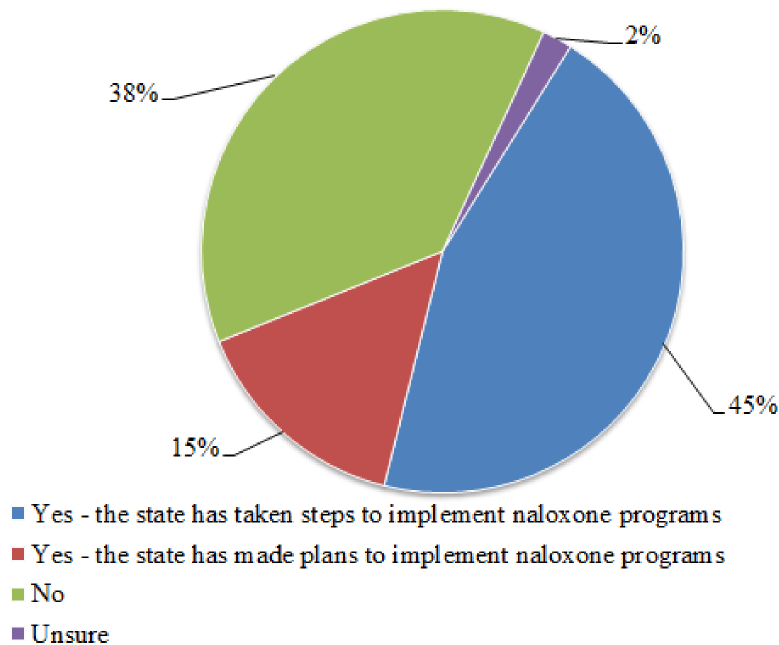
Figure 35. Distribution of Naloxone Overdose Reversal Kits to Clients and Families, 2014–2015



Various barriers exist for states' distribution of naloxone kits. The most common barrier is the cost to the state (72 percent, n=33 out of 46 responding), followed by public resistance or discrimination (33 percent, n=15). Twenty-two percent (n=10) responded that lay administration liability concerns were a barrier; 20 percent (n=9) named third-party prescription prohibition and 17 percent (n=8) indicated prescriber liability concerns as barriers. Twenty percent (n=9) listed other barriers, such as not having naloxone access laws in place.

A majority of states have worked to increase access to naloxone in 2015, 45 percent of the 47 reporting SSAs (n=21 out of 47 responding) have taken steps to implement naloxone training and access programs in the past year, and 15 percent (n=7) have made plans to implement naloxone programs (Figure 36). States that have started to implement naloxone training and access programs fund these programs through a combination of the SABG (38 percent, n=11), general state funds (31 percent, n=9), other federal grants (10 percent, n=3), and other funding sources (21 percent, n=6) such as special state funds or local funds.

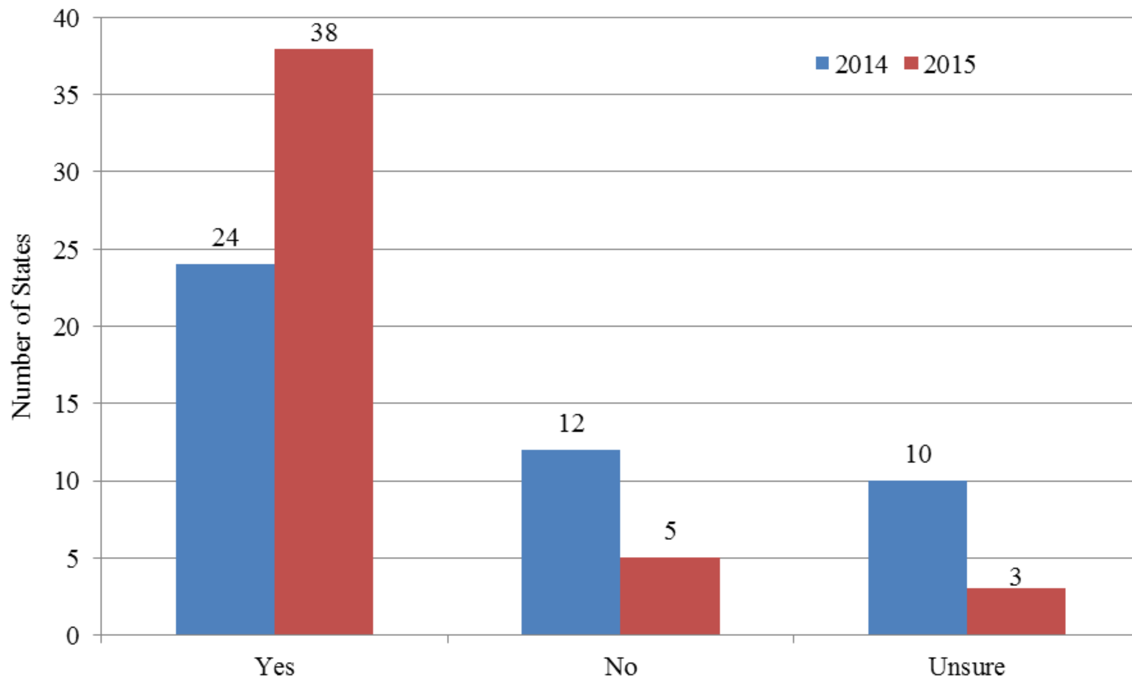
Figure 36. Stages of Implementation of Naloxone Training and Access Programs in States, 2015



Legislation governing naloxone administration can affect issues such as who can receive a prescription for naloxone or whether overdose witnesses receive criminal immunity if they seek medical assistance.[27] A large majority of responding states have statutes governing naloxone administration (83 percent, or 38 out of 46 responding), whereas only 5 states (or 11 percent) do not have any (Figure 37). This reflects a significant level of legislation in the past year, as sixty-one percent of states (n=28 of 46 responding) have changed laws or regulations that govern naloxone administration, 22 percent (n=10) are planning to change laws or regulations, and 11 percent (n=5) have not changed or made plans to change laws or regulations. Eight states that have changed or are planning to change laws characterized them as Good Samaritan Laws. Others described their state laws as addressing first responder access and administration, third-party prescribing, and liability protection for providers. The number of states that have changed or are planning to change laws is higher than in 2014.

[27] Davis, C. (2013). Legal interventions to reduce overdose mortality: Naloxone access and overdose Good Samaritan laws. The Network for Public Health Law. Retrieved from http://atforum.com/2013/05/legal-interventions-to-reduce-overdose-mortality-naloxone-access-and-overdose-good-samaritan-laws/

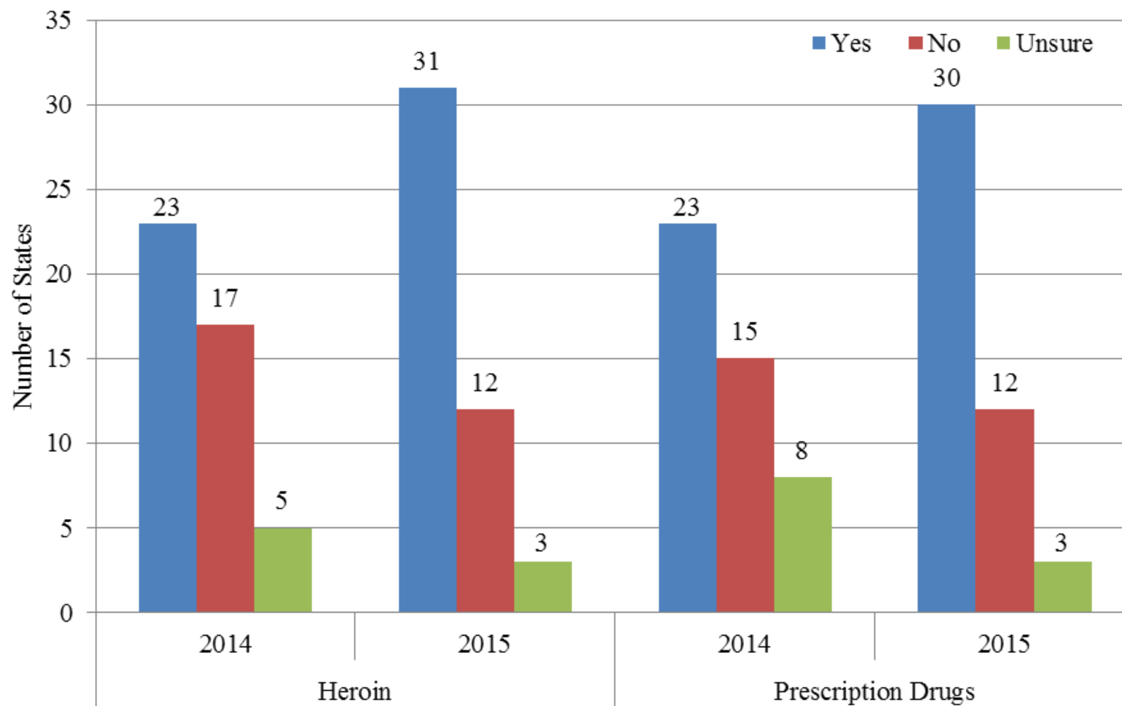
Figure 37. States With Laws or Regulations Governing Naloxone Administration, 2014–2015



Treatment Outcomes and Data Reporting

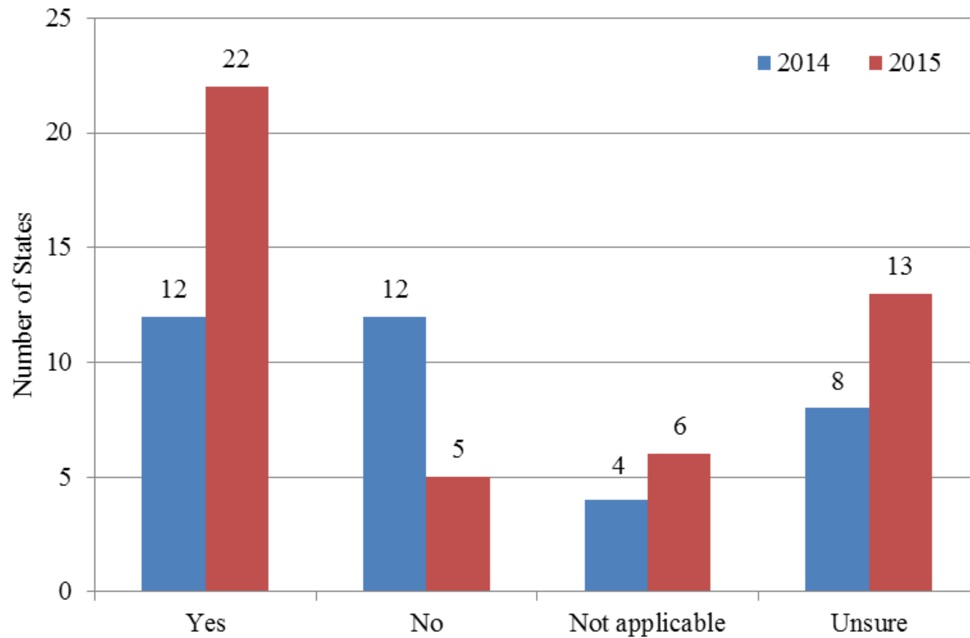
TEDS outcome data, such as abstinence and stable housing for individuals who have been through treatment for heroin and prescription drug abuse, can help assess the success of current treatment services in the states. In 2015, 67 percent of states (n=30 of 45 responding) have assessed data on the outcomes of patients treated for prescription drug abuse, 27 percent (n=12) have not, and 6 percent (n=3) were unsure (Figure 38). Similarly, 67 percent of states (n=31 of 46 responding) have assessed data on the outcomes of patients treated for heroin abuse, 26 percent (n=12) have not, and 7 percent (n=3) were unsure. For both heroin and prescription drug abuse, more states assessed data on patient outcomes in 2015 compared with 2014.

Figure 38. Number of States Collecting Data on Patient Outcomes of Patients, 2014–2015



Similar to outcomes data of those who have received treatment, data also can be collected to assess the effectiveness of prevention programs. In 2015, 48 percent of SSAs (n=22 of 46 responding) have an evaluation component to assess outcomes of their prescription drug abuse prevention programs or education initiatives that the state agency either administers or funds; 11 percent (n=5) do not; 28 percent (n=13) were unsure; and 13 percent (n=6) indicated that the question was not applicable (Figure 39). Although a similar number of states have initiatives with an evaluation component in 2015 compared with 2014, more respondents indicated that they were unsure and fewer responded with *no* in 2015.

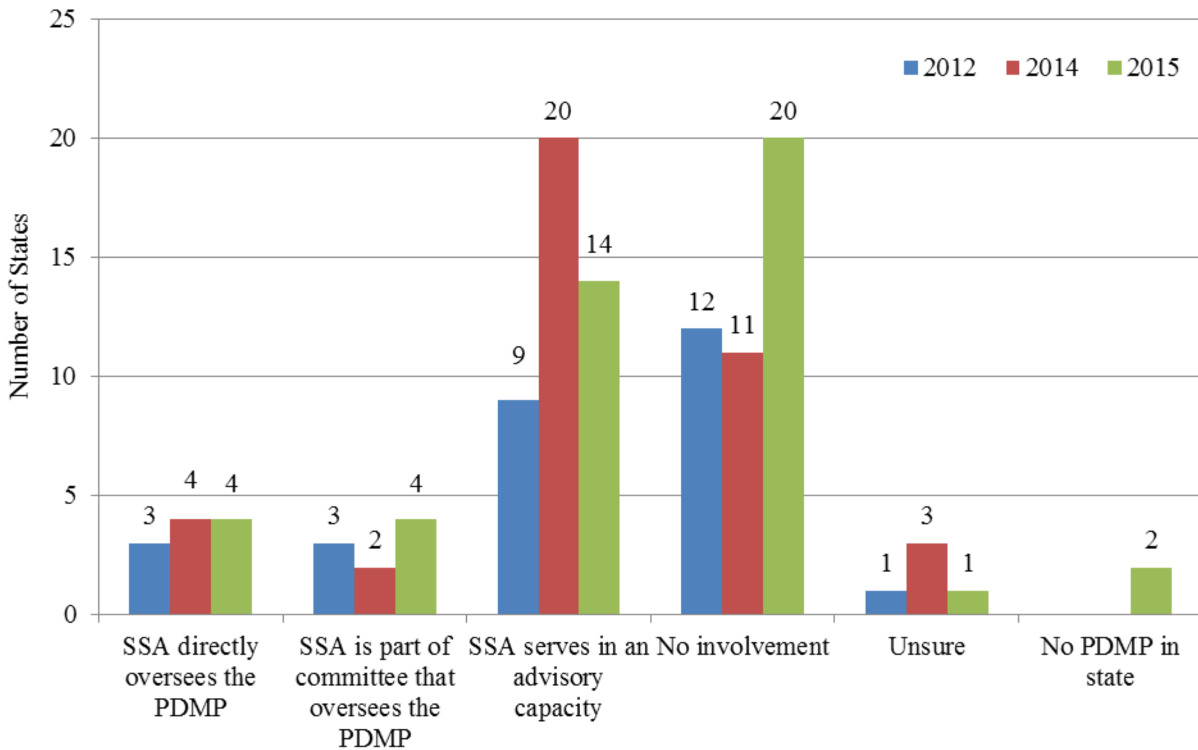
Figure 39. Number of States That Evaluate Prescription Drug Abuse Prevention Initiatives, 2014–2015



Prescription Drug Monitoring Program

PDMPs allow states to collect and analyze controlled substance prescription data. In 2015, 44 percent of SSAs (n=20 of 45 responding) are not involved with their state's PDMP; 31 percent (n=14) serve in an advisory capacity; 9 percent (n=4) directly oversee the PDMP; 9 percent (n=4) are part of the committee that oversees the PDMP; 4 percent (n=2) indicated that there is no PDMP in their state; and 1 state was unsure (Figure 40). Results from 2015 indicate that fewer SSAs are involved with the PDMP than in 2012 and 2014.

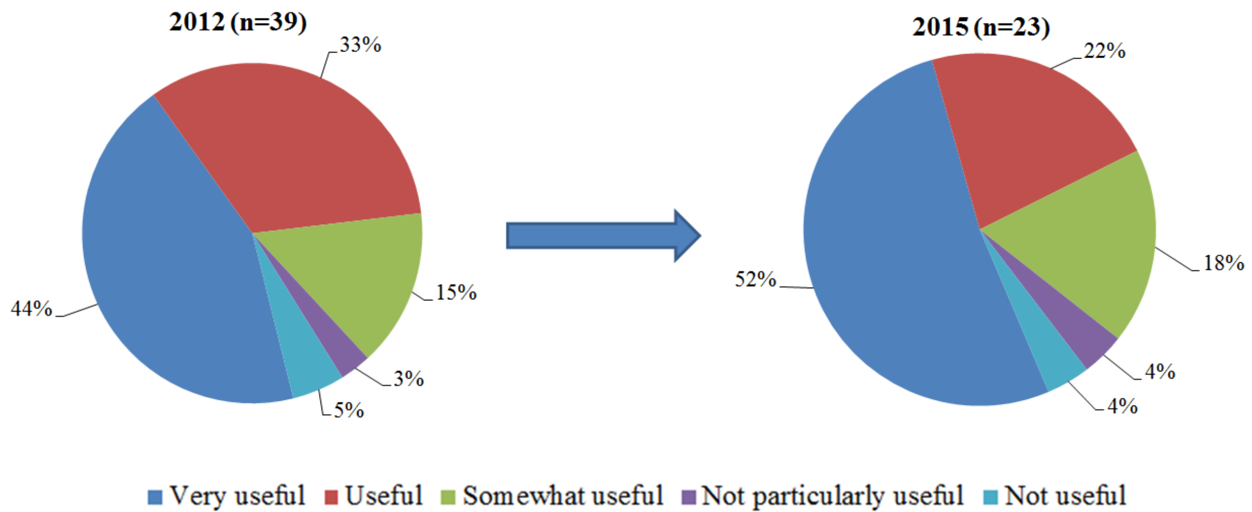
Figure 40. Single State Agency Roles With the Prescription Drug Monitoring Program, 2014–2015



Abbreviations: PDMP, Prescription Drug Monitoring Program; SSA, single state agency

Although OTPs cannot be required to report to PDMPs, office-based opioid treatment (OBOT) providers may have a requirement to check but not submit information. OBOT providers are not able to report substance use treatment data without consent. This requirement can improve patient care and safety and reduce prescription drug abuse, while ensuring that those with legitimate medical need for opioids have data access. Many states (52 percent, n=23 of 44 responding) have legislation requiring opioid prescribers to report to PDMPs. Thirty-three states receive data from or about PDMPs on a regular basis (n=14 of 42 responding receive data monthly or quarterly). Separate pharmacies filling prescriptions for medication-assisted treatment may submit data. Eighty-three percent (n=19 of 23 responding) of states that receive data from or about PDMPs describe the data that they receive as aggregate data. In 2015, most states that receive data from PDMPs (92 percent, 20 states) considered the data somewhat useful, useful, or very useful (Figure 41). Compared with 2012, when SSAs previously were asked about usefulness of PDMP data, the same percentage of respondents considered data to be somewhat useful, useful, or very useful.

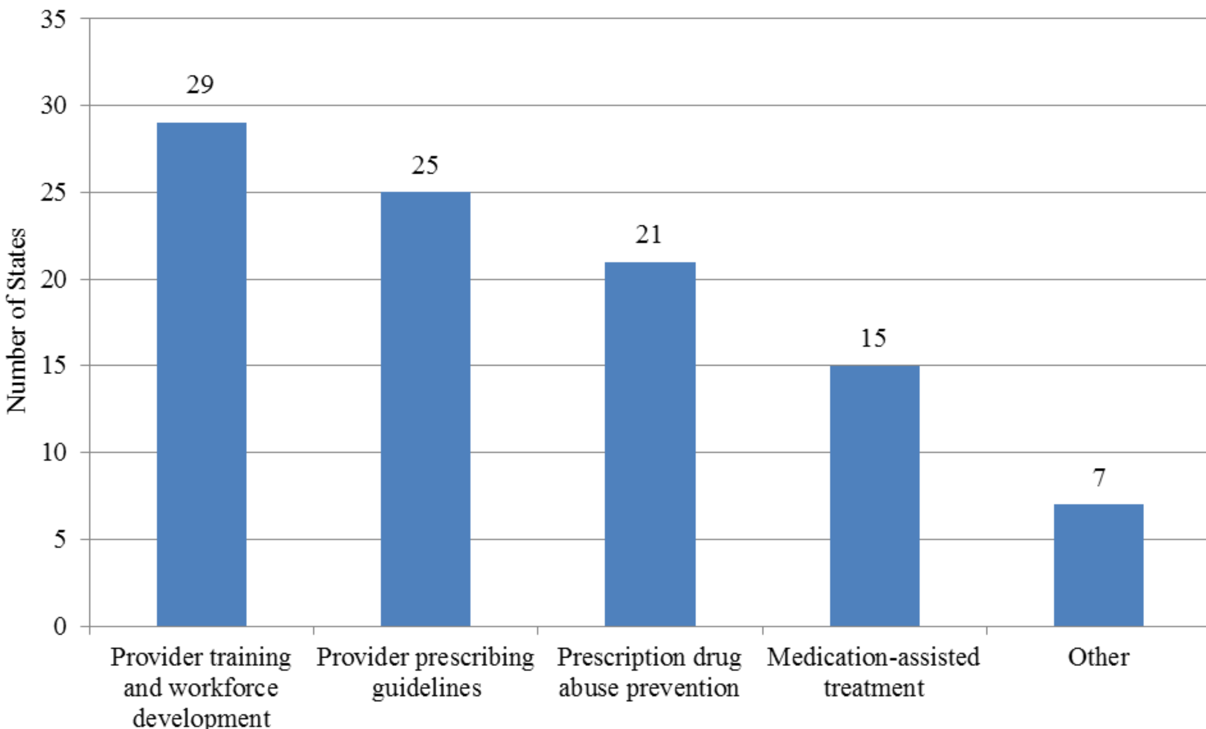
Figure 41. States' Rating of Usefulness of Prescription Drug Monitoring Program Data, 2012 and 2015



Other Information and Resources

Despite the tremendous amount of state efforts to address prescription drug and heroin abuse, SSAs require more training or technical assistance on some issues. Sixty-seven percent of SSAs (n=29) reported that they need training in provider workforce development, 58 percent (n=25) on provider prescribing guidelines, 49 percent (n=21) on prescription drug abuse prevention, and 35 percent (n=15) on MAT (Figure 42). An additional 16 percent (n=7) indicated another area of need, such as increased federal and state financial support or MAT for a specific population.

Figure 42. Number of States With Training or Technical Assistance Needs



Conclusion

Overall, prescription drug and heroin abuse are considered a priority issue across all states, which is likely the result of the increased number of treatment admissions and increased reports of prescription drug and heroin overdose. States have committed themselves to addressing this issue by enacting legislation, convening task forces, and providing education to communities, prescribers, pharmacists, patients, and their families.

Prescription opioids have garnered particular attention in recent years because of their increased use for pain treatment. As some users shift from prescription opioids to cheaper and more accessible heroin, states' prioritization of heroin abuse prevention and treatment is growing. To combat fatal prescription drug and heroin overdose, states and nonprofit groups distribute naloxone overdose reversal kits to individuals, families, and community members. Unfortunately, most states do not collect data about the number of people who have benefitted from naloxone or about the outcomes of individuals who have experienced overdose reversal. States that have successfully implemented naloxone distribution programs and have passed legislation regarding access to naloxone are a rich source of information for other states wishing to make progress in these areas.

This inquiry has focused on the efforts of states from the perspective of the state's SSA. It is likely that states are doing much more work on these issues. It would be beneficial to learn about the activities of other stakeholders such as physicians and pharmacists, other state agencies such as law enforcement and pharmacy boards, and other nongovernment agencies and organizations.

Many states feel that they have implemented promising and effective practices to approach heroin and prescription drug abuse. SSAs should be able to learn from each another about the types of practices that are working for their peers. Despite the many efforts states are employing to address the prescription drug and heroin problem, states still need further training and technical assistance on issues ranging from primary prevention to medication-assisted treatment. More research is needed overall to understand what works best for SSAs, with particular focus on states that already have instituted programs and policies addressing prescription drug and heroin abuse.

Chapter 8: Financing Mental and Substance Use Disorder Services

8.1 Key Highlights

- State governments vary widely in the amount of resources that they devote to behavioral health services.
  - States that expend more on SMHA services also tend to expend more on SSA services.
  - SMHA systems primarily rely on Medicaid for funding, whereas SSAs primarily rely on the SAMHSA block grants.
- Growth in SMHA expenditures slowed greatly during the recent recession.
  - SMHA-controlled expenditures for community mental health services grew faster than state psychiatric hospital expenditures.
  - SMHA central office and administration expenditures experienced major reductions during and after the recession.
  - Forensic and sex offender expenditures continue to grow as a share of state psychiatric hospital expenditures.
- SSAs managed budgets that totaled $4.95 billion, or about $15.50 per person, from all sources in FY 2014 (July 2013 through June 2014).
- The highest spending rate was in Alaska, where the SSA budget was $78 per capita. Seven states had spending less than $8 per capita. Half of the SSAs had budgets in the range of $10 to $25 per capita (the quartiles).
- SUD treatment represented 83 percent of SSA resources; primary prevention represented 11 percent; and administration and infrastructure represented 6 percent.
- SSA funding from all sources have grown only 0.7 percent annually since 1999.
- SSA prevention expenditures have decreased since 1999, falling from $580 million to $544 million, and the impact of inflation exacerbates this decrease.
- Primary prevention has declined progressively as a share of SSA budgets, reaching 11 percent in 2014, which is down from 14 percent at the peak.

8.2 SSA and SMHA Expenditures

SMHAs and SSAs collectively controlled the expenditures of more than $45.8 billion in FY 2014 (from July 1, 2013 through June 30, 2014, for most states). SMHA expenditures

represented $40.8 billion (89 percent of SMHA and SSA expenditures) and SSA expenditures of $5.0 billion (11 percent of SMHA and SSA expenditures). On a per capita basis (expenditures divided by state civilian population), states spent a total of $142.72 per person on mental health and substance use treatment in FY 2014 (Table 18). States varied from a high of approximately $400 per person in Alaska to less than $50 per person in Florida[28]and Puerto Rico (see Figure 43). SMHA per capita expenditures for mental health totaled $127.11 per person and SSA expenditures totaled $15.61 per person.

Table 18. Total and per Capita SSA and SMHA Expenditures for M/SUD Services, FY 2014

State	SMHA Mental Health Expenditures		SSA Expenditures for Treatment and Prevention		Combined SMHA and SSA Expenditures for Behavioral Health		
	Total, $	Per Capita, $	Total, $	Per Capita, $	Total, $	Per Capita, $	Per Capita Rank
Alabama	360,732,776	74.62	39,432,337	8.16	400,165,113	82.77	41
Alaska	226,522,776	316.98	57,697,469	80.74	284,220,245	397.72	1
Arizona	1,455,600,000	216.87	155,563,191	23.18	1,611,163,191	240.05	10
Arkansas[a]	127,217,599	42.98	18,105,719	6.12	145,323,318	49.10	50
California[b,c]	6,762,808,997	174.98	482,428,027	12.48	7,245,237,024	187.46	14
Colorado	648,479,958	121.90	58,191,422	10.94	706,671,380	132.84	23
Connecticut[a]	803,000,000	223.73	195,651,946	54.51	998,651,946	278.25	6
Delaware	88,264,967	94.73	23,126,498	24.82	111,391,465	119.55	29
District of Columbia	219,702,718	335.16	38,428,935	58.62	258,131,653	393.79	2
Florida[a,b]	714,700,000	36.05	221,856,365	11.19	936,556,365	47.24	51
Georgia[b]	603,383,638	60.15	123,320,263	12.29	726,703,901	72.44	44
Hawaii	188,065,000	137.04	29,872,184	21.77	217,937,184	158.81	18
Idaho	59,200,000	36.31	30,822,463	18.91	90,022,463	55.22	48
Illinois	857,000,000	66.67	214,521,142	16.69	1,071,521,142	83.36	40
Indiana	486,473,000	73.78	47,491,675	7.20	533,964,675	80.98	42
Iowa	479,100,000	154.27	42,064,986	13.54	521,164,986	167.82	16
Kansas	357,600,000	124.11	44,224,963	15.35	401,824,963	139.46	21
Kentucky	259,400,000	59.03	38,250,840	8.71	297,650,840	67.74	45
Louisiana	223,716,000	48.31	81,651,267	17.63	305,367,267	65.94	46
Maine[b]	481,988,765	362.75	34,899,849	26.27	516,888,614	389.02	3
Maryland[b]	1,138,600,000	191.45	159,551,868	26.83	1,298,151,868	218.28	13
Massachusetts[a]	763,400,000	113.27	128,988,270	19.14	892,388,270	132.41	24
Michigan[b]	1,232,600,000	124.43	131,591,086	13.28	1,364,191,086	137.72	22
Minnesota	1,064,081,317	195.09	155,383,793	28.49	1,219,465,110	223.58	12
Mississippi	294,723,000	98.93	20,543,947	6.90	315,266,947	105.83	33
Missouri	628,392,273	103.94	113,234,301	18.73	741,626,574	122.67	27
Montana	229,826,586	225.38	18,568,496	18.21	248,395,082	243.58	9
Nebraska[a]	140,149,583	74.76	30,376,049	16.20	170,525,632	90.96	38
Nevada	255,700,000	90.44	20,242,746	7.16	275,942,746	97.60	37
New Hampshire	195,443,878	147.46	14,508,069	10.95	209,951,947	158.40	19
New Jersey	1,902,860,000	213.12	143,482,109	16.07	2,046,342,109	229.19	11
New Mexico[a,c]	300,796,588	145.11	39,358,850	18.99	340,155,438	164.10	17
New York	4,952,100,000	251.12	525,200,787	26.63	5,477,300,787	277.75	7
North Carolina	989,552,016	100.59	156,480,301	15.91	1,146,032,317	116.49	32
North Dakota	69,014,123	94.23	24,813,886	33.88	93,828,009	128.10	26

[28] It is important to note that the expenditures reported for Florida in this report do not include Medicaid expenditures for behavioral health services through fee-for-service coverage or the statewide Medicaid managed care program.

State	SMHA Mental Health Expenditures		SSA Expenditures for Treatment and Prevention		Combined SMHA and SSA Expenditures for Behavioral Health		
	Total, $	Per Capita, $	Total, $	Per Capita, $	Total, $	Per Capita, $	Per Capita Rank
Ohio[a]	1,121,200,000	96.79	273,793,624	23.63	1,394,993,624	120.42	28
Oklahoma	228,730,000	59.29	67,140,930	17.40	295,870,930	76.69	43
Oregon	931,800,000	234.87	85,382,208	21.52	1,017,182,208	256.39	8
Pennsylvania[a]	3,664,900,000	286.76	110,420,858	8.64	3,775,320,858	295.40	5
Puerto Rico[a]	72,690,833	20.22	62,031,916	17.25	134,722,749	37.47	52
Rhode Island	111,123,514	105.72	25,629,500	24.38	136,753,014	130.10	25
South Carolina	275,400,000	57.49	38,076,877	7.95	313,476,877	65.44	47
South Dakota	73,724,628	86.77	25,747,854	30.31	99,472,482	117.08	31
Tennessee	619,200,000	94.86	62,363,746	9.55	681,563,746	104.41	34
Texas[b]	1,213,500,000	45.23	161,943,779	6.04	1,375,443,779	51.26	49
Utah[b]	213,200,000	72.58	45,613,086	15.53	258,813,086	88.10	39
Vermont	203,000,000	324.28	38,874,451	62.10	241,874,451	386.38	4
Virginia[b]	764,300,000	93.08	90,672,358	11.04	854,972,358	104.12	35
Washington	900,300,000	128.46	175,987,019	25.11	1,076,287,019	153.57	20
West Virginia[a]	170,800,000	92.37	18,833,001	10.19	189,633,001	102.56	36
Wisconsin[b]	644,800,000	112.05	31,987,744	5.56	676,787,744	117.61	30
Wyoming[a]	63,076,534	108.56	40,638,469	69.94	103,715,003	178.50	15
Total	40,831,941,067	127.11	5,015,063,519	15.61	45,847,004, 586	142.72	—[d]
Average (mean)	785,299, 636	133.64	96,443,529	21.01	881,494,992	154.65	—[d]
Median	419,916,388	104.83	52,594,572	16.97	459,356,789	125.39	—[d]

Abbreviations: FY, fiscal year; M/SUD, mental or substance use disorder; SMHA, state mental health agency; SSA, single state agency.

[a] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

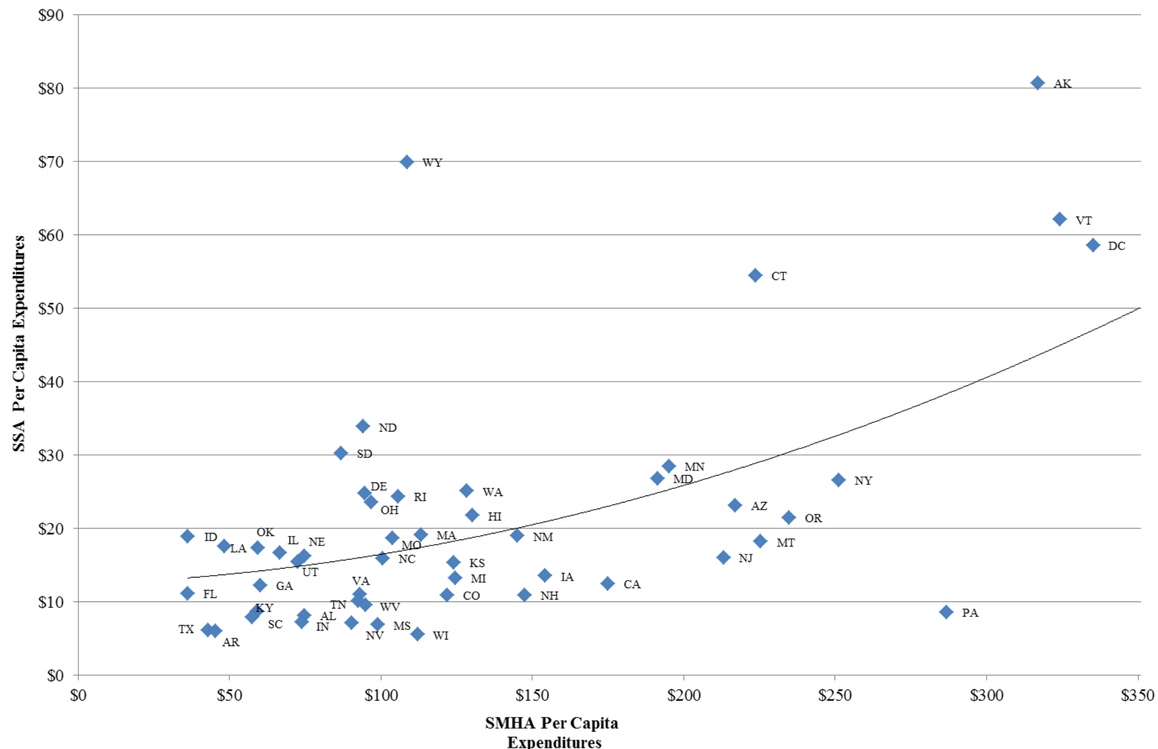
[b] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[c] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[d] No summary statistics were calculated on the rank.

Figure 43 shows the level of per capita expenditures for SSA and SMHA services in each state. This chart shows that states expending higher amounts in either mental health or SUD services also tend to expend higher amounts in the other service area. States that expend less in one service area also tended to expend less in the other service area (Pearson correlation of .565, significant at the 0.01 level, 2-tailed).

Figure 43. Fiscal Year 2014 Per Capita SMHA and SSA Expenditures, by State



Abbreviations: SMHA, state mental health agency; SSA, single state agency.

SSA and SMHA Funding Sources

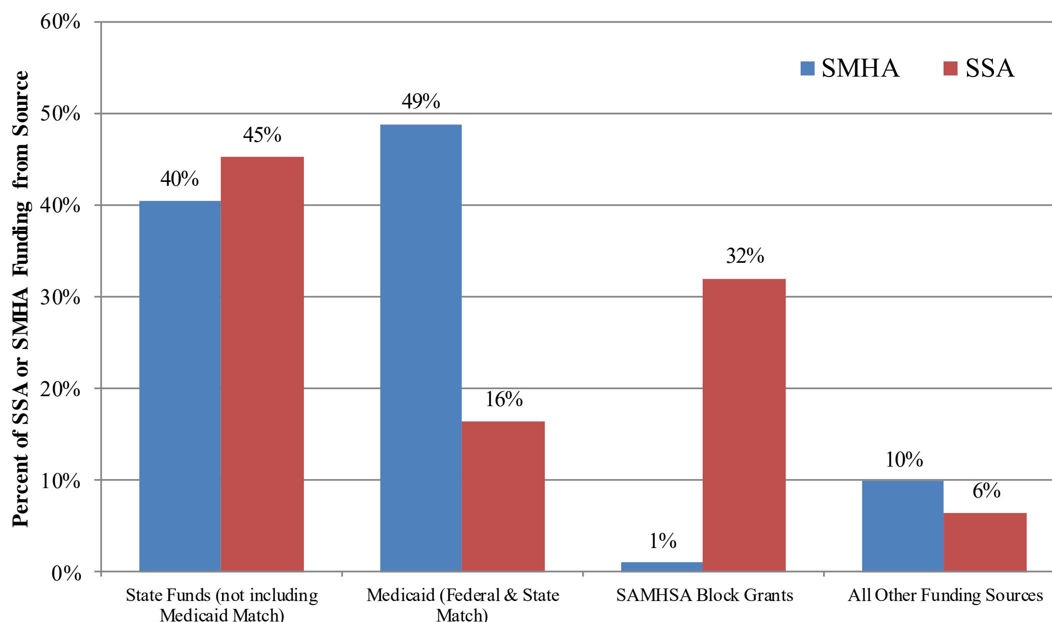
Figure 44 shows that there were major differences in the funding sources of SMHAs and SSAs in 2014. Medicaid was the largest funding source for SMHAs at 49 percent of total SMHA revenues, whereas for SSAs Medicaid represented only 16 percent of their funding. At 32 percent of total funding, the SABG was the second largest source of funds to SSAs, and the MHBG represented only 1 percent of SMHA funding. Table 19 shows how major funding sources varied by state.

Funds from the two SAMHSA Block Grants varied considerably from state to state, with SMHA funds from the MHBG ranging from a high of $58.4 million in California (1 percent) to a low of $301,447 in North Dakota (less than 1 percent). SABG funds that SSAs used ranged from a high of $248.9 million in California (52 percent of SSA funds) to a low of $2.7 million in the District of Columbia (7 percent of SSA funds). Note that state reporting of block grant expenditures during FY 2014 may include some shifting of expenditures between years and thus does not necessarily match the annual block grant allotments to states.

Medicaid was the largest single funding source for SMHAs for mental health services. Funds from Medicaid ranged from a high of $2.76 billion in Pennsylvania (75 percent of SMHA funds) to lows of no reported Medicaid funds in Puerto Rico and Wyoming, and $433,795 in Nebraska (less than one percent of SMHA funds), where a separate state agency operates the Medicaid program and full Medicaid billing for mental health was not available. Medicaid funding for SSAs ranged from a high of $161 million in California (33 percent) to a low of no funds in 22 states and Puerto Rico.

All Other Funding Sources includes local government contributions as well as first- and third-party payments for services, donations, and any other funding source. Other funding sources SMHAs used ranged from a high of $1.3 billion in California (19 percent) to a low of $276,212 in Wyoming (less than one percent). Other funding sources SSAs used ranged from a high of $23.0 million in Connecticut (12 percent) to a low of no funds in Mississippi and $175,557 in Nebraska (less than one percent).

Figure 44. Percentage of SSA and SMHA Funding by Major Source, FY 2014



Abbreviations: FY, fiscal year; SAMHSA, Substance Abuse and Mental Health Services Administration; SMHA, state mental health agency; SSA single state agency for substance use disorders.

Funds from state general and special revenues devoted to SMHAs ranged from over $2.7 billion in California (40 percent of total SMHA funds) to a low of $900,000 in Vermont (less than 1 percent of SMHA funding). For SSAs, state general and special funds ranged from a high of $414 million in New York (79 percent of SSA funds) to a low of $2.9 million in Arkansas (16 percent of SSA funds). See Table 20 for the percentage distribution of SSA and SMHA funding sources.

Table 19. SSA and SMHA Funding by Major Payment Source, FY 2014

State	State Funds (not including Medicaid Match)		Medicaid (Federal & State Match)		SAMHSA Block Grants		All Other Funding Sources	
	SMHA, $	SSA, $	SMHA, $	SSA, $	SMHA, $	SSA, $	SMHA, $	SSA, $
Alabama[a]	170,000,000	12,361,094	162,300,000	6,272,609	5,300,000	18,681,839	10,830,000	2,116,795
Alaska[b]	42,263,073	41,553,190	164,102,435	8,337,800	567,000	4,982,393	21,015,967	2,824,086
Arizona[a]	161,800,000	9,588,348	1,215,800,000	114,387,478	9,200,000	27,581,358	61,000,000	4,006,007
Arkansas[c]	80,734,258	2,938,662	35,361,746	0	3,611,662	10,534,788	7,279,541	4,632,269
California[a,b,d,e]	2,737,492,034	65,306,796	2,702,011,158	160,875,562	58,376,166	248,906,694	1,264,929,638	7,338,975
Colorado	150,427,609	22,087,289	475,720,301	1,185,629	6,130,688	27,205,397	16,201,360	7,713,107
Connecticut[c]	771,900,000	155,784,688	81,200,000	0	4,300,000	16,883,413	29,400,000	22,983,845
Delaware[a]	87,556,741	14,907,578	14,166,763	0	618,000	6,026,039	1,930,027	2,192,881
District of Columbia	190,958,668	26,479,250	12,074,452	0	742,792	2,662,960	15,926,806	9,286,725
Florida[c,d]	557,900,000	100,131,591	116,900,000	0	29,900,000	99,636,342	15,200,000	22,088,432
Georgia[a,d]	519,413,085	47,979,382	7,713,117	754,996	12,600,170	53,767,370	63,657,267	20,818,515
Hawaii	161,957,000	18,287,591	25,284,000	0	7,655,000	7,519,945	4,347,000	4,064,648
Idaho	42,700,000	18,451,890	5,500,000	2,020,312	700,000	6,894,375	10,300,000	3,455,886
Illinois[a]	537,500,000	85,363,225	339,800,000	51,532,625	14,800,000	67,706,393	13,900,000	9,918,899
Indiana	175,583,000	10,256,313	290,460,000	0	7,655,000	30,982,476	12,775,000	6,252,886
Iowa	23,700,000	19,896,291	370,100,000	0	2,700,000	13,422,031	87,285,000	8,746,664
Kansas	109,000,000	17,362,905	234,500,000	11,858,219	3,400,000	12,512,976	10,700,000	2,490,863
Kentucky	155,000,000	16,081,896	79,300,000	0	5,800,000	20,247,285	19,300,000	1,921,659
Louisiana	150,348,000	41,309,516	56,213,000	13,387	4,070,000	24,849,301	13,085,000	15,479,063
Maine[d]	48,269,303	11,877,266	400,894,455	13,382,119	1,516,633	6,670,567	31,308,374	2,969,897
Maryland[d]	699,700,000	117,710,917	410,400,000	0	7,300,000	31,737,430	21,200,000	10,103,521
Massachusetts[c]	749,800,000	90,106,640	106,000,000	0	8,900,000	32,265,047	13,700,000	6,616,583
Michigan[d]	250,100,000	29,818,131	931,700,000	43,931,488	9,900,000	51,011,476	40,900,000	6,829,991
Minnesota[a]	226,011,220	100,841,793	666,950,176	32,611,188	6,407,509	19,912,802	164,712,412	2,018,010
Mississippi	117,633,000	5,085,296	103,990,000	1,308,576	4,000,000	14,150,075	69,100,000	0
Missouri	339,825,815	43,483,572	387,159,848	38,356,443	7,852,761	23,597,305	36,783,243	7,796,981
Montana	54,712,244	7,123,370	172,731,364	2,036,579	1,185,990	6,670,567	1,196,988	2,737,980
Nebraska[c]	100,572,071	23,345,338	433,795	683	1,847,077	6,854,471	37,296,640	175,557
Nevada[a]	136,100,000	7,460,562	58,000,000	0	4,300,000	11,899,155	57,300,000	883,029
New Hampshire	44,199,796	4,846,868	115,567,714	0	1,391,267	5,845,703	34,285,100	3,815,498
New Jersey	1,078,892,000	98,880,979	553,197,000	0	13,098,000	39,192,072	257,673,000	5,409,058

State	State Funds (not including Medicaid Match)		Medicaid (Federal & State Match)		SAMHSA Block Grants		All Other Funding Sources	
	SMHA, $	SSA, $	SMHA, $	SSA, $	SMHA, $	SSA, $	SMHA, $	SSA, $
New Mexico[c,e]	114,235,314	21,005,580	180,212,089	3,620,966	1,737,972	8,735,946	4,611,213	5,996,358
New York	1,346,100,000	414,182,097	2,634,300,000	0	25,000,000	101,192,396	871,000,000	9,826,294
North Carolina	416,225,637	124,579,682	517,206,954	0	11,581,359	29,481,878	44,538,070	2,418,741
North Dakota	35,174,675	9,394,286	12,637,845	8,764,993	301,447	4,767,816	20,017,178	1,886,791
Ohio[b,c]	433,556,009	26,281,844	621,144,905	153,336,946	14,101,284	86,487,258	91,818,699	7,687,576
Oklahoma	156,527,000	37,484,103	48,885,000	3,424,017	5,783,000	17,579,842	17,535,000	8,652,968
Oregon	273,500,000	23,241,956	643,400,000	32,404,881	4,500,000	21,234,734	10,100,000	8,500,637
Pennsylvania[a,c]	819,000,000	46,800,533	2,762,600,000	0	13,700,000	51,762,364	69,600,000	11,857,961
Puerto Rico	66,769,513	34,762,544	0	0	5,935,283	22,369,385	985,000	4,899,987
Rhode Island	6,062,216	4,309,762	97,168,389	8,214,339	1,309,540	7,367,015	6,583,369	5,738,384
South Carolina	88,000,000	6,539,155	159,300,000	3,258,391	6,000,000	19,440,046	25,500,000	8,839,285
South Dakota	40,608,097	12,747,379	24,766,973	4,339,942	807,996	4,506,421	6,030,019	4,154,112
Tennessee	185,200,000	29,694,712	405,500,000	0	8,400,000	28,265,147	20,100,000	4,403,887
Texas[d]	791,500,000	36,194,943	204,300,000	0	34,800,000	125,173,687	182,900,000	575,149
Utah[d]	41,800,000	10,834,676	150,400,000	10,418,545	3,200,000	11,924,624	17,800,000	12,435,241
Vermont[b]	900,000	7,060,653	196,900,000	24,269,987	800,000	6,076,965	4,400,000	1,466,846
Virginia[a,d]	487,900,000	48,283,468	244,800,000	0	9,600,000	40,390,693	31,300,000	1,998,197
Washington	172,000,000	53,146,170	676,900,000	83,194,969	8,600,000	31,512,008	42,800,000	8,133,872
West Virginia[c]	93,300,000	10,674,920	71,900,000	0	2,100,000	6,256,259	3,500,000	1,901,822
Wisconsin[d]	332,900,000	3,713,098	160,300,000	69,900	6,300,000	25,432,638	145,300,000	2,772,108
Wyoming[c]	63,388,532	35,690,619	0	0	451,640	3,193,368	276,212	1,754,482
Total	16,636,695,910	2,263,330,407	20,108,153,479	824,183,569	410,835,236	1,603,960,535	4,061,213,123	323,589,008
Average (mean)	319,936,460	43,525,585	386,695,259	15,849,684	7,900,678	30,845,395	78,100,252	6,222,866
Median	159,163,500	23,293,647	163,201,218	412,448	5,791,500	19,676,424	20,058,589	4,766,128

Abbreviations: FY, fiscal year; SAMHSA, Substance Abuse and Mental Health Services Administration; SMHA, state mental health agency; SSA, single state agency.

[a] SSA data are subject to update.

[b] SSA data are estimates.

[c] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[d] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[e] Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 20. Percentage of SSA and SMHA Funds from Major Payment Sources, FY 2014

State	State Funds (Not Including Medicaid Match)		Medicaid (Federal and State Match)		SAMHSA Block Grants		All Other Funding Sources	
	SMHA, %	SSA, %	SMHA, %	SSA, %	SMHA, %	SSA, %	SMHA, %	SSA, %
Alabama[a]	49	31	47	16	2	47	3	5
Alaska[b]	19	72	72	14	0	9	9	5
Arizona[a]	11	6	84	74	1	18	4	3
Arkansas[c]	64	16	28	0	3	58	6	26
California[a,b,d,e]	40	14	40	33	1	52	19	2
Colorado	23	38	73	2	1	47	2	13
Connecticut[c]	87	80	9	0	0	9	3	12
Delaware[a]	84	64	14	0	1	26	2	9
District of Columbia	87	69	5	0	0	7	7	24
Florida[c,d]	77	45	16	0	4	45	2	10
Georgia[a d]	86	39	1	1	2	44	11	17
Hawaii	84	61	13	0	1	25	2	14
Idaho	72	60	9	7	1	22	17	11
Illinois[a]	59	40	38	24	2	32	2	5
Indiana	36	22	60	0	2	65	3	13
Iowa	5	47	77	0	1	32	18	21
Kansas	30	39	66	27	1	28	3	6
Kentucky	60	42	31	0	2	53	7	5
Louisiana	67	51	25	0	2	30	6	19
Maine[d]	10	34	83	38	0	19	6	9
Maryland[d]	61	74	36	0	1	20	2	6
Massachusetts[c]	85	70	12	0	1	25	2	5
Michigan[d]	20	23	76	33	1	39	3	5
Minnesota[a]	21	65	63	21	1	13	15	1
Mississippi	40	25	35	6	1	69	23	0
Missouri	44	38	50	34	1	21	5	7
Montana	24	38	75	11	1	36	1	15
Nebraska[c]	72	77	0	0	1	23	27	1
Nevada[a]	53	37	23	0	2	59	22	4
New Hampshire	23	33	59	0	1	40	18	26
New Jersey	57	69	29	0	1	27	14	4

State	State Funds (Not Including Medicaid Match)		Medicaid (Federal and State Match)		SAMHSA Block Grants		All Other Funding Sources	
	SMHA, %	SSA, %	SMHA, %	SSA, %	SMHA, %	SSA, %	SMHA, %	SSA, %
New Mexico[c,e]	38	53	60	9	1	22	2	15
New York	28	79	54	0	1	19	18	2
North Carolina	42	80	52	0	1	19	5	2
North Dakota	52	38	19	35	0	19	29	8
Ohio[b,c]	37	10	54	56	1	32	8	3
Oklahoma	68	56	21	5	3	26	8	13
Oregon	29	27	69	38	0	25	1	10
Pennsylvania[a,c]	22	42	75	0	0	47	2	11
Puerto Rico	91	56	0	0	8	36	1	8
Rhode Island	5	17	87	32	1	29	6	22
South Carolina	32	17	57	9	2	51	9	23
South Dakota	56	50	34	17	1	18	8	16
Tennessee	30	48	65	0	1	45	3	7
Texas[d]	65	22	17	0	3	77	15	0
Utah[d]	20	24	71	23	2	26	8	27
Vermont[b]	0	18	97	62	0	16	2	4
Virginia[a,d]	63	53	32	0	1	45	4	2
Washington	19	30	75	47	1	18	5	5
West Virginia[c]	55	57	42	0	1	33	2	10
Wisconsin[d]	52	12	25	0	1	80	23	9
Wyoming[c]	99	88	0	0	1	8	0	4
Total	40	45	49	16	1	32	10	6
Average (mean)	47	44	43	13	1	33	8	10
Median	47	41	41	1	1	29	6	8

Abbreviations: FY, fiscal year; SAMHSA, Substance Abuse and Mental Health Services Administration; SMHA, state mental health agency; SSA, single state agency.

[a] SSA data are subject to update.

[b] SSA data are estimates.

[c] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

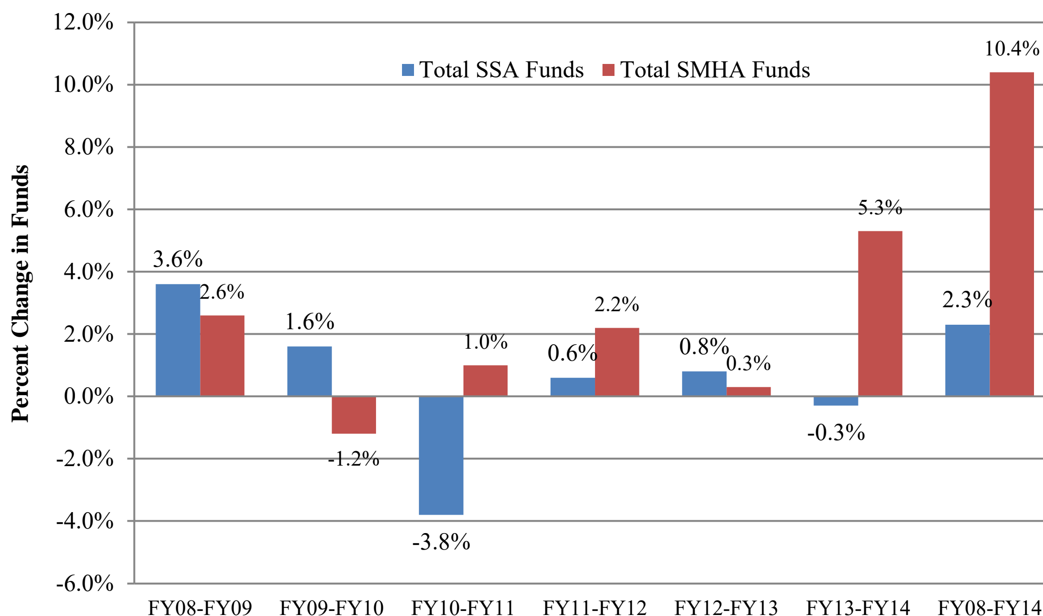
[d] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[e] Children's mental health expenditures are not included in SMHA-controlled expenditures.

SSA and SMHA Funding Over Time

The economic recession that began in the last decade had an impact on funding of both SSAs and SMHAs. From FY 2008 to FY 2014, total expenditures for SSAs increased by only 2.3 percent and SMHA expenditures increased slightly faster at 10.4 percent (over the 6 years). Figure 45 shows that both SSAs and SMHAs experienced declines or relatively flat funding for several years between FY 2009 and FY 2012.

Figure 45. Percentage Change in Total SSA and SMHA Funds, FY 2008–FY 2014



Abbreviations: FY, fiscal year; SMHA, state mental health agency; SSA, single state agency.

From FY 2008 to FY 2014, state funds to both SMHAs (up only 3.6 percent) and SSAs (up only 3.3 percent) were relatively flat over this 6-year time period (see Table 21). Both SSAs and SMHAs increased their reliance on Medicaid because that funding source showed the largest increase for SSAs and the second largest growth for SMHAs. The SAMHSA block grants were subject to slight reductions for both SMHAs and SSAs.

Table 21. SSA and SMHA Major Funding Sources, FY 2008 to FY 2014

Funding Source	FY 2008, $		FY 2014, $		FY 2008 to FY 2014 % Change	
	SSA	SMHA	SSA	SMHA	SSA	SMHA
State funds	2,192,412,306	16,061,413,401	2,265,508,240	16,636,695,910	3.3	3.6
Medicaid	624,689,826	17,019,598,135	824,183,569	20,108,153,479	31.9	18.1
SAMHSA block grants	1,668,321,153	405,537,084	1,607,501,201	405,238,235	–3.6	–0.1
Other federal	269,980,441	1,204,671,508	270,304,697	1,326,019,586	0.1	10.1
Other funds	158,903,291	2,629,975,240	62,265,220	2,742,313,857	–60.8	4.0
Total	4,914,307,017	37,321,195,368	5,029,762,927	41,218,421,066	2.3	10.4

Abbreviations: FY, fiscal year; SAMHSA, Substance Abuse and Mental Health Services Administration; SMHA, state mental health agency; SSA, single state agency.

8.3 Financing State Mental Health Agency Services

SMHA financing of public mental health services is a complex combination of state general funds, Medicaid, Medicare, federal block grants, and other funds. Although all SMHA receive state general revenues, Medicaid is now the largest single payer for mental health services nationally. Medicaid is a joint state–federal program that provides insurance to individuals with low income and those with disabilities. Each state has its own unique Medicaid system that can adopt a variety of state optional services and waivers that permit the use of managed care.

In 2015, 31 SMHAs were using a combination of managed care and fee-for-service plans to pay for mental health services, whereas 13 SMHAs relied on only fee-for-service approaches and 4 SMHAs were managed care only systems (see Figure 46).

Figure 46. Medicaid Reimbursement Approaches for Mental Health Services, by State, FY 2015

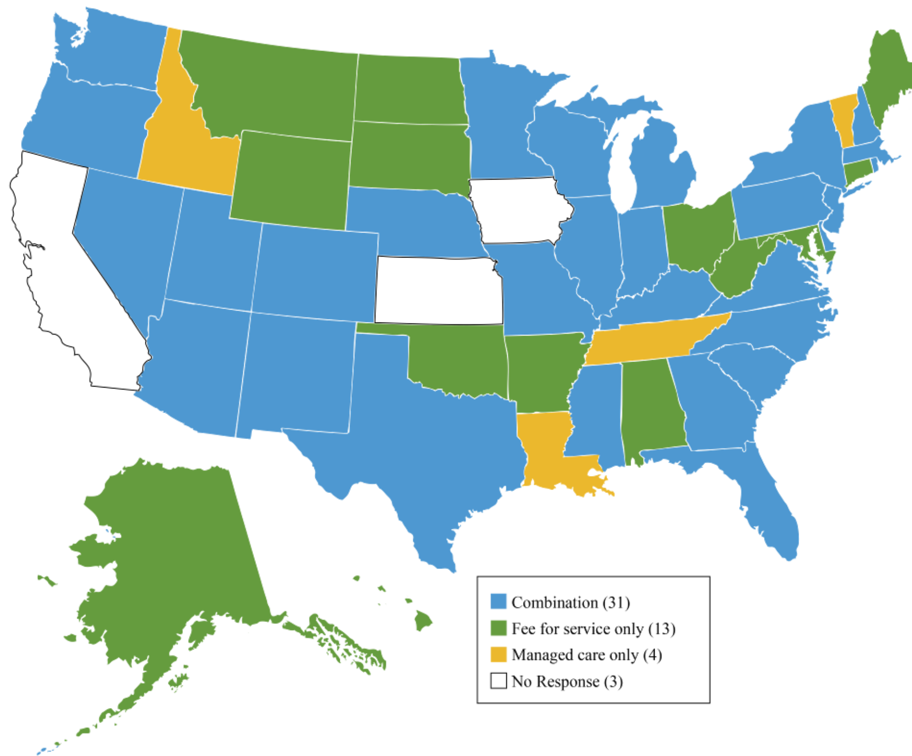


Table 22 shows the types of Medicaid waivers that states are using to finance mental health care. With 17 states using them, Medicaid § 1115 Research and Demonstration waivers were the most widely used Medicaid waivers, followed by 14 states using the § 1915(b) managed care waiver. Some states have more than one § 1915(b) waiver and use different waivers for children than for adults or other special populations. Thirteen states were using Medicaid § 1915(c) HCBS waivers, and 15 states had approved or were applying for the § 1915(i) Medicaid HCBS state plan option authorized under the Affordable Care Act to support some community-based and transitional mental health services and supports.

Table 22. Types of Medicaid Waivers Used to Pay for Mental Health Services, FY 2015

State	State Uses Managed Care to Provide Behavioral Health Services	Type of Medicaid Waivers Used to Provide Behavioral Health Services			1915(i) Home and Community Based Option
		1115 Waiver	1915(b)	1915(c) Waiver	
Alabama	Fee for service only	No	No	No	Applying
Alaska	Fee for service only	No	No	No	Applying
Arizona	Combination	Yes	No	No	No
Arkansas	Fee for service only	No	No	No	No
California	No response	No response	No response	No response	No response
Colorado	Combination	No	Yes	No	No
Connecticut	Fee for service only	No	No	Yes	No
Delaware	Combination	No	No	No	No
District of Columbia	Combination	No	No	No	No
Florida	Combination	Yes	No	No	Approved
Georgia	Combination	No	No	No	No
Hawaii	Combination	Yes	No	No	No
Idaho	Managed care only	No	Yes	No	Approved
Illinois	Combination	No	No	No	No
Indiana	Combination	No	Yes	Yes	No
Iowa	No response	No response	No response	No response	No response
Kansas	No response	No response	No response	No response	No response
Kentucky	Combination	Yes	Yes	Yes	No
Louisiana	Managed care only	No	Yes	Yes	Applying
Maine	Fee for service only	No	No	No	No
Maryland	Fee for service only	Yes	No	Yes	Approved
Massachusetts	Combination	Yes	Yes	No	No
Michigan	Combination	Yes	Yes	Yes	Approved
Minnesota	Combination	No	No	Yes	No
Mississippi	Combination	No	No	No	No
Missouri	Combination	No	No	No	No
Montana	Fee for service only	Yes	No	Yes	No
Nebraska	Combination	No	Yes	No	Approved
Nevada	Combination	No	No	No	Applying
New Hampshire	Combination	No	No	No	No
New Jersey	Combination	Yes	No	No	No
New Mexico	Combination	Yes	No	No	No
New York	Combination	Yes	No	Yes	No
North Carolina	Combination	No	Yes	No	Applying
North Dakota	Fee for service only	No	No	No	No
Ohio	Fee for service only	No	No	No	Applying
Oklahoma	Fee for service only	No	No	No	No
Oregon	Combination	Yes	No	No	Approved
Pennsylvania	Combination	No	Yes	No	No

State	State Uses Managed Care to Provide Behavioral Health Services	Type of Medicaid Waivers Used to Provide Behavioral Health Services			1915(i) Home and Community Based Option
		1115 Waiver	1915(b)	1915(c) Waiver	
Rhode Island	Combination	Yes	No	No	No
South Carolina	Combination	No	No	No	Applying
South Dakota	Fee for service only	No	No	No	No
Tennessee	Managed care only	Yes	No	No	No
Texas	Combination	Yes	Yes	Yes	Applying
Utah	Combination	No	Yes	No	No
Vermont	Managed care only	Yes	No	No	No
Virginia	Combination	No	No	Yes	No
Washington	Combination	No	Yes	No	No
West Virginia	Fee for service only	No	No	No	No
Wisconsin	Combination	Yes	Yes	Yes	Approved
Wyoming	Fee for service only	No	No	Yes	No
Totals	4=Managed care only	17=Yes	14=Yes	13=Yes	8=Applying
	13=Fee for service only	31=No	34=No	35=No	7=Approved
	31=Combination	3=No response	3=No response	3=No response	33=No
	3=No response				3=No response

SMHAs are working closely with state Medicaid agencies on the design of Medicaid services for individuals with mental illness. Medicaid rates are the responsibility of the state Medicaid agency, but SMHAs often work closely with their state Medicaid agencies to establish rates for mental health services. Sixteen SMHAs are responsible for setting rates for mental health services that SMHA-funded programs provide, and 15 SMHAs are responsible for setting rates for mental health services that SMHA-operated programs provide. In nine states, the SMHA is responsible for setting Medicaid rates for services in various Medicaid options, and in three states the SMHA sets rates for mental health services in non-SMHA-funded (private) programs.

In 31 states, SMHAs are responsible for paying the Medicaid match for mental health services that SMHA-funded programs provide, and 25 SMHAs are responsible for the Medicaid match for mental health services that SMHA-operated mental health programs provide. Local counties and cities in 13 states are responsible for paying a portion of the state Medicaid match.

Local county and city governments receive dedicated taxes for mental health services in 10 states, and the SMHA receives dedicated state taxes to support mental health services in two states (Indiana and South Carolina).

To better meet the mental health needs of children, SMHAs are working with state Medicaid agencies to enhance access to school-based care. In 37 states, Medicaid now reimburses for mental health services in schools. In 14 states, Medicaid also pays for school-based transportation services.

To help support individuals moving from psychiatric inpatient settings into the community, 18 SMHAs have a portable benefit that can follow the person into the community. The following are examples:

- In Connecticut, the Department of Mental Health and Addiction Services (DMHAS) funds an array of community services and supports that are available to assist clients with community reintegration. The DMHAS also manages a discretionary community discharge fund to develop person-centered reintegration plans that assist clients in the community. This fund provides enhanced community-based treatment and recovery supports.

- In Missouri, one of the strategies of the Inpatient Redesign process was to move 100 individuals who were committed voluntarily by guardians from inpatient settings to the community and use redirected general revenue to enhanced services and residential supports to ensure the success of those placements and minimize any risk to public safety.

- In North Dakota, Money Follows the Person provides individuals with approximately $2,500 to re-establish themselves in the community.

State Mental Health Agency Revenues and Expenditures for Mental Health Services, FY 2014

The SMHAs in the 50 states, the District of Columbia, and Puerto Rico were responsible for the expenditures of more than $40.8 billion used to provide mental health treatment and support in FY 2014. These expenditures came from a mixture of state general and special funds, Medicaid, Medicare, federal block grants, and other federal funds, as well as some private insurance payments and other sources of funding. These expenditures, which the SMHA system controls, covered services to more than 7.3 million individuals with mental illness in every state. They also were used to pay for services in state psychiatric hospitals and community mental health programs, as well as the SMHA's central office expenses for prevention programs, administration, planning, research and evaluation, and training. SMHAs expended $127.11 per civilian resident of the United States, with a median per capita expenditure of $104.83. SMHA per capita expenditures ranged from a high of $362.79 in Maine—Alaska, District of Columbia, and Vermont all had per capita expenditures above $300—to a low of under $50 per capita in Arkansas, Florida, Idaho, Louisiana, Puerto Rico, and Texas (see Figure 47 and Table 23

Figure 47. Total Per Capita State Mental Health Agency Controlled Expenditures for Mental Health Services, FY 2014

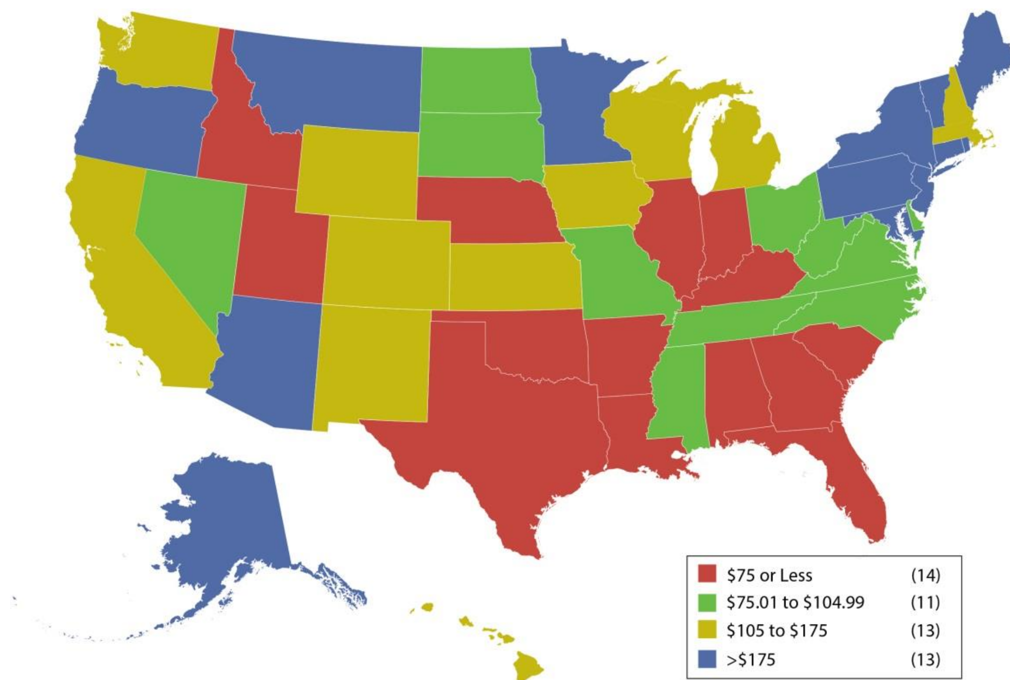


Table 23 shows per capita expenditures using two different denominators. First, the per capita expenditures number (using total state population) divides the SMHA expenditures by the total civilian population in each state. The second per capita number (per capita < 138 percent of the FPL) divides the SMHA expenditures by the number of persons in each state living at or below 138 percent FPL in 2013 (as the U.S. Census Bureau determines). This second per capita estimate (under 138 percent FPL) adjusts for higher expenditures in states with greater numbers of individuals with lower incomes who may be more likely to access SMHA mental health services. The <138 percent FPL per capita SMHA expenditure was $596.98, ranging from a high of $2,159.57 in Vermont to a low of $154.02 in Arkansas.

Table 23. SMHA-Controlled Expenditures, per Capita Expenditures, and Under 138% of FPL per Capita Expenditures for Mental Health Services, FY 2014

State	Total Expenditure, $	Per Capita Expenditures (Based on Total State Population), $	Per Capita (<138% FPL), $
Alabama	360,732,776	74.62	321.80
Alaska	226,522,776	316.98	1,887.69
Arizona	1,455,600,000	216.87	766.51
Arkansas[a]	127,217,599	42.98	154.02
California[b,c]	6,762,808,997	174.98	760.46
Colorado	648,479,958	121.90	772.00
Connecticut[a]	803,000,000	223.73	1,421.24
Delaware	88,264,967	94.73	469.49
District of Columbia	219,702,718	335.16	1,277.34
Florida[a,b]	714,700,000	36.05	157.49
Georgia[b]	603,383,638	60.15	246.48
Hawaii	188,065,000	137.04	777.13
Idaho	59,200,000	36.31	181.60

State	Total Expenditure, $	Per Capita Expenditures (Based on Total State Population), $	Per Capita (<138% FPL), $
Illinois	857,000,000	66.67	352.82
Indiana	486,473,000	73.78	391.06
Iowa	479,100,000	154.27	926.69
Kansas	357,600,000	124.11	677.27
Kentucky	259,400,000	59.03	214.20
Louisiana	223,716,000	48.31	166.70
Maine[b]	481,988,765	362.75	2,008.29
Maryland[b]	1,138,600,000	191.45	1,229.59
Massachusetts[a]	763,400,000	113.27	637.76
Michigan[b]	1,232,600,000	124.43	565.67
Minnesota	1,064,081,317	195.09	1,168.04
Mississippi	294,723,000	98.93	321.40
Missouri	628,392,273	103.94	516.77
Montana	229,826,586	225.38	1,003.61
Nebraska[a]	140,149,583	74.76	491.75
Nevada	255,700,000	90.44	346.48
New Hampshire	195,443,878	147.46	1,039.60
New Jersey	1,902,860,000	213.12	1,266.04
New Mexico[a,c]	300,796,588	145.11	460.64
New York	4,952,100,000	251.12	1,097.05
North Carolina	989,552,016	100.59	370.62
North Dakota	69,014,123	94.23	605.39
Ohio[a]	1,121,200,000	96.79	465.81
Oklahoma	228,730,000	59.29	252.46
Oregon	931,800,000	234.87	1,158.96
Pennsylvania[a]	3,664,900,000	286.76	1,498.32
Puerto Rico[a]	72,690,833	20.22	NA
Rhode Island	111,123,514	105.72	505.11
South Carolina	275,400,000	57.49	246.77
South Dakota	73,724,628	86.77	585.12
Tennessee	619,200,000	94.86	370.11
Texas[b]	1,213,500,000	45.23	191.43
Utah[b]	213,200,000	72.58	491.24
Vermont	203,000,000	324.28	2,159.57
Virginia[b]	764,300,000	93.08	618.87
Washington	900,300,000	128.46	705.56
West Virginia[a]	170,800,000	92.37	368.90
Wisconsin[b]	644,800,000	112.05	693.33
Wyoming[a]	63,076,534	108.56	568.26
Total	40,831,941,067	127.11	596.98
Average (mean)	785,229,636	133.64	704.52
Median	419,916,388	104.83	568.26

Abbreviations: FPL, federal poverty level; FY, fiscal year; SMHA, state mental health agency.

[a] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[b] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[c] Children's mental health expenditures are not included in SMHA-controlled expenditures.

SMHA Expenditures per Individuals Served

In FY 2014, SMHA systems expended $40.8 billion to provide mental health services to almost 7.3 million individuals—an average expenditure of $5,602 per individual served. Table 24

shows that there was a wide variation in expenditures per individual served across states, ranging from a high of $14,779 in Hawaii to a low of $1,641 in Kentucky. Some of the variation in levels of expenditures per client between states likely is due to variations in the inclusion of Medicaid funding for mental health services in the SMHA-controlled expenditures. That is, states where Medicaid expenditures are paid via managed care systems with no involvement of the SMHA are not likely to include Medicaid funds in state reports from the SMHA system.

Table 24. SMHA Expenditures per Individual Served, FY 2014

State	Total Clients Served: 2014 URS	Percent of State Population Served	Total SMHA MH Expenditures: FY 2014, $	FY 2014 per Capita (Population) Expenditures, %	2014 Expenditures per Client, $	State Population (2014 Civilian)	Client Utilization Rank	Per Capita Rank	Expenditure per Client Rank
Alabama	94,478	1.95	360,732,776	74.62	3,818	4,834,455	32	39	35
Alaska	22,284	3.12	226,522,776	316.98	10,165	714,617	17	4	2
Arizona	158,045	2.35	1,455,600,000	216.87	9,210	6,711,844	26	10	4
Arkansas[a]	67,641	2.29	127,217,599	42.98	1,881	2,959,597	27	49	50
California[b,c]	695,885	1.80	6,762,808,997	174.98	9,718	38,649,435	34	14	3
Colorado	113,269	2.13	648,479,958	121.90	5,725	5,319,728	30	22	22
Connecticut[a]	92,857	2.59	803,000,000	223.73	8,648	3,589,082	23	9	7
Delaware	9,830	1.06	88,264,967	94.73	8,979	931,729	46	32	6
District of Columbia	23,872	3.64	219,702,718	335.16	9,203	655,510	11	2	5
Florida[a,b]	231,792	1.17	714,700,000	36.05	3,083	19,823,803	44	51	44
Georgia[b]	163,570	1.63	603,383,638	60.15	3,689	10,031,414	39	43	38
Hawaii	12,725	0.93	188,065,000	137.04	14,779	1,372,348	49	18	1
Idaho	14,106	0.87	59,200,000	36.31	4,197	1,630,236	50	50	32
Illinois	135,197	1.05	857,000,000	66.67	6,339	12,853,463	48	42	17
Indiana	128,192	1.94	486,473,000	73.78	3,795	6,593,783	33	40	36
Iowa	111,351	3.59	479,100,000	154.27	4,303	3,105,573	13	15	31
Kansas	131,963	4.58	357,600,000	124.11	2,710	2,881,261	3	21	48
Kentucky	158,084	3.60	259,400,000	59.03	1,641	4,394,020	12	45	51
Louisiana	48,828	1.05	223,716,000	48.31	4,582	4,630,784	47	47	28
Maine[b]	68,116	5.13	481,988,765	362.75	7,076	1,328,700	1	1	12
Maryland[b]	165,346	2.78	1,138,600,000	191.45	6,886	5,947,280	22	13	13
Massachusetts[a]	32,046	0.48	763,400,000	113.27	—[d]	6,739,788	51	23	n
Michigan[b]	251,019	2.53	1,232,600,000	124.43	4,910	9,905,670	24	20	25
Minnesota	200,568	3.68	1,064,081,317	195.09	5,305	5,454,343	10	12	24
Mississippi	91,818	3.08	294,723,000	98.93	3,210	2,978,985	18	29	43
Missouri	74,670	1.24	628,392,273	103.94	8,416	6,045,759	41	27	9
Montana	39,634	3.89	229,826,586	225.38	5,799	1,019,749	7	8	21
Nebraska[a]	22,579	1.20	140,149,583	74.76	6,207	1,874,773	43	38	18
Nevada	30,358	1.07	255,700,000	90.44	8,423	2,827,183	45	36	8
New Hampshire	46,749	3.53	195,443,878	147.46	4,181	1,325,422	14	16	33
New Jersey	347,245	3.89	1,902,860,000	213.12	5,480	8,928,508	6	11	23

State	Total Clients Served: 2014 URS	Percent of State Population Served	Total SMHA MH Expenditures: FY 2014, $	FY 2014 per Capita (Population) Expenditures, %	2014 Expenditures per Client, $	State Population (2014 Civilian)	Client Utilization Rank	Per Capita Rank	Expenditure per Client Rank
New Mexico[a,c]	93,300	4.50	300,796,588	145.11	3,224	2,072,862	4	17	42
New York	729,421	3.70	4,952,100,000	251.12	6,789	19,720,081	9	6	14
North Carolina	219,448	2.23	989,552,016	100.59	4,509	9,837,634	28	28	29
North Dakota	17,322	2.37	69,014,123	94.23	3,984	732,431	25	33	34
Ohio[a]	398,720	3.44	1,121,200,000	96.79	2,812	11,584,339	15	30	47
Oklahoma	79,751	2.07	228,730,000	59.29	2,868	3,857,974	31	44	46
Oregon	120,566	3.04	931,800,000	234.87	7,729	3,967,379	20	7	11
Pennsylvania[a]	615,570	4.82	3,664,900,000	286.76	5,954	12,780,269	2	5	19
Puerto Rico[a]	15,721	0.44	72,690,833	20.22	4,624	3,595,839	52	52	27
Rhode Island	32,100	3.05	111,123,514	105.72	3,462	1,051,133	19	26	40
South Carolina	80,864	1.69	275,400,000	57.49	3,406	4,790,211	37	46	41
South Dakota	15,277	1.80	73,724,628	86.77	4,826	849,611	35	37	26
Tennessee	249,308	3.82	619,200,000	94.86	2,484	6,527,724	8	31	49
Texas[b]	324,439	1.21	1,213,500,000	45.23	3,740	26,832,262	42	48	37
Utah[b]	48,567	1.65	213,200,000	72.58	4,390	2,937,638	38	41	30
Vermont	24,500	3.91	203,000,000	324.28	8,286	626,000	5	3	10
Virginia[b]	112,944	1.38	764,300,000	93.08	6,767	8,211,651	40	34	15
Washington	151,618	2.16	900,300,000	128.46	5,938	7,008,603	29	19	20
West Virginia[a]	57,811	3.13	170,800,000	92.37	2,954	1,849,064	16	35	45
Wisconsin[b]	100,901	1.75	644,800,000	112.05	6,390	5,754,380	36	24	16
Wyoming[a]	17,491	3.01	63,076,534	108.56	3,606	581,037	21	25	39
Total	7,289,756	2.27	40,831,941,067	127.11	5,601	321,226,964	—[e]	—[e]	—[e]
Average	140,188	2.48	785,229,636	133.64	5,512	6,177,442			
Median	93,079	2.32	419,916,388	104.83	4,826	4,180,700			
Minimum	9,830	0.44	59,200,000	20.22	1,641	581,037			

Abbreviations: FY, fiscal year; MH, mental health; NA, not applicable; SMHA, state mental health agency; URS, Uniform Reporting System.

Notes: Total clients served from URS Table 2. Expenditures per client divides total served by SMHA expenditures.

[a] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[b] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[c] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[d] Massachusetts reported expenditures for their Medicaid Managed Care System, but URS data do not include clients that system serves.

[e] No summary statistics are calculated for rank.

SMHA Expenditures by Type of Mental Health Program

Every SMHA funds or operates community mental health programs, and every state operates state psychiatric inpatient beds (usually provided in a facility called a *state psychiatric hospital*). In FY 2014, SMHAs spent $30.6 billion providing community-based mental health services, which represented 75.0 percent of total SMHA expenditures. Expenditures for state psychiatric hospital-inpatient services were an additional $9.4 billion, representing 23.0 percent of total SMHA expenditures. SMHAs spent an additional $845 million (2.1 percent) on administration, prevention, research, and training they conducted (see Figure 48 and Table 25).

Figure 48. State Mental Health Agency Controlled Expenditures by Type of Mental Health Program, FY 2014

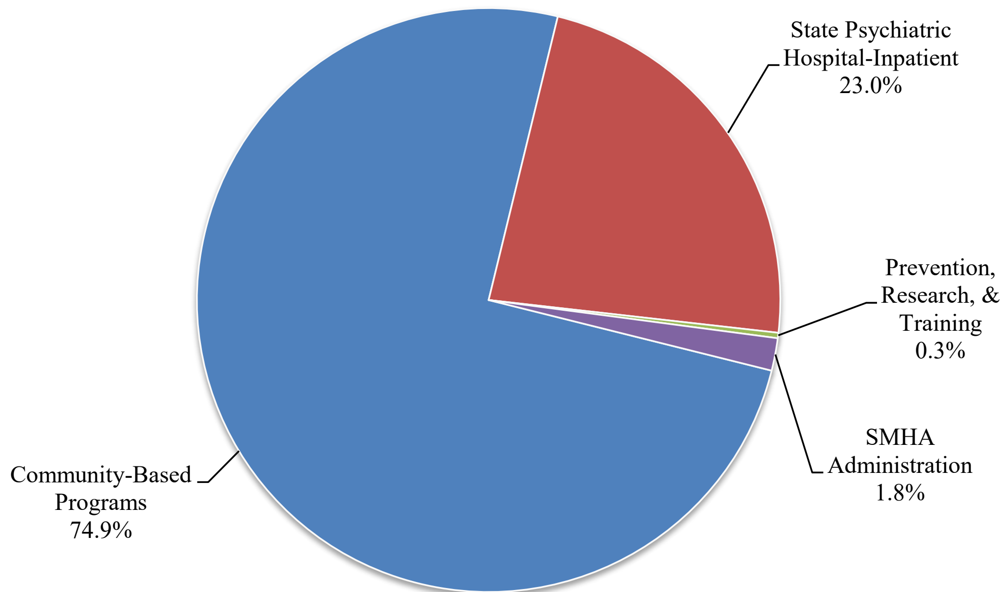


Table 25. State Mental Health Agency Controlled Expenditures and Per Capita Expenditures by Type of Mental Health Program and State, FY 2014

State	State Psychiatric Hospital Inpatient			Community Based Programs			Prevention, Research, Training, and Administration			Total SMHA Expenditures	
	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Total, $	Per Capita, $
Alabama	99,620,000	20.61	28	253,312,776	52.40	70	7,800,000	1.61	2	360,732,776	74.62
Alaska	27,202,302	38.07	12	192,947,874	270.00	85	6,372,600	8.92	3	226,522,776	316.98
Arizona	72,300,000	10.77	5	1,365,100,000	203.39	94	18,200,000	2.71	1	1,455,600,000	216.87
Arkansas[a]	48,387,972	16.35	38	74,507,177	25.17	59	4,322,451	1.46	3	127,217,599	42.98
California[b,c]	1,246,283,472	32.25	18	5,479,791,841	141.78	81	36,733,684	0.95	1	6,762,808,997	174.98
Colorado	120,900,000	22.73	19	522,145,787	98.15	81	5,434,171	1.02	1	648,479,958	121.90
Connecticut[a]	211,400,000	58.90	26	538,600,000	150.07	67	53,000,000	14.77	7	803,000,000	223.73
Delaware	32,082,814	34.43	36	53,614,212	57.54	61	2,567,941	2.76	3	88,264,967	94.73
District of Columbia	87,019,956	132.75	40	84,560,728	129.00	38	48,122,034	73.41	22	219,702,718	335.16
Florida[a,b]	326,300,000	16.46	46	366,700,000	18.50	51	21,700,000	1.09	3	714,700,000	36.05
Georgia[b]	214,629,046	21.40	36	388,754,592	38.75	64	0	0	0	603,383,638	60.15
Hawaii	67,500,000	49.19	36	113,065,000	82.39	60	7,500,000	5.47	4	188,065,000	137.04
Idaho	27,800,000	17.05	47	28,600,000	17.54	48	2,800,000	1.72	5	59,200,000	36.31
Illinois	232,400,000	18.08	27	606,100,000	47.15	71	18,500,000	1.44	2	857,000,000	66.67
Indiana	156,920,000	23.80	32	323,901,000	49.12	67	5,652,000	0.86	1	486,473,000	73.78
Iowa	49,000,000	15.78	10	418,800,000	134.85	87	11,300,000	3.64	2	479,100,000	154.27
Kansas	89,800,000	31.17	25	266,600,000	92.53	75	1,200,000	0.42	0	357,600,000	124.11
Kentucky	128,200,000	29.18	49	121,600,000	27.67	47	9,600,000	2.18	4	259,400,000	59.03
Louisiana	110,688,000	23.90	49	113,028,000	24.41	51	0	0	0	223,716,000	48.31
Maine[b]	51,671,164	38.89	11	417,905,735	314.52	87	12,411,866	9.34	3	481,988,765	362.75
Maryland[b]	247,000,000	41.53	22	860,400,000	144.67	76	31,200,000	5.25	3	1,138,600,000	191.45
Massachusetts[a]	97,400,000	14.45	13	642,300,000	95.30	84	23,700,000	3.52	3	763,400,000	113.27
Michigan[b]	251,100,000	25.35	20	974,900,000	98.42	79	6,600,000	0.67	1	1,232,600,000	124.43
Minnesota	130,404,443	23.91	12	926,017,064	169.78	87	7,659,810	1.40	1	1,064,081,317	195.09
Mississippi	112,666,000	37.82	38	178,012,000	59.76	60	4,045,000	1.36	1	294,723,000	98.93
Missouri	256,991,894	42.51	41	351,469,803	58.13	56	19,930,577	3.30	3	628,392,273	103.94
Montana	32,370,888	31.74	14	194,779,674	191.01	85	2,676,024	2.62	1	229,826,586	225.38
Nebraska[a]	46,874,840	25.00	33	90,705,576	48.38	65	2,569,167	1.37	2	140,149,583	74.76
Nevada	70,600,000	24.97	28	177,600,000	62.82	69	7,500,000	2.65	3	255,700,000	90.44
New Hampshire	57,642,923	43.49	29	135,963,768	102.58	70	1,837,187	1.39	1	195,443,878	147.46
New Jersey	530,711,000	59.44	28	1,346,292,000	150.79	71	25,857,000	2.90	1	1,902,860,000	213.12
New Mexico[a,c]	28,900,000	13.94	10	271,896,588	131.17	90	0	0	0	300,796,588	145.11

State	State Psychiatric Hospital Inpatient			Community Based Programs			Prevention, Research, Training, and Administration			Total SMHA Expenditures	
	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Total, $	Per Capita, $
New York	1,218,000,000	61.76	25	3,503,700,000	177.67	71	230,400,000	11.68	5	4,952,100,000	251.12
North Carolina	325,479,918	33.09	33	652,196,087	66.30	66	11,876,011	1.21	1	989,552,016	100.59
North Dakota	14,193,055	19.38	21	54,738,736	74.74	79	82,332	0.11	0	69,014,123	94.23
Ohio[a]	223,600,000	19.30	20	858,500,000	74.11	77	39,100,000	3.38	3	1,121,200,000	96.79
Oklahoma	43,650,000	11.31	19	170,701,000	44.25	75	14,379,000	3.73	6	228,730,000	59.29
Oregon	207,200,000	52.23	22	720,800,000	181.68	77	3,800,000	0.96	0	931,800,000	234.87
Pennsylvania[a]	357,100,000	27.94	10	3,294,400,000	257.77	90	13,400,000	1.05	0	3,664,900,000	286.76
Puerto Rico[a]	37,851,896	10.53	52	34,838,937	9.69	48	0	0	0	72,690,833	20.22
Rhode Island	38,914,515	37.02	35	70,519,604	67.09	63	1,689,395	1.61	2	111,123,514	105.72
South Carolina	104,700,000	21.86	38	157,800,000	32.94	57	12,900,000	2.69	5	275,400,000	57.49
South Dakota	46,223,035	54.40	63	26,923,088	31.69	37	578,505	0.68	1	73,724,628	86.77
Tennessee	128,700,000	19.72	21	475,700,000	72.87	77	14,800,000	2.27	2	619,200,000	94.86
Texas[b]	417,588,693	15.56	34	760,746,331	28.35	63	35,164,976	1.31	3	1,213,500,000	45.23
Utah[b]	55,200,000	18.79	26	156,800,000	53.38	74	1,200,000	0.41	1	213,200,000	72.58
Vermont	14,000,000	22.36	7	182,200,000	291.05	90	6,800,000	10.86	3	203,000,000	324.28
Virginia[b]	344,700,000	41.98	45	388,300,000	47.29	51	31,300,000	3.81	4	764,300,000	93.08
Washington	239,200,000	34.13	27	642,800,000	91.72	71	18,300,000	2.61	2	900,300,000	128.46
West Virginia[a]	54,100,000	29.26	32	116,200,000	62.84	68	500,000	0.27	0	170,800,000	92.37
Wisconsin[b]	211,800,000	36.81	33	431,700,000	75.02	67	1,300,000	0.23	0	644,800,000	112.05
Wyoming[a]	32,036,244	55.14	51	30,255,714	52.07	48	784,576	1.35	1	63,076,534	108.56
Total	9,377,004,070	29.19	23	30,609,790,692	95.29	75	845,146,307	2.63	2	40,831,941,067	127.11
Average (mean)	108,327,001	31.89	29	588,649,821	97.70	69	16,902,926	4.05	2	785,229,636	133.64
Median	102,160,000	26.65	28	297,898,794	73.49	70	7,579,905	1.54	2	419,916,388	104.83

Abbreviations: FY, fiscal year; SMHA, state mental health agency

Note: Community-based programs includes ambulatory and residential services in state psychiatric hospitals.

[a] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[b] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[c] Children's mental health expenditures are not included in SMHA-controlled expenditures.

SMHA-Controlled Expenditures by Age of Individuals Served

In FY 2014, SMHAs expended $26.7 billion (65.4 percent to total expenditures) on mental health services for individuals aged 18 years and over and $10.4 billion (25.5 percent) on mental health services for children and adolescents aged 0 to 17 years. Because of the way that SMHAs allocate funding to community mental health programs and SMHA central office functions such as research, evaluation, training, prevention and health promotion, 9.1 percent ($3.7 billion) of funds were not allocated to specific age groups. Per capita expenditures for children's mental health services that SMHAs provided were $142.37 per child in the country, which was slightly higher than the $108.20 per adult in the country (see Table 26).

Expenditures for inpatient services for children (aged 17 years and younger) served in state psychiatric hospitals were $421 million (4.5 percent of state psychiatric hospital inpatient expenditures). It should be noted that many states do not serve children in their state psychiatric hospitals, and in FY 2014 there were 25 states that reported no state psychiatric hospital expenditures for children.

Expenditures for children's mental health services were much higher in community mental health programs than in state psychiatric hospitals. Among community mental health services, children's mental health expenditures totaled $9.9 billion (33 percent of total SMHA community mental health expenditures) (Figure 49). Expenditures for adult community mental health systems served totaled $17.2 billion (58 percent), and $2.7 billion (9 percent) of community mental health expenditures could not be allocated by age group.

Table 26. State Mental Health Agency Controlled Total and per Capita Expenditures, by Age Group, FY 2014 (in Millions)

State	Children/Adolescents (Age 0 17)			Adults/Elderly (Age 18 and Older)			Unallocated By Age			Total SMHA	
	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Expenditures, $	Per Capita, $
Alabama	30.7	27.76	9	184.5	49.5	51	145.5	30.10	40	360.7	74.62
Alaska	118.9	637.50	52	101.2	191.7	45	6.4	8.92	3	226.5	316.98
Arizona	450.6	277.86	31	986.8	193.9	68	18.2	2.71	1	1,455.6	216.87
Arkansas[a]	12.2	17.29	10	63.3	28.1	50	51.7	17.45	41	127.2	42.98
California[b,c]	1,978.0	216.11	29	4,151.9	140.8	61	632.8	16.37	9	6,762.8	174.98
Colorado	176.4	141.53	27	463.0	113.7	71	9.1	1.72	1	648.5	121.90
Connecticut[a]	0.0	0.00	0	750.0	266.6	93	53.0	14.77	7	803.0	223.73
Delaware	0.0	0.00	0	85.7	117.8	97	2.6	2.76	3	88.3	94.73
District of Columbia	27.9	242.11	13	143.7	265.9	65	48.1	73.41	22	219.7	335.16
Florida[a,b]	89.1	21.98	12	603.9	38.3	84	21.7	1.09	3	714.7	36.05
Georgia	88.3	35.43	15	515.0	68.3	85	NA	0.00	NA	603.4	60.15
Hawaii	31.1	100.72	17	149.5	140.5	79	7.5	5.47	4	188.1	137.04
Idaho	12.2	28.30	21	44.2	36.9	75	2.8	1.72	5	59.2	36.31
Illinois	225.9	75.59	26	612.6	62.1	71	18.5	1.44	2	857.0	66.67
Indiana	113.5	71.72	23	367.4	73.3	76	5.7	0.86	1	486.5	73.78
Iowa	162.6	223.98	34	305.2	128.3	64	11.3	3.64	2	479.1	154.27
Kansas	136.1	188.33	38	180.2	83.5	50	41.3	14.33	12	357.6	124.11
Kentucky	51.6	50.96	20	197.9	58.5	76	9.9	2.25	4	259.4	59.03
Louisiana	15.5	13.93	7	208.2	59.2	93	NA	0.00	NA	223.7	48.31
Maine[b]	184.0	710.62	38	285.5	266.9	59	12.4	9.34	3	482.0	362.75
Maryland[b]	316.1	234.05	28	707.3	153.9	62	115.2	19.37	10	1,138.6	191.45
Massachusetts[a]	86.6	62.28	11	653.1	122.1	86	23.7	3.52	3	763.4	113.27
Michigan[b]	228.7	102.84	19	997.3	129.8	81	6.6	0.67	1	1,232.6	124.43
Minnesota	323.5	252.39	30	732.9	175.7	69	7.7	1.40	1	1,064.1	195.09
Mississippi	93.4	127.74	32	197.3	87.8	67	4.0	1.36	1	294.7	98.93
Missouri	86.7	62.28	14	521.7	112.1	83	19.9	3.30	3	628.4	103.94
Montana	114.6	509.26	50	112.6	141.6	49	2.7	2.62	1	229.8	225.38
Nebraska[a]	14.4	30.81	10	123.2	87.5	88	2.6	1.37	2	140.1	74.76
Nevada	27.3	41.16	11	139.2	64.3	54	89.2	31.55	35	255.7	90.44
New Hampshire	45.4	170.02	23	148.2	140.0	76	1.8	1.39	1	195.4	147.46
New Jersey	336.6	167.30	18	1,466.2	212.0	77	100.1	11.21	5	1,902.9	213.12
New Mexico[a,c]	2.9	5.85	1	297.9	189.6	99	NA	0.00	NA	300.8	145.11
New York	718.1	169.81	15	2,884.0	186.2	58	1,350.0	68.46	27	4,952.1	251.12

State	Children/Adolescents (Age 0 17)			Adults/Elderly (Age 18 and Older)			Unallocated By Age			Total SMHA	
	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Total, $	Per Capita, $	%	Expenditures, $	Per Capita, $
North Carolina	392.7	171.69	40	578.3	76.6	58	18.6	1.89	2	989.6	100.59
North Dakota	3.6	21.49	5	65.3	115.8	95	0.1	0.11	0	69.0	94.23
Ohio[a]	412.1	156.20	37	670.0	74.9	60	39.1	3.38	3	1,121.2	96.79
Oklahoma	24.6	25.84	11	189.7	65.3	83	14.4	3.73	6	228.7	59.29
Oregon	296.7	345.80	32	627.1	201.7	67	8.0	2.02	1	931.8	234.87
Pennsylvania[a]	2,109.9	781.19	58	1,526.1	151.4	42	28.9	2.26	1	3,664.9	286.76
Puerto Rico[a]	8.6	10.64	12	64.1	23.0	88	NA	0.00	NA	72.7	20.22
Rhode Island	0.0	0.00	0	109.4	130.5	98	1.7	1.61	2	111.1	105.72
South Carolina	60.0	55.32	22	202.5	54.6	74	12.9	2.69	5	275.4	57.49
South Dakota	14.5	69.01	20	36.9	57.7	50	22.3	26.30	30	73.7	86.77
Tennessee	205.1	137.23	33	399.3	79.3	64	14.8	2.27	2	619.2	94.86
Texas[b]	157.3	22.11	13	1,021.0	51.8	84	35.2	1.31	3	1,213.5	45.23
Utah[b]	70.8	78.31	33	127.2	62.6	60	15.2	5.17	7	213.2	72.58
Vermont	91.0	748.44	45	105.2	208.6	52	6.8	10.86	3	203.0	324.28
Virginia[b]	126.2	67.52	17	606.8	95.7	79	31.3	3.81	4	764.3	93.08
Washington	136.5	85.17	15	606.1	112.1	67	157.7	22.50	18	900.3	128.46
West Virginia[a]	3.0	7.89	2	127.9	87.1	75	39.9	21.58	23	170.8	92.37
Wisconsin[b]	8.5	6.54	1	203.3	45.6	32	433.0	75.25	67	644.8	112.05
Wyoming[a]	0.8	6.00	1	61.5	138.8	97	0.8	1.35	1	63.1	108.56
Total	10,420.80	142.37	25	26,708.30	108.20	65	3,702.70	11.53	9	40,831.90	127.11
Average	200.4	150.27	21	513.6	115.76	71	77.1	10.44	9	785.2	133.64

Abbreviations: FY, fiscal year; SMHA, state mental health agency; NA, not applicable because services provided but exact expenditures are unallocatable.

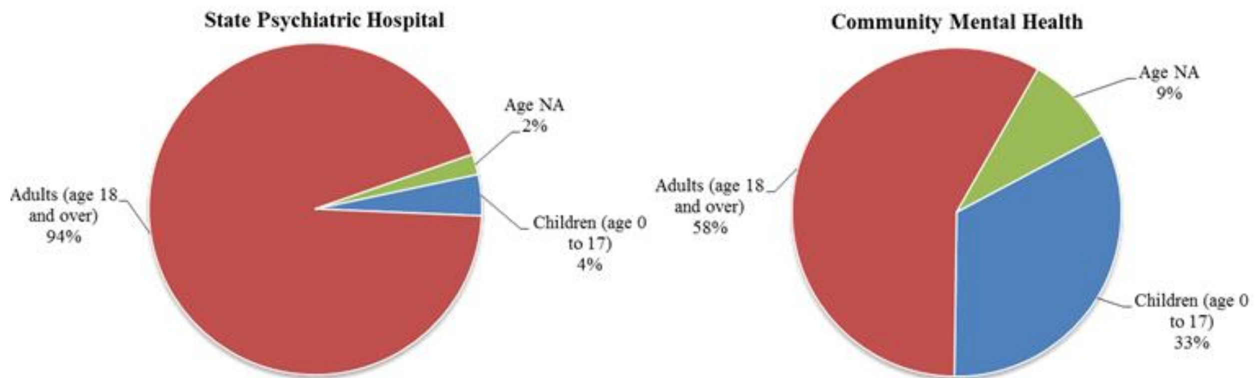
Note: In Connecticut, Delaware, and Rhode Island, a separate state agency is responsible for providing mental health services to children.

[a] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[b] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[c] Children's mental health expenditures are not included in SMHA-controlled expenditures.

Figure 49. Expenditures for Mental Health Services in State Psychiatric Hospital and Community Mental Health Programs, by Age, FY 2014



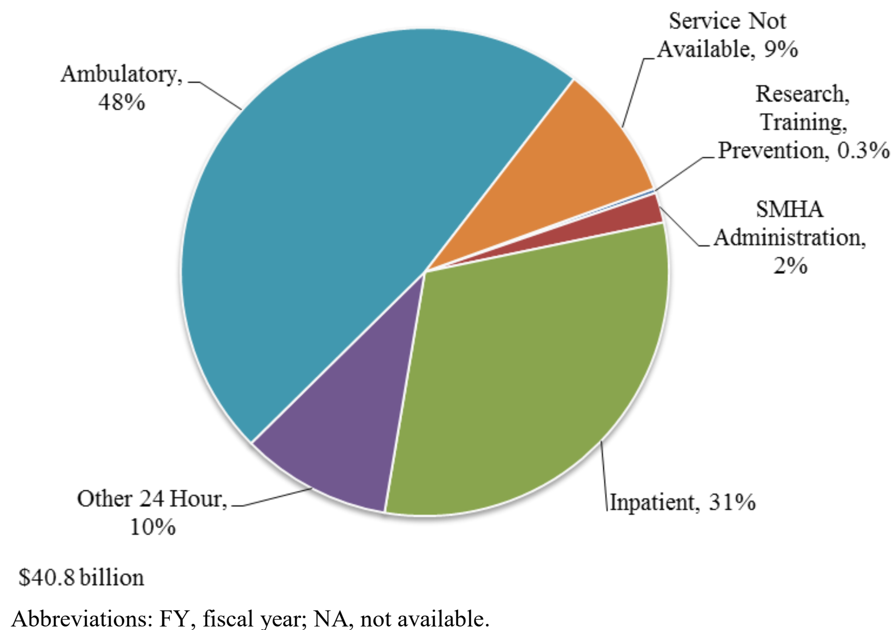
Abbreviations: FY, fiscal year; NA, not available.

Expenditures by Type of Mental Health Service

SMHAs provide mental health services in a variety of settings and a variety of intensity levels. These services range from providing psychiatric inpatient care in state psychiatric hospitals and purchasing inpatient care in local general hospitals to other 24-hour care in residential settings less intensive than inpatient care and a variety of ambulatory (outpatient-based) services and supports. Ambulatory services include those provided for less than 24 hours and include individual and group outpatient therapy, medication monitoring, and case management. They also include more intensive day services such as ACT team services and supports, supported employment, supportive housing, psychosocial rehabilitation, and day treatment.

In FY 2014, SMHAs spent almost half (48 percent at $19.5 billion) of their funds for ambulatory services and 31 percent of their funds for inpatient care (Figure 50). SMHAs provided other 24-hour residential care to support individuals who needed a safe and secure bed while they were receiving treatment. SMHAs expended $3.9 billion (10 percent) providing these other 24-hour residential services and supports.

Figure 50. Total SMHA-Controlled Expenditures by Type of Mental Health Services, FY 2014



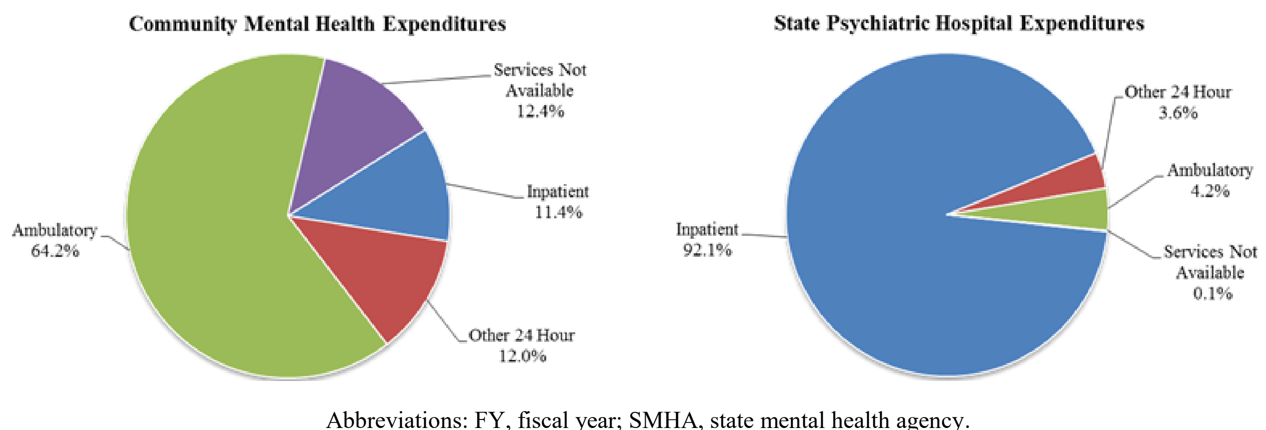
Abbreviations: FY, fiscal year; NA, not available.

Most ambulatory services were provided through the SMHA's community mental health system, but in seven states the state's psychiatric hospitals provided $428 million of ambulatory services. In some states, the state hospital may offer these hospital-based, outpatient ambulatory services in clinics it operates, which may be located off the hospital's grounds.

Most psychiatric inpatient care (73 percent) was provided at state psychiatric hospitals, but 27 percent of inpatient expenditures were for the purchase of psychiatric inpatient care through community mental health providers at general hospitals or private psychiatric hospitals. In FY 2014, community mental health systems provided more than $3.4 billion of psychiatric inpatient care (11.4 percent of community programs).

Figure 51 shows the distribution of mental health service expenditures at state psychiatric hospitals and community mental health programs.

Figure 51. Community Mental Health and State Psychiatric Hospital Expenditures, by Type of Mental Health Service, FY 2014



Abbreviations: FY, fiscal year; SMHA, state mental health agency.

Funding Sources for SMHA Mental Health Services

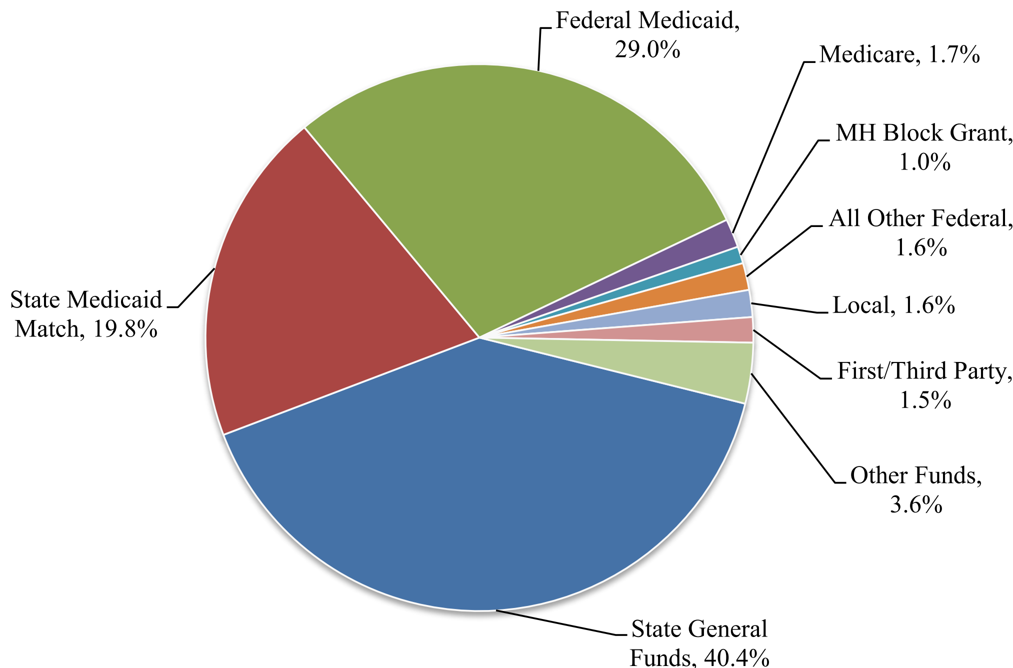
States use a mixture of state, federal, local, and other funding sources to finance the SMHA's mental health service system, and each state's financing mixture is unique. In FY 2014, SMHAs reported a total of $41.2 billion in total SMHA-controlled revenues for mental health, of which 60 percent ($24.8 billion) came from state government sources. The largest single state government source of SMHA funds was state general revenue funds of $15.6 billion (38 percent of total funds), followed by state Medicaid match funds of $8.2 billion and state special revenues of $1 billion).

The federal government was the second largest payer (33 percent) of SMHA mental health services. The federal share of Medicaid was the largest single federal payment source at $11.9 billion (29 percent of total SMHA funds), followed by Medicare (1.7 percent), the MHBG (1.0 percent), and other federal funds (1.1 percent). Cities and county governments contributed their own local tax dollars to pay for SMHA mental health services in 11 states, and local funds accounted for $0.7 billion (1.6 percent of total SMHA funds). SMHAs received only 1.5 percent of their funds from first-party and third-party payments (insurance payments and copays for services). All other sources—which include donations, funds from foundations, and other sources—contributed an additional $1.5 billion (4 percent).

All Medicaid funds (combining the state match with the federal Medicaid match) were the largest single payment source at $20.1 billion (49 percent of all SMHA funds). See

Figure 51 and Table 27 for details regarding the total SMHA revenues by funding source.

Figure 52. Percentage of SMHA-Controlled Revenues for Mental Health Services by Funding Sources, FY 2014



Abbreviations: FY, fiscal year; MH, mental health; SMHA, state mental health agency.
Note: Percentages may not total 100 percent because of rounding.

Table 27 shows that states vary widely in how much they rely on Medicaid or state general revenue funds. States ranged from relying primarily on general funds in states like Wyoming (99 percent), Puerto Rico (91 percent), the District of Columbia (87 percent), and Connecticut (87 percent) to a few states that receive very little of their funds from state general funds, such as Vermont (less than 1 percent), Rhode Island (5 percent), and Iowa (5 percent). Medicaid contributes more than 80 percent of SMHA funds in Vermont (97 percent), Rhode Island (87 percent), Arizona (84 percent), and Maine (83 percent). States that organize their community mental health system through counties had the highest use of local government funds: Wisconsin (20 percent), Minnesota (10 percent), and Iowa (9 percent).

Table 27. State Mental Health Agency Controlled Mental Health Revenues by Revenue Source, FY 2014

State	State General Funds		Total Medicaid		Medicare		MHBG		Other Federal		Local Government		Other Funds		Total SMHA Revenues	
	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in million s)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	Per Capita
Alabama	170.0	49	162.3	47	9.8	3	5.3	1.5	0.9	<1	0.0	0	0.1	<1	348.4	72.1
Alaska	42.3	19	164.1	72	3.3	1	0.6	0.2	0.6	<1	0.0	0	17.1	7	227.9	319.0
Arizona	161.8	11	1,215.8	84	0.4	<1	9.2	0.6	2.6	<1	0.0	0	58.0	4	1,447.8	215.7
Arkansas[a]	80.7	64	35.4	28	3.7	3	3.6	2.8	0.6	1	0.0	0	2.9	2	127.0	42.9
California[b,c]	2,737.5	40	2,702.0	40	31.3	0	58.4	0.9	110.0	2	0.0	0	1,123.6	17	6,762.8	175.0
Colorado	150.4	23	475.7	73	8.4	1	6.1	0.9	4.8	1	0.0	0	3.0	<1	648.5	121.9
Connecticut[a]	771.9	87	81.2	9	0.4	0	4.3	0.5	16.5	2	0.0	0	12.5	1	886.8	247.1
Delaware	87.6	84	14.2	14	0.6	1	0.6	0.6	0.8	1	0.0	0	0.5	<1	104.3	111.9
District of Columbia	191.0	87	12.1	5	2.9	1	0.7	0.3	12.8	6	0.0	0	0.2	<1	219.7	335.2
Florida[a,b]	557.9	77	116.9	16	0.0	0	29.9	4.2	15.2	2	0.0	0	0.0	0	719.9	36.3
Georgia[b]	519.4	86	7.7	1	3.9	1	12.6	2.1	15.2	3	0.0	0	44.6	7	603.4	60.1
Hawaii	162.0	84	25.3	13	0.3	0	2.1	1.1	3.9	2	0.0	0	0.1	<1	193.6	141.1
Idaho	42.7	72	5.5	9	3.3	6	0.7	1.2	5.5	9	0.0	0	1.5	3	59.2	36.3
Illinois	537.5	59	339.8	38	2.3	0	14.8	1.6	10.0	1	0.0	0	1.6	<1	906.0	70.5
Indiana	175.6	36	290.5	60	2.9	1	7.7	1.6	9.2	2	0.0	0	0.7	<1	486.5	73.8
Iowa	23.7	5	370.1	77	3.7	1	2.7	0.6	14.5	3	44.2	9	24.9	5	483.8	155.8
Kansas	109.0	30	234.5	66	10.0	3	3.4	1.0	0.7	<1	0.0	0	0.0	0	357.6	124.1
Kentucky	155.0	60	79.3	31	12.5	5	5.8	2.2	2.4	1	0.0	0	4.4	2	259.4	59.0
Louisiana	150.3	67	56.2	25	1.1	0	4.1	1.8	3.3	1	0.0	0	8.7	4	223.7	48.3
Maine[b]	48.3	10	400.9	83	6.3	1	1.5	0.3	25.0	5	0.0	0	0.0	0	482.0	362.8
Maryland[b]	699.7	61	410.4	36	0.0	0	7.3	0.6	21.2	2	0.0	0	0.0	0	1,138.6	191.4
Massachusetts[a]	749.8	85	106.0	12	6.5	1	8.9	1.0	4.7	1	0.0	0	2.5	<1	878.4	130.3
Michigan[b]	250.1	20	931.7	76	13.4	1	9.9	0.8	0.5	<1	26.7	2	0.3	<1	1,232.6	124.4
Minnesota	226.0	21	667.0	63	9.2	1	6.4	0.6	9.7	1	108.5	10	37.3	4	1,064.1	195.1
Mississippi	117.6	40	104.0	35	6.2	2	4.0	1.4	4.0	1	0.0	0	58.9	20	294.7	98.9
Missouri	339.8	44	387.2	50	6.7	1	7.9	1.0	28.7	4	0.0	0	1.4	0	771.6	127.6
Montana	54.7	24	172.7	75	0.0	0	1.2	0.5	1.2	1	0.0	0	0.0	0	229.8	225.4
Nebraska[a]	100.6	72	0.4	<1	4.7	3	1.8	1.3	0.8	1	0.0	0	31.8	23	140.1	74.8
Nevada	136.1	53	58.0	23	3.7	1	4.3	1.7	51.7	20	0.0	0	1.9	1	255.7	90.4
New Hampshire	44.2	23	115.6	59	13.6	7	1.4	0.7	15.0	8	0.0	0	5.7	3	195.4	147.5
New Jersey	1,078.9	57	553.2	29	51.6	3	13.1	0.7	9.4	<1	116.2	6	80.5	4	1,902.9	213.1
New Mexico[a,c]	114.2	38	180.2	60	1.1	<1	1.7	0.6	3.5	1	0.0	0	0.0	0	300.8	145.1

State	State General Funds		Total Medicaid		Medicare		MHBG		Other Federal		Local Government		Other Funds		Total SMHA Revenues	
	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in million s)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	%	$ (in millions)	Per Capita
New York	1,346.1	28	2,634.3	54	309.2	6	25.0	0.5	98.4	2	91.3	2	372.1	8	4,876.4	247.3
North Carolina	416.2	42	517.2	52	23.0	2	11.6	1.2	1.5	<1	0.0	0	20.0	2	989.6	100.6
North Dakota	35.2	52	12.6	19	2.9	4	0.3	0.4	4.1	6	0.0	0	12.9	19	68.1	93.0
Ohio[a]	433.6	37	621.1	54	5.2	0	14.1	1.2	15.0	1	69.6	6	1.9	<1	1,160.6	100.2
Oklahoma	156.5	68	48.9	21	5.0	2	5.8	2.5	5.9	3	0.0	0	6.6	3	228.7	59.3
Oregon	273.5	29	643.4	69	2.9	0	4.5	0.5	1.6	<1	0.0	0	5.6	1	931.5	234.8
Pennsylvania[a]	819.0	22	2,762.6	75	13.5	0	13.7	0.4	27.0	1	19.1	1	10.0	<1	3,664.9	286.8
Puerto Rico[a]	66.8	91	0.0	0	0.0	0	5.9	8.1	1.0	1	0.0	0	0.0	0	73.7	20.5
Rhode Island	6.1	5	97.2	87	0.0	0	1.3	1.2	6.6	6	0.0	0	0.0	0	111.1	105.7
South Carolina	88.0	32	159.3	57	5.3	2	6.0	2.2	2.5	1	3.6	1	14.1	5	278.8	58.2
South Dakota	40.6	56	24.8	34	4.8	7	0.8	1.1	0.8	1	0.0	0	0.4	1	72.2	85.0
Tennessee	185.2	30	405.5	65	7.5	1	8.4	1.4	8.9	1	0.0	0	3.7	1	619.2	94.9
Texas[b]	791.5	65	204.3	17	27.5	2	34.8	2.9	43.3	4	32.4	3	79.7	7	1,213.5	45.2
Utah[b]	41.8	20	150.4	71	1.0	<1	3.2	1.5	1.2	1	14.0	7	1.6	1	213.2	72.6
Vermont	0.9	<1	196.9	97	0.0	0	0.8	0.4	4.4	2	0.0	0	0.0	0	203.0	324.3
Virginia[b]	487.9	63	244.8	32	21.1	3	9.6	1.2	1.6	<1	0.0	0	8.6	1	773.6	94.2
Washington	172.0	19	676.9	75	24.1	3	8.6	1.0	2.7	<1	0.0	0	16.0	2	900.3	128.5
West Virginia[a]	93.3	55	71.9	42	2.5	1	2.1	1.2	0.3	<1	0.0	0	0.7	<1	170.8	92.4
Wisconsin[b]	332.9	52	160.3	25	6.5	1	6.3	1.0	7.8	1	126.5	20	4.5	1	644.8	112.1
Wyoming[a]	63.4	99	0.0	0	0.0	0	0.5	0.7	0.3	<1	0.0	0	0.0	0	64.1	110.3
Total	16,636.8	40.4	20,108.3	48.8	685.8	1.7	405.3	1.0	639.8	1.6	652.1	1.6	2,083.1	5.1	41,211.1	128.3
Average (mean)	319.9	48.1	386.7	44.4	13.2	1.7	7.8	1.3	12.3	2.8	12.5	1.3	40.1	4.0	792.5	135.4
Median	159.2	49.0	163.2	42.0	4.3	1.0	5.6	1.0	4.6	1.5	0.0	0.0	3.0	2.0	419.8	111.1

Abbreviations: FY, fiscal year; MHBG, Mental Health Block Grant; SMHA, state mental health agency.

[a] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[b] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[c] Children’s mental health expenditures are not included in SMHA-controlled expenditures.

Financing Community Mental Health Services

SMHAs have been very creative in maximizing an array of available funding sources to finance a comprehensive set of community-based mental health treatments and supports. All states received state general revenue funds to pay for mental health services, and these funds were used most often to pay for crisis services, outpatient services, residential support services, psychiatric inpatient care, ACT, residential room and board, and peer- and consumer-run services (see Table 28). Many more states used general revenue funds rather than Medicaid for inpatient, wraparound, and peer/consumer services. States used Medicaid most frequently to fund outpatient, case management, and crisis services.

Table 28. Number of States Using Funding Sources to Finance Community Mental Health Services, by Type of Service, 2015 (N=46 States)

Funding Source	Inpatient Hospital Services	Residential: Room & Board	Residential Support Services	Outpatient Testing & Treatment	Extensive/ Intensive Outpatient	Collateral Treatment	Case Management	Crisis Services	Assertive Community Treatment	Supported Employment	School Based Services	Wraparound Services	In Home Services	Peer/Consumer Run Services	Co occurring MH & SA Services
State general fund	37	37	40	41	37	28	40	44	35	35	29	32	29	37	23
State special funds	7	7	8	10	7	3	5	9	6	3	4	4	5	4	4
State Medicaid match	30	7	26	34	32	16	32	32	25	13	26	20	24	17	14
Medicaid (federal)	22	7	28	41	38	22	39	37	32	16	23	24	27	20	20
Clinic option	5	0	2	17	13	6	5	9	5	1	4	2	2	0	7
Rehabilitation option	2	4	18	25	24	10	16	22	21	7	13	10	19	13	12
Targeted case management	0	0	1	1	2	1	21	2	3	1	0	3	3	2	0
1915(i) option	0	0	2	2	3	0	1	3	1	3	0	0	2	2	0
1115 waiver	9	0	4	8	9	4	7	7	5	5	1	2	3	4	0
1915(b) waiver	5	0	5	9	7	4	7	7	6	4	4	6	7	4	3
1915(c) waiver (HCB)	1	1	6	1	1	1	6	2	0	3	3	5	6	0	4
EPSDT	6	2	5	9	8	5	5	5	1	1	7	6	7	1	1
Other Medicaid	9	0	0	3	3	0	0	2	0	0	2	0	0	0	1
Medicare	23	1	2	16	9	0	0	4	3	0	0	0	1	0	4
Veterans Affairs	5	1	3	6	4	3	4	3	3	3	2	1	2	1	1
SAMHSA MH Block Grant	1	6	16	27	21	10	22	19	14	14	20	20	13	30	10
Social Services Block Grant	1	4	6	5	4	4	8	5	3	4	3	4	3	2	3
Housing and Urban Development	0	9	3	1	0	1	3	1	1	1	0	2	2	1	1
Other federal	1	2	6	2	4	2	5	3	0	4	1	3	1	3	4

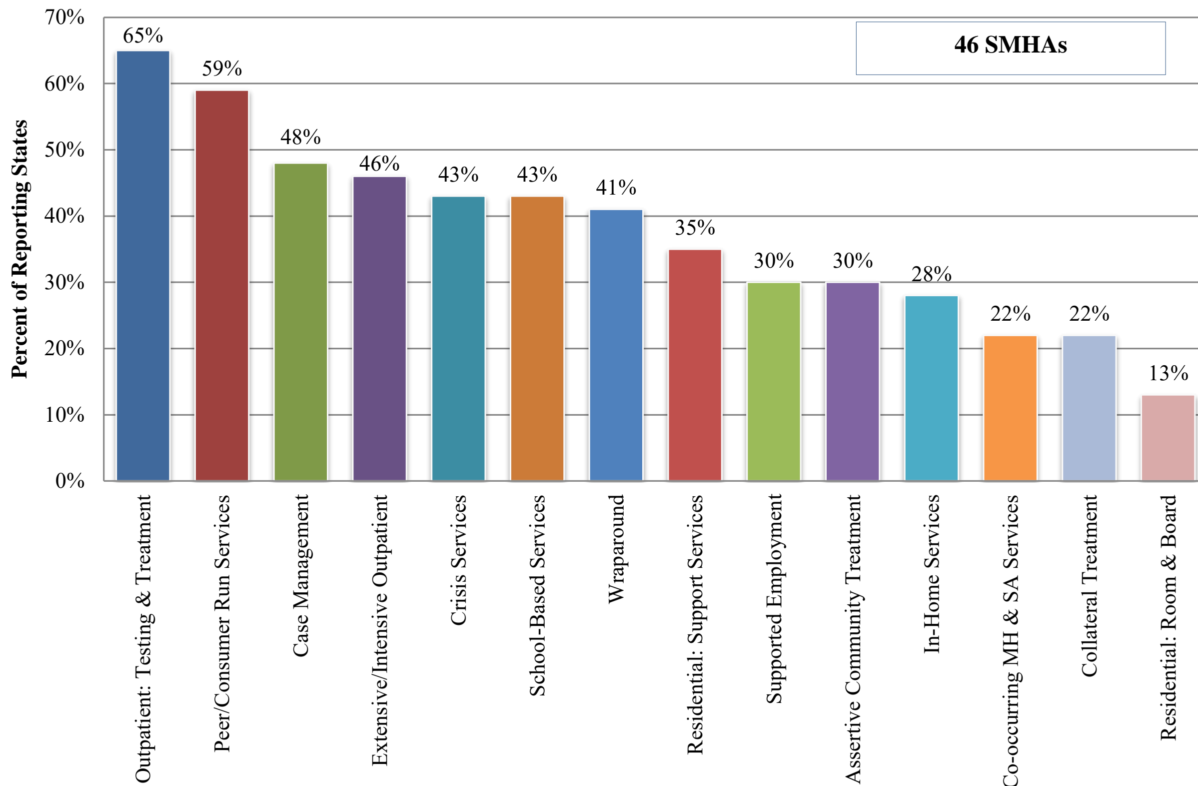
Funding Source	Inpatient Hospital Services	Residential: Room & Board	Residential Support Services	Outpatient Testing & Treatment	Extensive/ Intensive Outpatient	Collateral Treatment	Case Management	Crisis Services	Assertive Community Treatment	Supported Employment	School Based Services	Wraparound Services	In Home Services	Peer/Consumer Run Services	Co occurring MH & SA Services
Local government	12	11	13	16	13	9	14	15	13	10	9	9	10	11	8
First party	17	15	13	21	18	13	17	15	10	7	5	9	10	7	5
Third party	23	8	9	25	20	9	12	15	11	6	6	7	9	6	10
Charity	3	3	3	5	3	2	3	2	1	2	1	2	1	2	0
Other funds	1	0	0	1	1	1	1	1	0	2	2	1	1	1	1

Abbreviations: EPSDT, Early and Periodic Screening, Diagnostic, and Treatment; FY, fiscal year; HCBS, home- and community-based services; MH, mental health; SA, substance abuse; SAMHSA, Substance Abuse and Mental Health Services Administration; SMHA, state mental health agency.

States used the SAMHSA MHBG to pay for a variety of services, with peer and consumer services and outpatient services being the most frequently cited. States also used the MHBG to fund school-based, wraparound, and residential support services (see Figure 53). Six states used the MHBG to fund 10 or more different mental health services. Some states focused their MHBG funds on only one or two mental health services. The following are examples:

- Mississippi used the MHBG to provide co-occurring M/SUD services.
- New Hampshire focused on peer services.
- Hawaii focused on residential support and outpatient services.
- Massachusetts focused on ACT and individual and family flexible support services (individualized and targeted set of interventions and services intended to prevent out-of-home placement, sustain youths with their families and communities, and help youths successfully function in the community).
- Pennsylvania focused on peer and collateral services and supports.

Figure 53. Percentage of SMHAs using the SAMHSA MHBG to Fund Specific Mental Health Services, 2015



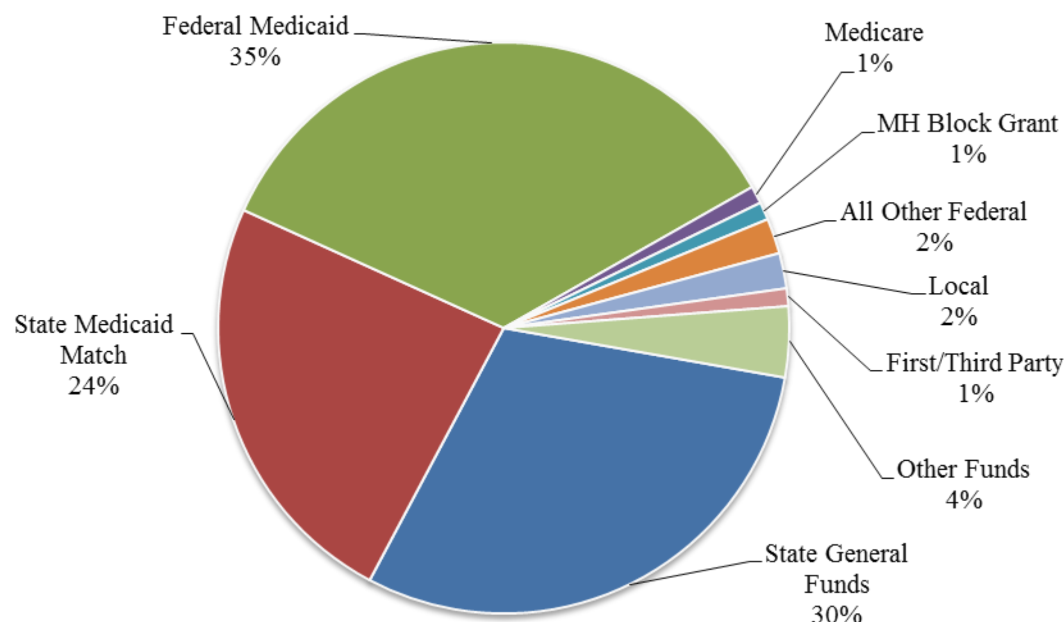
Abbreviations: FY, fiscal year; MH, mental health; MHBG, Mental Health Block Grant; SA, substance abuse; SAMHSA, Substance Abuse and Mental Health Services Administration; SMHA, state mental health agency.

State Mental Health Agency Funding Sources for Community Mental Health Services, FY 2014

Community mental health programs received 73 percent ($29.9 billion) of total SMHA funds in FY 2014. As highlighted in Table 28, most states rely heavily on Medicaid, using a variety of Medicaid options and waivers to finance community mental health services. Medicaid (state and federal shares combined) contributed 59.0 percent ($17.65 billion) of all SMHA community mental health funding in FY 2014, and in 21 states Medicaid represented more than 70 percent of community funding.

State government sources contributed $16.0 billion to community mental health services, divided between state general funds ($8.2 billion), the state Medicaid match ($7.2 billion), and state special funds ($591.5 million). Federal government sources contributed $11.8 billion (39.3 percent) to SMHA community mental health services. Medicaid by far was the largest single federal funding source ($10.5 billion), followed by the SAMHSA MHBG ($390.3 million), Medicare ($319.6 million), and other federal funds ($401.5 million). See Figure 54 for percentage of funding sources for community mental health services.

Figure 54. Funding Sources for Community Mental Health Services, FY 2014



Abbreviations: FY, fiscal year; MH, mental health.

Financing State Psychiatric Hospitals, FY 2014

State general funds were the major funding source for state psychiatric hospitals, followed by Medicaid, Medicare, and third-party (insurance) payments (see Table 29). For adults ages 21 to 64 years, the highest number of states relied on state general funds, on first- and third-party payments; more states relied on Medicare than on Medicaid. For children and adolescents (under age 21 years), state general funds, Medicaid, and first- and third-party payment sources were the funding sources most frequently used. For forensic and sex offender patient groups, states relied most heavily on state general funds.

Medicaid has limitations on paying for care in psychiatric hospitals or residential facilities that meet its criteria as an institution for mental disease (IMD). Under section 1905(a) of the Social Security Act (the Act), there is a general prohibition on Medicaid payment for any services provided to any individual who is younger than 65 years and residing in an IMD, unless the payment is for inpatient psychiatric hospital services for individuals under age 21 pursuant to section 1905(a)(16) of the Act, as defined in section 1905(h) of the Act.[29] Medicaid's IMD statutory exclusion is defined as "a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services."[30]

---

[29]Centers for Medicare & Medicaid Services. (2012). Center for Medicaid and CHIP Services, *CMCS Information Bulletin*. Inpatient psychiatric services for individuals under age 21. Retrieved from: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-11-28-12.pdf

[30] U.S. Government Publishing Office. (2011). *42 CFR 435.1010 – Definitions relating to Institutional status*, p178. Retrieved from: https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol4/pdf/CFR-2011-title42-vol4-sec435-1010.pdf

The Medicaid statute referenced above excludes reimbursement for services to individuals who are patients in an IMD, with two exceptions. Under this broad exclusion, no Medicaid payment can be made for services provided to patients in IMDs either inside or outside the facility. The exceptions are the following:

1. The exclusion does not apply to individuals over the age of 65 when coverage for such individuals includes, at state option through a state plan amendment, inpatient services of an IMD that is certified as an inpatient hospital or nursing facility
2. The exclusion does not affect coverage of inpatient psychiatric services for individuals under age 21 (or 22 for those receiving such services when attaining age 21) provided by a psychiatric hospital, a psychiatric unit of a general hospital, or a psychiatric residential treatment facility that meets the federal requirements for inpatient psychiatric services.

Neither of these exceptions would apply to IMDs with patients who are between ages 21 and 65.

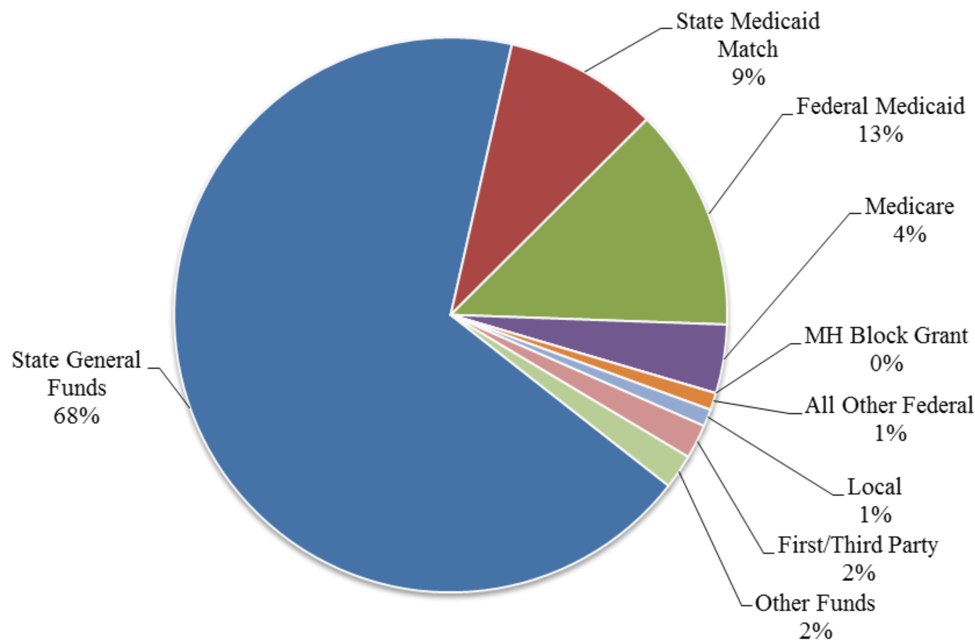
Table 29. Number of SMHAs Using Funding Sources for Mental Health Services in State Psychiatric Hospitals, by Hospital Patient Group and Type of Service, 2015 (N=45 States)

State	Children and Youth (< 21 Years)	Adults (21 64 Years)	Older Adults (65+ Years)	Forensic	Sex Offender	Other 24 Hour Care (Residential)	State Hospital Ambulatory
State general fund	28	43	35	42	23	13	8
State special funds	7	9	9	7	5	1	2
State Medicaid match	23	9	22	6	4	7	4
Medicaid (federal)	23	11	17	5	2	6	3
Medicare	6	22	28	9	2	2	1
Veterans Affairs	1	7	7	3	1	1	1
Other federal	3	5	4	1	0	0	0
Local government	6	7	5	5	1	1	2
First party	22	29	27	9	6	7	4
Third party	26	34	31	9	5	6	5
Charity	3	3	3	1	1	0	1
Other funds	0	1	2	2	1	0	0

Abbreviations: FY, fiscal year; SMHA, state mental health agency.

SMHAs used $10.4 billion in funding to provide state psychiatric hospital services in FY 2014 (25 percent of total SMHA funds). As shown in Figure 55, the largest share of funding for state psychiatric hospitals is from state general and special funds (68 percent), followed by Medicaid (22 percent for the combined state and federal shares), and Medicare (4 percent). Medicaid payments for care in state psychiatric hospitals were much lower than Medicaid payments for community mental health services in FY 2014 because of the IMD exclusion, which prohibits payment for services to individuals in an IMD.

Figure 55. Funding Sources for State Psychiatric Hospitals, FY 2014



Abbreviations: FY, fiscal year; MH, mental health.

Funding for state psychiatric hospitals can depend on the age and legal status of patients being served in those hospitals. There is a weak correlation between large percentages of patients who have a forensic or sex offender status and are in the states' psychiatric hospitals and the percentage of general funds that the state devotes to the psychiatric hospitals. That is, the larger the forensic and sex offender expenditures, the larger the reliance on state general funds.

State Psychiatric Hospital Expenditures per Patient Day by Type of Patient

State psychiatric hospitals provided more than 14.7 million patient days of inpatient service during FY 2014, with associated expenditures of $9.2 billion. (*Patients days* were the total number of days that patients were in a state psychiatric hospital during the year. For example, a patient in the hospital for a 7-day stay had 7 days of care, and a patient in the hospital the entire year had 365 patient days). The average expenditure per patient day for civil status adult patient in state psychiatric hospitals was $812, with a range from a low of $296 per patient day in Florida to a high of $5,134 per patient day in Vermont (Table 30). Average expenditures per inpatient day for children in state psychiatric hospitals were the highest of any group ($894 per patient day). Services for sex offenders had the lowest average cost per patient day ($388) (see Table 31).

Table 30. State Psychiatric Hospital Inpatient Expenditures per Patient Day for Civil Status Patients, by State, FY 2014

State	Civil Status Children and Adolescents			Civil Status Adults		
	Patient Days	Expenditures, $	Per Patient Day, $	Patient Days	Expenditures, $	Per Patient Day
Alabama	2,658	1,300,000	489	150,423	83,320,000	554
Alaska	2,377	3,063,287	1,289	15,226	19,622,051	1,289
Arizona	NA	NA	NA	41,201	30,600,000	743
Arkansas[a]	10,140	6,638,354	655	19,437	12,724,822	655
California[b,c]	NA	NA	NA	200,210	126,756,509	633
Colorado	4,378	5,100,000	1,165	74,544	50,200,000	673
Connecticut[a]	NA	NA	NA	74,933	102,700,000	1,371
Delaware	NA	NA	NA	26,956	21,174,657	786
District of Columbia	NA	NA	NA	30,111	26,366,484	876
Florida[a,b]	NA	NA	NA	556,300	164,400,000	296
Georgia[b]	NA	NA	NA	111,130	81,554,218	734
Hawaii	NA	NA	NA	NA	NA	NA
Idaho	4,181	2,700,000	646	48,769	23,200,000	476
Illinois	NA	NA	NA	133,955	76,500,000	571
Indiana	18,214	11,296,000	620	168,414	94,752,000	563
Iowa	6,019	6,700,000	1,113	42,079	32,600,000	775
Kansas	NA	NA	NA	NA	44,400,000	NA
Kentucky	NA	NA	NA	NA	NA	NA
Louisiana	NA	NA	NA	119,613	63,502,000	531
Maine	NA	NA	NA	NA	44,981,220	NA
Maryland[b]	3,650	2,600,000	712	87,029	60,400,000	694
Massachusetts[b]	7,341	6,400,000	872	171,464	139,700,000	815
Michigan[a]	18,247	25,900,000	1,419	166,135	154,500,000	930
Minnesota[b]	2,947	6,271,888	2,128	39,143	41,581,880	1,062
Mississippi	41,429	26,181,000	632	159,429	81,498,000	511
Missouri	8,182	10,147,097	1,240	167,309	114,857,897	687
Montana	NA	NA	NA	40,629	22,437,118	552
Nebraska	NA	NA	NA	21,334	11,612,428	544
Nevada a	12,353	7,000,000	567	75,878	51,100,000	673
New Hampshire	6,461	NA	NA	50,845	57,642,923	1,134
New Jersey	NA	NA	NA	430,125	369,833,000	860
New Mexico	NA	NA	NA	23,234	17,200,000	740
New York[a,c]	132,300	180,600,000	1,365	1,059,300	775,200,000	732
North Carolina	20,768	21,031,356	1,013	288,274	291,935,252	1,013
North Dakota	NA	NA	NA	37,991	18,036,275	475
Ohio	NA	NA	NA	176,051	105,700,000	600

State	Civil Status Children and Adolescents			Civil Status Adults		
	Patient Days	Expenditures, $	Per Patient Day, $	Patient Days	Expenditures, $	Per Patient Day
Oklahoma[a]	NA	NA	NA	41,439	24,905,000	601
Oregon	NA	NA	NA	61,322	59,000,000	962
Pennsylvania	NA	NA	NA	412,379	280,300,000	680
Puerto Rico	NA	1,455,164	NA	NA	26,450,147	NA
Rhode Island[a]	NA	NA	NA	34,026	38,914,515	1,144
South Carolina[a]	12,874	11,100,000	862	95,568	53,200,000	557
South Dakota	18,598	5,948,670	320	65,432	19,556,847	299
Tennessee	NA	NA	NA	138,276	101,800,000	736
Texas	79,793	30,268,495	379	354,058	183,766,122	519
Utah	18,382	14,400,000	783	54,234	25,900,000	478
Vermont[b]	NA	NA	NA	713	3,660,433	5,134
Virginia[b]	12,215	10,600,000	868	367,121	276,600,000	753
Washington	17,000	11,000,000	647	274,000	178,200,000	650
West Virginia[b]	NA	NA	NA	53,292	30,400,000	570
Wisconsin	10,797	8,500,000	787	28,956	22,900,000	791
Wyoming[a]	NA	NA	NA	24,986	18,827,110	754
Total	471,304	416,201,311	892	6,813,273	4,756,968,908	681
Average (mean)	19,638	17,341,721	894	144,963	95,139,378	812
Median	11,506	7,750,000	787	74,933	52,150,000	687
Minimum	2,377	1,300,000	320	713	3,660,433	296

Abbreviations: FY, fiscal year; NA, not applicable (services provided but exact expenditures are unallocatable).

[a] Medicaid revenues for community programs are not include in SMHA-controlled expenditures.

[b] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[c] Children's mental health expenditures are not included in SMHA-controlled expenditures.

Table 31. State Psychiatric Hospital Inpatient Expenditures Per Patient Day for Forensic Status Patients and Sex Offenders by State, FY 2014

State	Forensic Patients			Sex Offenders		
	Patient Days	Expenditures, $	Per Patient Day, $	Patient Days	Expenditures, $	Per Patient Day, $
Alabama	41,693	15,000,000	360	NA	0	NA
Alaska	3,505	4,516,964	1,289	NA	0	NA
Arizona	47,358	32,100,000	678	32,932	9,600,000	292
Arkansas[a]	44,335	29,024,796	655	NA	0	NA
California[b,c]	1,442,856	913,497,777	633	325,420	206,029,186	633
Colorado	100,503	65,600,000	653	NA	0	NA
Connecticut[a]	79,237	108,700,000	1,372	NA	0	NA
Delaware	14,150	10,908,157	771	NA	NA	NA
District of Columbia	65,289	59,966,707	918	729	686,765	942
Florida[a,b]	390,300	131,200,000	336	235,595	30,700,000	130
Georgia[b]	226,390	133,074,828	588	NA	0	NA
Hawaii	NA	NA	NA	NA	NA	NA
Idaho	3,615	1,900,000	526	NA	0	NA
Illinois	287,985	126,000,000	438	199,290	29,900,000	150
Indiana	85,775	50,872,000	593	NA	0	NA
Iowa	986	200,000	203	37,919	9,400,000	248
Kansas	NA	26,500,000	NA	NA	18,900,000	NA
Kentucky	17,108	11,400,000	666	NA	0	NA
Louisiana	124,205	47,186,000	380	NA	NA	NA
Maine	NA	6,689,944	NA	NA	0	NA
Maryland[b]	265,289	184,000,000	694	NA	0	NA
Massachusetts[b]	64,076	52,300,000	816	NA	0	NA
Michigan[a]	79,718	70,700,000	887	NA	NA	NA
Minnesota[b]	120,573	82,550,675	685	NA	NA	NA
Mississippi	11,367	4,987,000	439	NA	0	NA
Missouri	144,476	87,088,924	603	72,053	45,509,667	632
Montana	27,488	9,933,770	361	NA	NA	NA
Nebraska	25,587	11,978,537	468	55,888	23,283,875	417
Nevada[a]	24,820	10,500,000	423	3,586	2,000,000	558
New Hampshire	NA	NA	NA	NA	NA	NA
New Jersey	167,016	144,028,000	862	171,550	16,850,000	98
New Mexico	18,518	11,700,000	632	NA	0	NA
New York[a,c]	242,500	205,100,000	846	111,800	57,100,000	511
North Carolina	4,378	12,513,310	2,858	NA	0	NA
North Dakota	32,173	NA	NA	22,567	6,081,913	270
Ohio	196,538	117,900,000	600	NA	NA	NA
Oklahoma[a]	56,869	18,745,000	330	NA	0	NA
Oregon	154,037	148,200,000	962	NA	0	NA
Pennsylvania	79,811	70,200,000	880	14,055	6,600,000	470
Puerto Rico	NA	12,398,076	NA	NA	0	NA
Rhode Island[a]	NA	NA	NA	NA	0	NA
South Carolina[a]	65,927	26,400,000	400	59,982	14,000,000	233
South Dakota	NA	NA	NA	NA	0	NA
Tennessee	35,804	26,900,000	751	NA	0	NA
Texas	392,183	203,554,076	519	NA	0	NA
Utah	35,691	14,900,000	417	NA	0	NA
Vermont[b]	2,014	10,339,567	5,134	NA	NA	NA
Virginia[b]	87,423	28,100,000	321	115,479	29,400,000	255
Washington	119,000	50,000,000	420	NA	0	NA

State	Forensic Patients			Sex Offenders		
	Patient Days	Expenditures, $	Per Patient Day, $	Patient Days	Expenditures, $	Per Patient Day, $
West Virginia[b]	39,042	23,700,000	607	NA	0	NA
Wisconsin	249,236	132,000,000	530	128,579	48,400,000	376
Wyoming[a]	8,295	8,070,674	973	NA	0	NA
Total	5,725,139	3,553,124,782	616	1,587,424	554,441,406	337
Average (mean)	127,225	75,598,400	784	99,214	12,893,986	388
Median	65,289	29,024,796	619	66,018	0	334
Minimum	986	200,000	203	729	0	98

Abbreviations: FY, fiscal year; NA, not applicable (services provided but exact expenditures are unallocatable).

[a] Medicaid revenues for community programs are not include in SMHA-controlled expenditures.

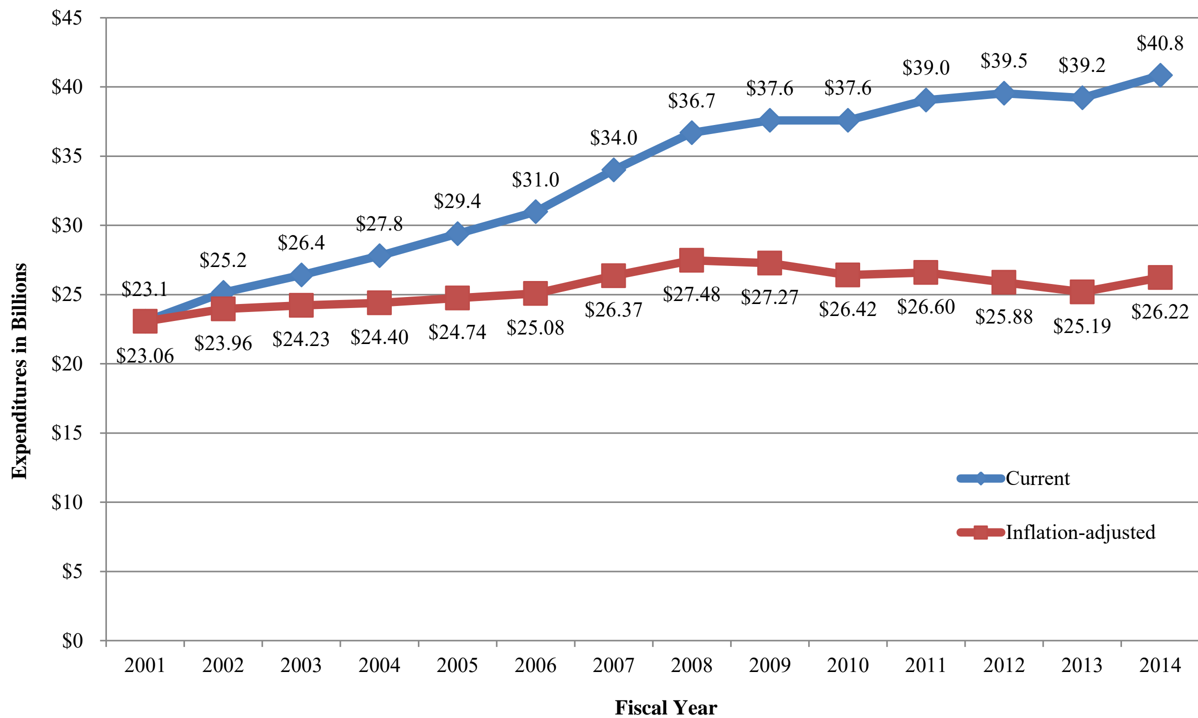
[b] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[c] Children's mental health expenditures are not included in SMHA-controlled expenditures.

Trends in State Mental Health Agency Revenues and Expenditures

Over the past 34 years, the financing of SMHAs have undergone major changes that are continuing in FY 2014 and beyond with health reform, health–behavioral health integration, and changing service mixes for individuals. From FY 2001 through FY 2014 SMHA-controlled expenditures for mental health grew at an average annual rate of 4.5 percent per year (from $23.1 billion in FY 2001 to $40.8 billion in FY 2014). However, the impact of the recession that affected America in the last decade is evident in SMHA expenditure data. From FY 2001 through 2008, SMHAs averaged expenditure growth of 6.9 percent per year, but from FY 2008 through FY 2014, growth in expenditures averaged only 1.8 percent per year. Adjusted for inflation, SMHA expenditures were lower in FY 2014 ($26.22 billion) than they were in FY 2008 ($27.48 billion), with a decrease of 0.8 percent per year since FY 2008 (see Figure 56).

Figure 56. State Mental Health Agency Controlled Expenditures for Mental Health, FY 2001 Through FY 2014 (Current and Inflation-Adjusted)



The recession that began during FY 2008 hit state government revenues hard, and its impact on state budgets lasted until FY 2013. Since the 2008 recession began, two types of SMHA expenditures increased—community mental health (up an average 2.6 percent per year) and SMHA central office/administration (up an average 0.7 percent per year). Expenditures for state psychiatric hospitals decreased by 0.4 percent per year from FY 2008 to FY 2014 (see Table 32).

When SMHA expenditures were adjusted for population growth and inflation (using the medical component of the consumer price index), total SMHA expenditures had a very slight overall decline from FY 2001 through FY 2014 (down 0.1 percent per year), but since the recession, SMHA expenditures have declined an average of 2.0 percent per year. Since the 2008 recession began, in inflation and population adjusted dollars, SMHA expenditures for all types of mental health programs have decreased. Community mental health expenditures had the smallest decrease at an average decline of 1.2 percent per year, whereas expenditures for state psychiatric hospital inpatient services (down an average 4.1 percent per year) and SMHA administration (down an average 3.0 percent per year) had the largest reductions.

From FY 2013 to FY 2014, total SMHA-controlled expenditures increased (up 3.3 percent). During this same time period, expenditures for state psychiatric hospital inpatient care decreased slightly (down 0.6 percent), whereas community mental health expenditures increased at a faster 4.2 percent. However, adjusted for inflation and population growth, total SMHA expenditures increased by only 0.7 percent from FY 2013 through FY 2014, whereas state psychiatric hospital inpatient expenditures decreased by 3.1 percent and expenditures for community mental health services increased by 1.5 percent.

Table 32. Annual Percentage Change in State Mental Health Agency Controlled Expenditures for Mental Health in Current and Population and Inflation Adjusted Dollars, FY 2001–2014

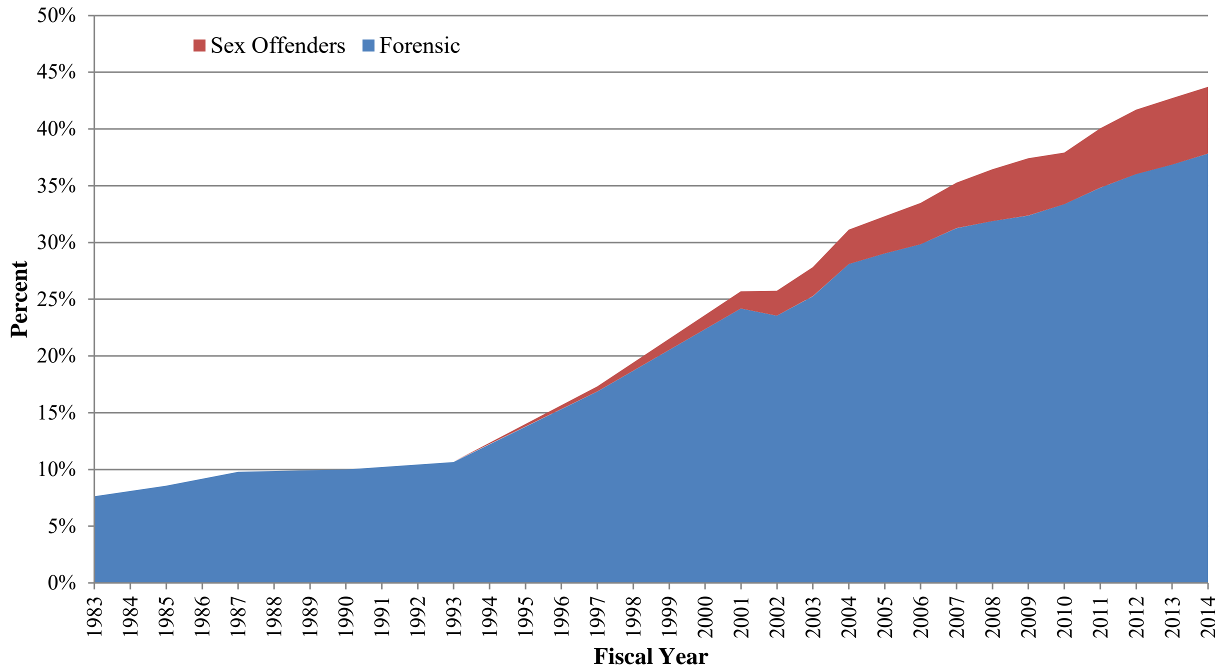
Annualized Change	State Hospital Inpatient	Community	SMHA Administration	Total	Population
Annual Percentage Change In Expenditures, Not Inflation Or Population Adjusted					
FY 2001–FY 2014	1.9	5.6	2.7	4.5	0.9
FY 2001–FY 2008	4.0	8.2	4.4	6.9	0.9
FY 2008–FY2014	–0.4	2.6	0.7	1.8	0.8
FY 2013–FY2014	–0.6	4.2	1.8	3.3	0.8
Population and Inflation Adjusted Annual Percentage Change					
FY 2001–FY 2014	–2.5	0.9	–1.8	–0.1	—
FY 2001–FY 2008	–1.2	2.8	–0.8	1.6	—
FY 2008–FY2014	–4.1	–1.2	–3.0	–2.0	—
FY 2013–FY 2014	–3.1	1.5	–0.8	0.7	—

Abbreviations: FY, fiscal year; SMHA, state mental health agency.

SMHA Expenditures for Forensic Expenditures Over Time

There has been a shift over the past 30 years within state psychiatric hospitals—states are expending an increasing proportion of their resources on services to individuals with forensic and sex offender legal statuses (see Figure 57). In FY 2014, expenditures for forensic and sex offender patients represented 43.7 percent of total state psychiatric hospital expenditures, an increase from 25.7 percent in FY 2001 and 36.4 percent in FY 2008. In FY 2014, SMHAs expended $3.6 billion on forensic expenditures in state psychiatric hospitals and another $554 million on sex offender services in state hospitals. In six states (California, District of Columbia, Nebraska, Oregon, Vermont, and Wisconsin) expenditures for forensic and sex offender services exceeded 70 percent of state psychiatric hospital expenditures.

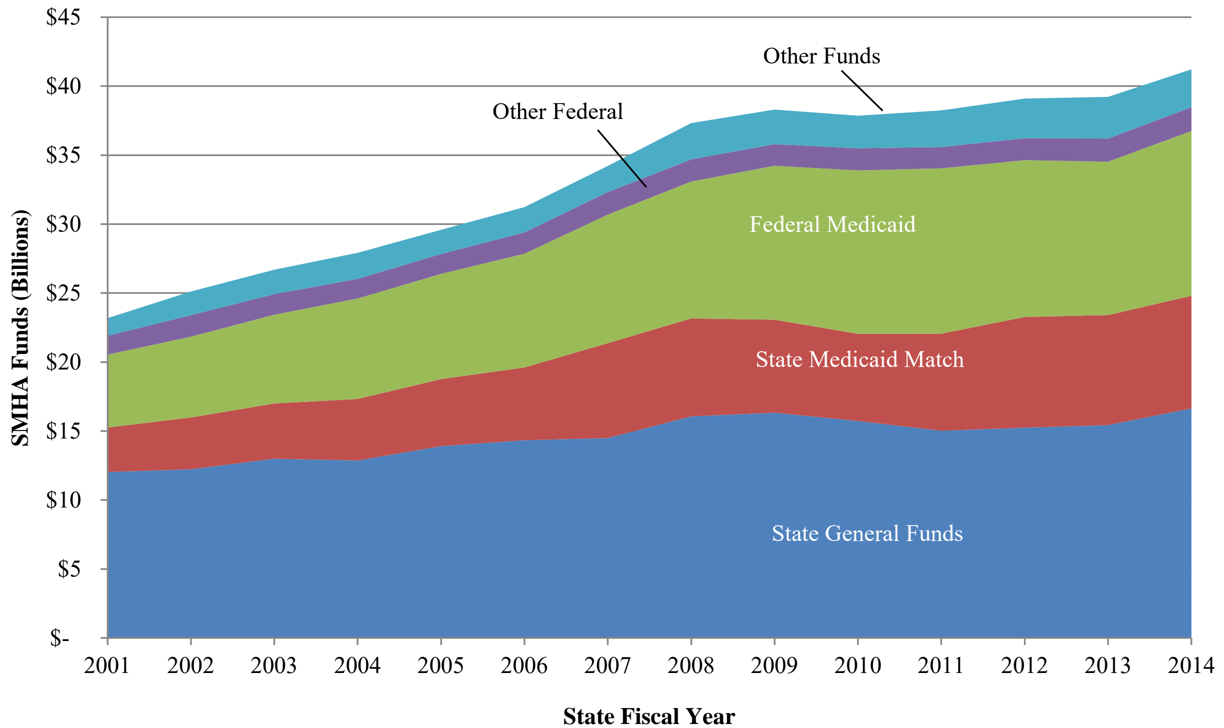
Figure 57. Expenditures for Forensic Patients and Sex Offenders as a Percentage of Total State Psychiatric Hospital Expenditures, FY 1983 Through FY 2014



Trends in SMHA Funding Sources Over Time

From FY 2001 to FY 2014, the major funding sources have grown at varying rates, with Medicaid being the source of the largest increase in SMHA funding (see Figure 58). From FY 2001 through FY 2014, total SMHA funds grew from $23.2 billion to $41.2 billion, an increase of 4.5 percent per year. Medicaid funds that SMHAs used grew at 6.8 percent per year, whereas state general fund expenditures grew at only 2.5 percent per year. Since the recession began in FY 2008, state general spending by SMHAs has been flat (an increase of 0.6 percent per year), and states experienced reductions of 3.7 percent from FY 2009 through 2010 and of 4.5 percent from FY 2010 through FY 2011.

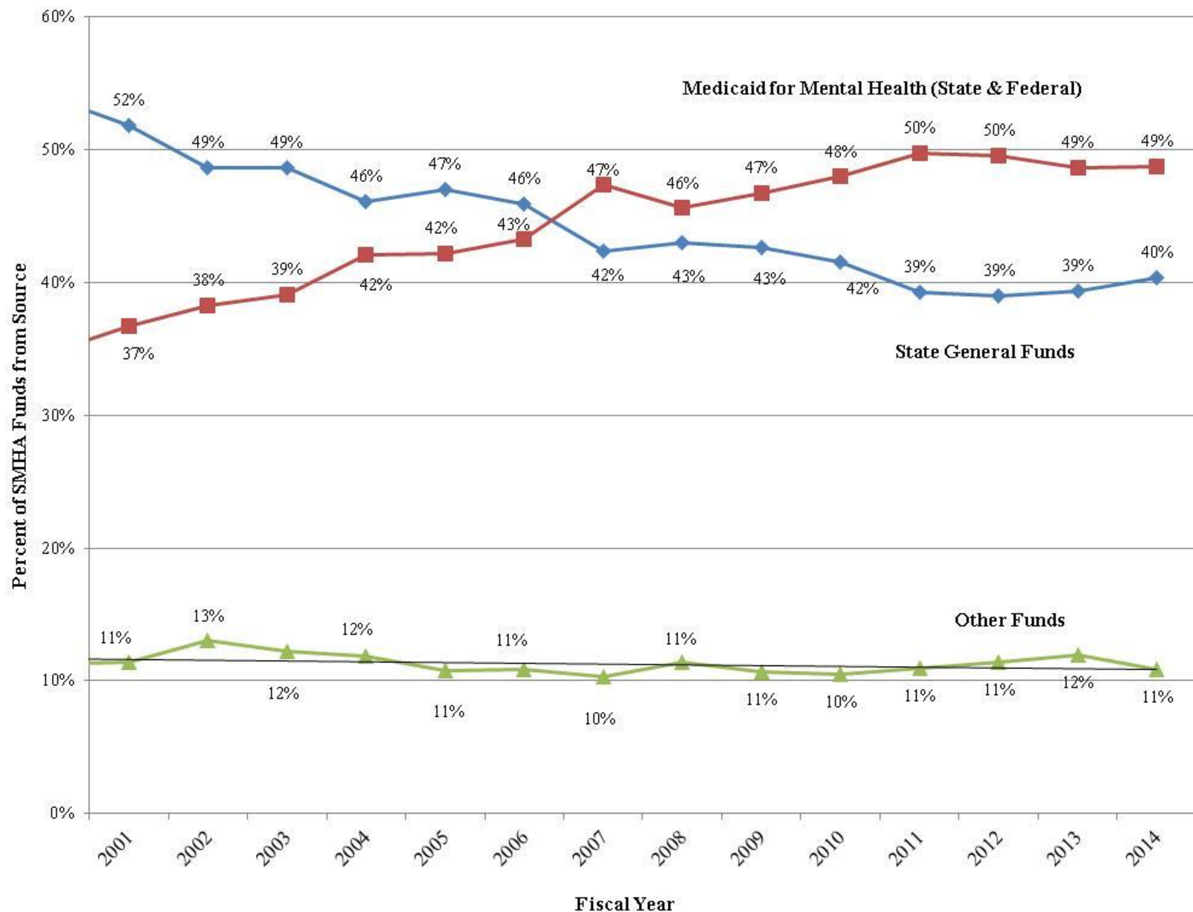
Figure 58. State Mental Health Agency Controlled Revenues for Mental Health Services, FY 2001 Through FY 2014



Abbreviations: FY, state fiscal year; SMHA, state mental health agency.

Because Medicaid funds to SMHAs grew much faster than state general funds, the relative proportions of funds from various major sources have changed since FY 2001 (see Figure 59). In FY 2001, SMHAs still received over half (52 percent) of their funding from state general fund sources and only 37 percent from Medicaid. As SMHAs increased their use of Medicaid, its proportion of total SMHA funding grew until it surpassed state general funds between FY 2006 and FY 2007.

Figure 59. Percentage of Major State Mental Health Agency Funding From State and Federal Sources, FY 2001 Through FY 2014



Abbreviations: FY, fiscal year; SMHA, state mental health agency.

8.4 Financing of Single State Agency Substance Use Disorder Services

SSAs have two distinct primary missions. First, they provide SUD treatment services to people lacking or with inadequate health insurance. Second, SSAs fund the community-based prevention services for the entire population. As such, they are a vital element of the national system for providing SUD services to the nation. This section presents the most current financial data available about this vital segment in the nation's SUD effort and summarizes the broad trends in funding for SSA efforts.

Although Medicaid augments SSA treatment spending for people with low incomes, providing $3.9 billion in care in calendar year 2011, Medicaid does not support community-based substance abuse prevention activities.

Single State Agency Expenditures for Substance Use Disorder Services

SSAs managed budgets that totaled $4.95 billion from all sources in FY 2014 (July 2013 through June 2014; see Table 33). The two largest state SSA budgets were in California and New York, at $482.4 million and $525.2 million, respectively. The smallest state budgets were in New

Hampshire and Arkansas, at $15 and $18 million, respectively. The median SSA budget was $46 million, and the quartiles were $31 million and $144 million (see Table 33).

Table 33. Expenditures of Single State Agencies, by Service Provided, FY 2014 (Expenditures in Millions)

State	Primary Prevention		Treatment and Other Prevention		Other		Total SSA Expenditures, $
	$	%	$	%	$	%	
Alabama	3.9	10	33.6	85	1.9	5	39.4
Alaska	14.5	25	38.0	66	5.2	9	57.7
Arizona	7.3	5	140.2	90	8.1	5	155.6
Arkansas	2.5	14	14.4	80	1.1	6	17.9
California	57.0	12	406.9	84	18.5	4	482.4
Colorado	10.2	17	46.4	80	1.6	3	58.2
Connecticut	12.7	6	170.2	87	12.8	7	195.7
Delaware	2.9	13	19.6	85	0.6	3	23.1
District of Columbia	4.5	12	31.9	83	2.0	5	38.4
Florida	49.9	23	164.8	74	7.1	3	221.9
Georgia	13.0	11	105.9	86	4.4	4	123.3
Hawaii	4.6	15	23.0	77	2.3	8	29.9
Idaho	3.1	10	27.5	89	0.2	1	30.8
Illinois	18.5	9	185.2	86	10.8	5	214.5
Indiana	8.0	17	38.0	80	1.5	3	47.5
Iowa	7.3	17	33.0	78	1.7	4	42.1
Kansas	4.8	11	38.0	86	1.4	3	44.2
Kentucky	6.1	16	31.0	81	1.2	3	38.3
Louisiana	5.0	6	74.2	91	2.5	3	81.7
Maine	4.0	12	29.2	84	1.6	5	34.9
Maryland	6.3	4	142.5	89	10.7	7	159.6
Massachusetts	7.9	6	117.7	91	3.4	3	129.0
Michigan	13.1	10	117.1	89	1.4	1	131.6
Minnesota	5.6	4	148.8	96	1.0	1	155.4
Mississippi	3.7	18	15.4	75	1.4	7	20.5
Missouri	7.3	6	102.8	91	3.1	3	113.2
Montana	2.3	12	15.3	82	1.0	5	18.6
Nebraska	2.1	7	27.9	92	0.3	1	30.4
Nevada	5.2	26	12.4	61	2.7	13	20.2
New Hampshire	2.6	18	11.2	77	0.7	5	14.5
New Jersey	13.2	9	121.4	85	8.9	6	143.5
New Mexico	4.8	12	34.1	87	0.4	1	39.4
New York	52.1	10	411.3	78	61.8	12	525.2
North Carolina	9.0	6	142.7	91	4.8	3	156.5
North Dakota	1.1	4	23.3	94	0.4	2	24.8
Ohio	26.1	10	235.1	86	12.6	5	273.8
Oklahoma	9.4	14	53.4	80	4.3	6	67.1
Oregon	7.0	8	63.7	75	14.7	17	85.4
Pennsylvania	19.4	17	74.0	66	18.3	16	111.7
Rhode Island	3.9	15	19.6	76	2.2	9	25.6
South Carolina	7.8	21	28.4	75	1.8	5	38.1
South Dakota	4.3	17	20.5	79	1.0	4	25.7
Tennessee	9.2	15	47.7	76	5.4	9	62.4
Texas	40.2	25	107.8	67	14.0	9	161.9
Utah	5.5	12	35.8	78	4.4	10	45.6
Vermont	3.7	9	34.4	88	0.8	2	38.9
Virginia	10.2	11	77.4	85	3.0	3	90.7
Washington	9.3	5	158.7	90	8.0	5	176.0
West Virginia	2.2	12	15.6	83	1.1	6	18.8

State	Primary Prevention		Treatment and Other Prevention		Other		Total SSA Expenditures, $
	$	%	$	%	$	%	
Wisconsin	8.9	28	23.0	72	0.1	0	32.0
Wyoming	9.7	24	29.5	73	1.5	4	40.6
Total	553.0	11.2	4,119.2	83.1	282.0	5.7	4,954.2
Average	10.7	—	80.8	—	5.5	—	97.1
Median	7.0	11.7	38.0	82.7	2.0	4.5	45.6
Minimum	1.1	3.6	11.2	61.0	0.1	0.4	14.5
Maximum	57.0	27.7	411.3	95.8	61.8	17.2	525.2

Abbreviations: FY, fiscal year; SSA, singe state agency.

[a] No total was calculated on the percentage data.

Per capita SSA spending averaged $15.50, which is $4.95 billion divided by 319 million individuals. The median SSA spent just over $16 per capita (see Figure 60). There are major differences across states on a per capita basis. The highest spending rate was in Alaska, where the SSA budget was $78 per capita. South Carolina, Indiana, Nevada, Mississippi, Arkansas, Texas, and Wisconsin had spending less than $8 per capita. Approximately half of the SSAs had budgets in the range of $10 to $25 per capita (the quartiles), and the median value was $16 per capita. Another fundamental feature of the SSAs is that they are responsible for funding primary prevention and treatment as well as other prevention. Primary prevention services are those directed at individuals who do not require treatment for an SUD. The SABG requires SSAs to "set aside" at least 20 percent of their BG funds on primary prevention.

Figure 60. Frequency Distribution of Single State Agency per Capita Spending on Substance Use Disorder Services, FY 2014

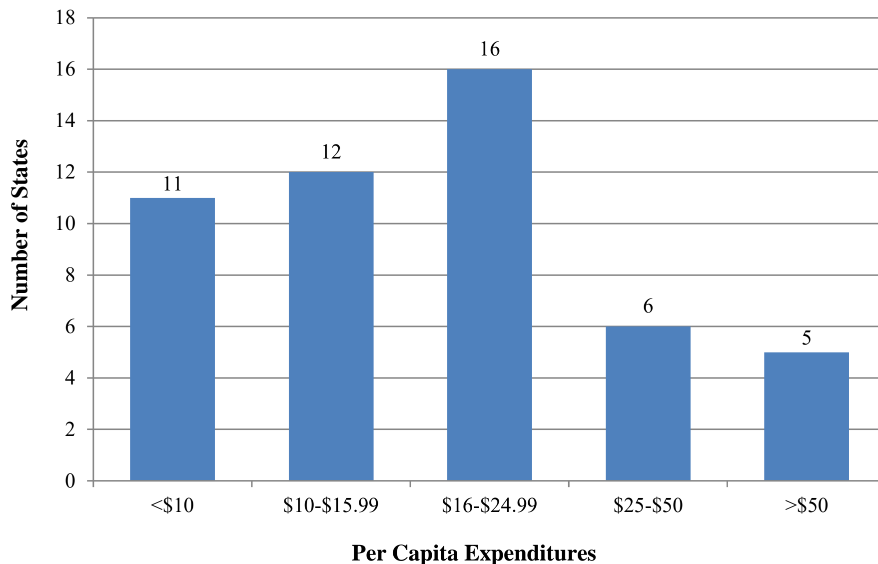
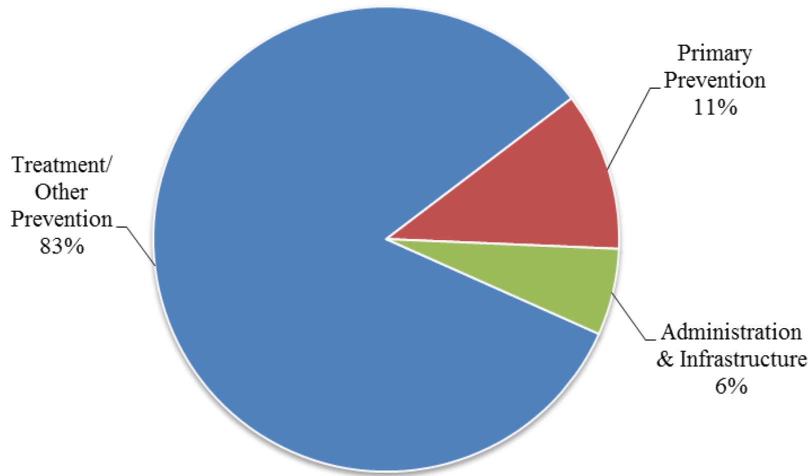


Figure 61 illustrates that SSAs spent 11 percent of their budget ($553 million) for primary prevention versus 83 percent ($4.1 billion) for treatment. They spent the remaining 6 percent ($282 million) for infrastructure and administrative support activities, including data and evaluation, training and other workforce support, and oversight and review of funded entities (e.g., providers, local and regional government).

Figure 61. How Single State Agencies Spend Budgets on Primary Prevention and Other Services



Funding Sources for Substance Use Disorder Services

The sources of funding for SSAs varied somewhat from state to state. On average, 44 percent ($2.2 billion) came from the state itself (Table 34 and Figure 62), followed by the SABG at 32 percent ($1.6 billion), Medicaid at 17 percent ($820 million), and other sources at 6 percent ($350 million, largely other federal awards). In addition, Medicaid funds were a mixture of state (39 percent) and federal (61 percent) dollars; thus, across all funding sources, state and federal funding of SSAs was roughly equal.

The SSA budgets reveal that nearly 67 percent of SSA spending for primary prevention came from the SABG, 20 percent from state funding, and the final additional 12 percent from other federal awards such as the Partnerships for Success and Targeted Capacity Expansion Grants.

Support for SSAs through the SABG is determined by a formula largely based on population, so funding per capita was reasonably equivalent across states; however, there was substantial variability across SSAs in their levels of state general revenue and Medicaid funding. Because the SABG formula is based largely on population and prevalence of SUDs, funding for almost three-quarters of SSAs falls in the range of $4 to $6 per capita. In contrast, state general revenue support averaged almost exactly $7 per capita; the range was from about $1 per capita in Arkansas, Texas, and Wisconsin to about $60 per capita in Alaska and Wyoming.

Table 34. Single State Agency Funding Sources, FY 2014

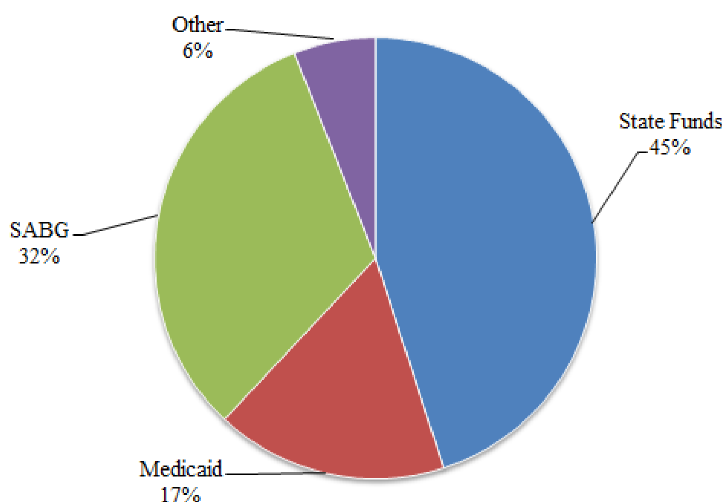
State	State Funds		Medicaid		SABG		Other Funds		Total SSA
	$, billion	%	$, billion	%	$, billion	%	$, billion	%	$, billion
Alabama	12.4	31.3	6.3	15.9	18.7	47.4	2.1	5.4	39.4
Alaska	41.6	72.0	8.3	14.5	5.0	8.6	2.8	4.9	57.7
Arizona	9.6	6.2	114.4	73.5	27.6	17.7	4.0	2.6	155.6
Arkansas	2.9	16.2	0.0	0.0	10.5	58.2	4.6	25.6	18.1
California	65.3	13.5	160.9	33.3	248.9	51.6	7.3	1.5	482.4
Colorado	22.1	38.0	1.2	2.0	27.2	46.8	7.7	13.3	58.2
Connecticut	155.8	79.6	0.0	0.0	16.9	8.6	23.0	11.7	195.7
Delaware	14.9	64.5	0.0	0.0	6.0	26.1	2.2	9.5	23.1
District of Columbia	26.5	68.9	0.0	0.0	2.7	6.9	9.3	24.2	38.4
Florida	100.1	45.1	0.0	0.0	99.6	44.9	22.1	10.0	221.9

State	State Funds		Medicaid		SABG		Other Funds		Total SSA
	$, billion	%	$, billion	%	$, billion	%	$, billion	%	$, billion
Georgia	48.0	38.9	0.8	0.6	53.8	43.6	20.8	16.9	123.3
Hawaii	18.3	61.2	0.0	0.0	7.5	25.2	4.1	13.6	29.9
Idaho	18.5	59.9	2.0	6.6	6.9	22.4	3.5	11.2	30.8
Illinois	85.4	39.8	51.5	24.0	67.7	31.6	9.9	4.6	214.5
Indiana	10.3	21.6	0.0	0.0	31.0	65.2	6.3	13.2	47.5
Iowa	19.9	47.3	0.0	0.0	13.4	31.9	8.7	20.8	42.1
Kansas	17.4	39.3	11.9	26.8	12.5	28.3	2.5	5.6	44.2
Kentucky	16.1	42.0	0.0	0.0	20.2	52.9	1.9	5.0	38.3
Louisiana	41.3	50.6	0.0	0.0	24.8	30.4	15.5	19.0	81.7
Maine	11.9	34.0	13.4	38.3	6.7	19.1	3.0	8.5	34.9
Maryland	117.7	73.8	0.0	0.0	31.7	19.9	10.1	6.3	159.6
Massachusetts	90.1	69.9	0.0	0.0	32.3	25.0	6.6	5.1	129.0
Michigan	29.8	22.7	43.9	33.4	51.0	38.8	6.8	5.2	131.6
Minnesota	100.8	64.9	32.6	21.0	19.9	12.8	2.0	1.3	155.4
Mississippi	5.1	24.8	1.3	6.4	14.2	68.9	0.0	0.0	20.5
Missouri	43.5	38.4	38.4	33.9	23.6	20.8	7.8	6.9	113.2
Montana	7.1	38.4	2.0	11.0	6.7	35.9	2.7	14.7	18.6
Nebraska	23.3	76.9	0.0	0.0	6.9	22.6	0.2	0.6	30.4
Nevada	7.5	36.9	0.0	0.0	11.9	58.8	0.9	4.4	20.2
New Hampshire	4.8	33.4	0.0	0.0	5.8	40.3	3.8	26.3	14.5
New Jersey	98.9	68.9	0.0	0.0	39.2	27.3	5.4	3.8	143.5
New Mexico	21.0	53.4	3.6	9.2	8.7	22.2	6.0	15.2	39.4
New York	414.2	78.9	0.0	0.0	101.2	19.3	9.8	1.9	525.2
North Carolina	124.6	79.6	0.0	0.0	29.5	18.8	2.4	1.5	156.5
North Dakota	9.4	37.9	8.8	35.3	4.8	19.2	1.9	7.6	24.8
Ohio	26.3	9.6	153.3	56.0	86.5	31.6	7.7	2.8	273.8
Oklahoma	37.5	55.8	3.4	5.1	17.6	26.2	8.7	12.9	67.1
Oregon	23.2	27.2	32.4	38.0	21.2	24.9	8.5	10.0	85.4
Pennsylvania	46.8	42.4	0.0	0.0	51.8	46.9	11.9	10.8	110.4
Rhode Island	4.3	16.8	8.2	32.1	7.4	28.7	5.7	22.4	25.6
South Carolina	6.5	17.2	3.3	8.6	19.4	51.1	8.8	23.2	38.1
South Dakota	12.7	49.5	4.3	16.9	4.5	17.5	4.2	16.1	25.7
Tennessee	29.7	47.6	0.0	0.0	28.3	45.3	4.4	7.1	62.4
Texas	36.2	22.4	0.0	0.0	125.2	77.3	0.6	0.4	161.9
Utah	10.8	23.8	10.4	22.8	11.9	26.1	12.4	27.3	45.6
Vermont	7.1	18.2	24.3	62.4	6.1	15.6	1.5	3.8	38.9
Virginia	48.3	53.3	0.0	0.0	40.4	44.5	2.0	2.2	90.7
Washington	53.1	30.2	83.2	47.3	31.5	17.9	8.1	4.6	176.0
West Virginia	10.7	56.7	0.0	0.0	6.3	33.2	1.9	10.1	18.8
Wisconsin	3.7	11.6	0.1	0.2	25.4	79.5	2.8	8.7	32.0
Wyoming	35.7	87.8	0.0	0.0	3.2	7.9	1.8	4.3	40.6
Total	2,228.5	45.0	824.2	16.6	1,581.8	31.9	318.7	6.4	4,953.0
Average	43.7	43.7	16.2	12.0	31.0	35.7	6.2	8.5	96.5
Median	23.2	39.8	0.8	0.6	19.4	28.3	4.5	7.6	47.5

Abbreviations: FY, fiscal year; SABG, Substance Abuse Prevention and Treatment Block Grant; SSA, single state agency.

[a] No total was calculated on the percentage data.

Figure 62. Sources of Funding for Single State Agencies, 2013–2014



Abbreviation: SABG, Substance Abuse and Prevention Treatment Block Grant.

Medicaid Spending for Substance Use Disorder Services

The data presented above illustrate the importance of using caution in interpreting SSA budgets. SSA budgets generally are underestimates of total state spending for SUD services. State Medicaid agency reimbursements for SUD services probably are the largest omission. Twenty-four SSAs reported having no Medicaid funding. The Medicaid share of SSA budgets reflects situations in which the state made a legislative or administrative decision to have the SSA manage certain SUD treatment services and their related funds to provide SUD care for a specific segment of the Medicaid population, such as pregnant women or adolescents. In these situations, the state is using the expertise of the SSA to oversee SUD services.

The most recent data are from a 2012 study for the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE). The researchers performed a rigorous analysis of state-by-state SUD treatment spending on Medicaid.[31] The project forecasted spending on SUD treatment of $3.95 billion in 2011, which was almost 5 times greater than the $820 million in Medicaid funds that SSAs manage. The authors observed that all states pay for some types of SUD treatment through Medicaid, even if this overage is only hospital emergency department (coverable by the state plan's outpatient hospital benefit) or inpatient care for overdoses and alcohol poisoning (coverable under the state plan's inpatient hospital benefit). The study estimated that states paid an average of 39 percent of Medicaid spending on SUD services, and the federal government paid 61 percent.

Bouchery and colleagues concluded that there are major differences across states in spending per capita for adolescents and adults, although limited data for Medicaid managed care plans hindered accuracy. The project advised that these differences are due to the types of individuals that the Medicaid programs covered (only few cover childless adults) and the types of SUD services included in plans—both of which are well-known variations of Medicaid plans across

[31] Bouchery, E., Harwood, R., Malsberger, R., Caffery, E., Nysenbaum, J., & Hourihan, K. (2012). *Medicaid substance abuse treatment spending: Findings report*. Assistant Secretary for Planning and Evaluation. Retrieved from: http://aspe.hhs.gov/daltcp/reports/2012/MSATspend.pdf

states. It is expected that over time these differences will become less accentuated as the Affordable Care Act and the MHPAEA affects Medicaid plans. However, major differences will continue to exist between states that expand Medicaid eligibility and those that do not.

Trends in Single State Agency Expenditures and Funding Sources

Long-term trends in SSA expenditures can be analyzed by linking data from state 2015 SABG reports with data from the state profile system that NASADAD operates for FY 1985 through 1999, known as the *State Resources and Services Related to Alcohol and Other Drug Problems*.[32] Both of these sources collected data from SSAs about their budgets, sources of funding, and expenditures on primary prevention, treatment, and infrastructure and administration.

Between 1985 and 2014, SSA expenditures nearly quadrupled, growing from $1.42 billion to $4.95 billion (see Table 35). Over this time period, growth in total budgets averaged 4.3 percent per year. The greatest source of funding was state funds, which were just over 50 percent of the total in 1985, and they still constituted the single largest funding source in 2014, at 45 percent. State support averaged 3.9 percent growth per year. The major source of growth was federal Block Grant support. The SABG in 2014 was 6.5 times greater than the value in 1985 and grew at an annual rate of 6.5 percent per year, from about one-quarter of a billion dollars to $1.58 billion in 2014. Other funding sources—including other federal supports, local sources, and Medicaid—decreased in share from 33 percent of SSA funding to just 23 percent, with annual growth that averaged 3.1 percent. The NASADAD *State Resources and Services Related to Alcohol and Other Drug Problems* reports did not break out Medicaid funding.

Table 35. Trends in Single State Agency Expenditures and Funding Sources, FY 1985–2014

Funding Source	Expenditures, $ in Billions				
	1985	1989	1994	1999	2014
State funds	0.71	1.13	1.44	1.64	2.23
SABG	0.24	0.47	1.06	1.36	1.58
Other	0.47	0.86	1.31	1.46	1.14
Total budget	1.42	2.46	3.81	4.46	4.95
	Annual Growth Rate, %				
	1985 1989	1989 1994	1994 1999	1999 2014	1985 2014
State funds	11.6	4.8	2.6	2.0	3.9
SABG	16.8	16.4	4.9	1.0	6.5
Other	15.1	8.4	2.2	–1.6	3.1
Total budget	13.5	9.8	3.1	0.7	4.3

Abbreviation: SABG, Substance Abuse Block Grant.

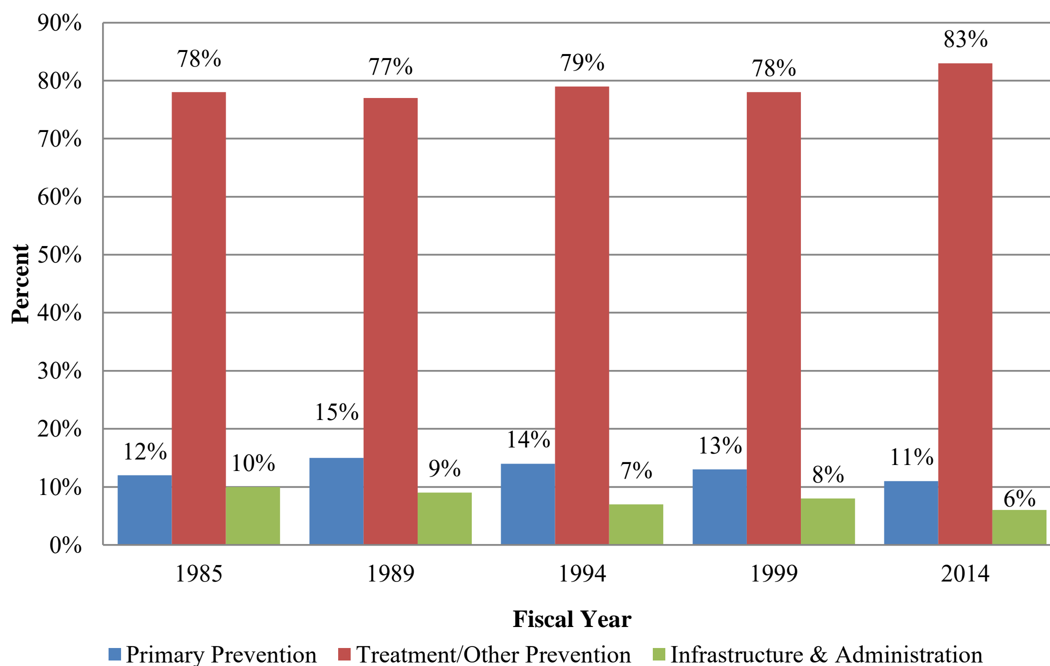
Funding growth has changed dramatically over the 29-year period between 1985 and 2014. There was double-digit growth from 1985 until about 1991, and then growth rates steadily declined. In the most recent period from 1999 through 2014, SSA budgets grew by only 0.7 percent per year. State funds and the SABGs did have modest growth (about 2 and 1 percent per year, respectively), but other funding sources (e.g., other federal and local funds, Medicaid) declined by 1.6 percent per year. The time period from 1985 through 1991 included what has

[32] National Association of State Alcohol/Drug Abuse Directors. *State resources and services related to alcohol and other drug problems,* editions 1986 through 2001. Washington, DC.

been called the *cocaine epidemic*, during which SSA budgets more than doubled in 6 years, from $1.4 billion in 1985 to $3.2 billion in 1991.

As discussed above, SSAs have two primary missions: treatment and primary prevention in communities. Over time, there have been modest changes in how they allocate resources between primary prevention and treatment. Figure 63 illustrates the trends. Primary prevention consistently has composed between 11 and 15 percent of the total SSA budget, reaching the lowest value since 1985 in the 2014 budgets. SUD treatment garnered almost 80 percent of resources from 1985 through 1999 and increased to 83 percent in 2014. State spending on administration and infrastructure gradually declined over the 29 years, from 10 percent of total SSA spending in 1985 to 6 percent in 2014. This item includes funding for building the workforce, and it is clear from these data that workforce support has not grown and is most likely to have declined over this time period. Another question is how this line item has been affected by the trend of SSAs to contract out management of service systems to insurance and managed care companies. Insurance and managed care spend about 20 percent of funds that they manage for administration, versus 7 to 8 percent that SSAs used to manage their grantees. It is noteworthy that in Medicaid insurance plans, administration costs are capped at 20 percent.

Figure 63. Trends in Single State Agency Share Spent on Substance Use Disorder Prevention and Treatment, FY 1985–2014



Note: Percentages may not total 100 percent because of rounding.

Primary prevention has demonstrated the most marked trends in funding swings over the 29 years examined. This amount was $160 million (12 percent share) in 1985, which more than doubled to $340 million (15 percent share) in 1989—an annual growth rate of 19 percent. In contrast, during this period the share for treatment grew by only 13 percent per annum. By 1992, prevention spending had reached $490 million; however, SSA primary prevention expenditures have grown only negligibly since that year. These expenditures reached a high of $580 million

in 1999 and are currently $550 million. Primary prevention has progressively declined as a share of SSA budgets, reaching 11 percent in 2014.

Page left blank intentionally

Glossary

ACO	Accountable Care Organization
ACT	Assertive Community Treatment
ARRA	American Recovery and Reinvestment Act
ASPE	Office of the Assistant Secretary for Planning and Evaluation
CBHSQ	Center for Behavioral Health Statistics and Quality (within SAMHSA)
CBITS	Cognitive-Behavioral Intervention for Treatment in Schools
CCBHC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CFRI	Center for Financing Reform and Innovations (within SAMHSA)
CHIP	Children's Health Insurance Program
CIT	Crisis Intervention Team
CMHC	Community Mental Health Center
CMHS	Center for Mental Health Services (within SAMHSA)
CMS	Centers for Medicare & Medicaid Services
CSAT	Center for Substance Abuse Treatment (within SAMHSA)
D-SNP	Dual Eligible Special Needs Plan (within Medicare)
DSH	Disproportionate Share Hospital
EBP	Evidence-Based Practice
EHR	Electronic Health Record (*see also PHR)*
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
FY	Fiscal Year
GBMI	Guilty But Mentally Ill
HCBS	Home and Community-Based Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HITECH Act	Health Information Technology for Economic and Clinical Health Act (within the ARRA)
ICCD	International Center for Clubhouse Development
IMD	Institution for Mental Disease
MATCH	Modular Approach to Therapy for Children
MH	Mental Health
MHBG	Mental Health Block Grant
MHPAEA	Multidimensional Treatment Foster Care
MLTSS	Managed Long Term Services and Supports
MTFC	Multidimensional Treatment Foster Care
M/SUD	Mental or Substance Use Disorder
NASADAD	National Association of State Alcohol and Drug Abuse Directors
NASMHPD	National Association of State Mental Health Program Directors
NFIB	National Federal Independent Business
NGRI	Not Guilty by Reason of Insanity
NRI	NASMHPD Research Institute
NSDUH	National Survey on Drug Use and Health

N-SSATS	National Survey of Substance Abuse Treatment Services
OBOT	Office-Based Opioid Treatment
OTP	Opioid Treatment Programs
PCP	Primary Care Provider
PDMP	Prescription Drug Monitoring Programs
PHR	Personal Health record (*see also EHR)*
SAMHSA	Substance Abuse and Mental Health Services Administration
SABG	Substance Abuse Prevention and Treatment Block Grant
SED	Serious Emotional Disturbance
SMHA	State Mental Health Agency
SMI	Serious Mental Illness
SPS	SMHA Profiling System
SSA	Single State Agency
SSDI	Social Security Disability Insurance
SUD	Substance Use Disorder
TEDS	Treatment Episodes Data Set
URS	Uniform Reporting System
VistA	Veterans Health Information Systems and Technology Architecture
WRAP	Wellness Recovery Action Plan
WebBGAS	Web Block Grant Application System

This page intentionally left blank

Appendix A: Profiles of State Mental Health Agencies[1]

[1] Data for this section was compiled in summer of 2015 from the most recent reported data by states. Please see Chapter 2 of the main report for a more complete description of methods, sources, and limitation.

This page intentionally left blank

Contents

Alabama Mental Health 2015 .... A-5
Alaska Mental Health 2015 .... A-9
Arizona Mental Health 2015 .... A-13
Arkansas Mental Health 2015 .... A-17
California Mental Health 2015 .... A-21
Colorado Mental Health 2015 .... A-25
Connecticut Mental Health 2015 .... A-29
Delaware Mental Health 2015 .... A-34
District of Columbia Mental Health 2015 .... A-38
Florida Mental Health 2015 .... A-42
Georgia Mental Health 2015 .... A-47
Hawaii Mental Health 2015 .... A-51
Idaho Mental Health 2015 .... A-55
Illinois Mental Health 2015 .... A-59
Indiana Mental Health 2015 .... A-63
Iowa Mental Health 2015 .... A-67
Kansas Mental Health 2015 .... A-71
Kentucky Mental Health 2015 .... A-75
Louisiana Mental Health 2015 .... A-79
Maine Mental Health 2015 .... A-83
Maryland Mental Health 2015 .... A-87
Massachusetts Mental Health 2015 .... A-91
Michigan Mental Health 2015 .... A-95
Minnesota Mental Health 2015 .... A-100
Mississippi Mental Health 2015 .... A-104
Missouri Mental Health 2015 .... A-108
Montana Mental Health 2015 .... A-112
Nebraska Mental Heath 2015 .... A-116
Nevada Mental Health 2015 .... A-120
New Hampshire Mental Health 2015 .... A-124
New Jersey Mental Health 2015 .... A-128
New Mexico Mental Health 2015 .... A-132
New York Mental Health 2015 .... A-136
North Carolina Mental Health 2015 .... A-140
North Dakota Mental Health 2015 .... A-144
Ohio Mental Health 2015 .... A-148
Oklahoma Mental Health 2015 .... A-152
Oregon Mental Health 2015 .... A-156
Pennsylvania Mental Health 2015 .... A-161
Rhode Island Mental Health 2015 .... A-165
South Carolina Mental Health 2015 .... A-169
South Dakota Mental Health 2015 .... A-173
Tennessee Mental Health 2015 .... A-177
Texas Mental Health 2015 .... A-181
Utah Mental Health 2015 .... A-185
Vermont Mental Health 2015 .... A-189
Virginia Mental Health 2015 .... A-193
Washington Mental Health 2015 .... A-197
West Virginia Mental Health 2015 .... A-201
Wisconsin Mental Health 2015 .... A-205
Wyoming Mental Health 2015 .... A-209

This page intentionally left blank

Alabama Mental Health 2015

Department of Mental Health

http://www.mh.alabama.gov

Eligibility Criteria for State Mental Health Services

Only adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds and Medicaid. There is no income cap for state mental health agency (SMHA) services; however, there is an illness severity requirement for individuals to be eligible for SMHA services. For an individual to receive services from a contracted community mental health center, the individual has to meet the SMI criteria for adults and the SED criteria for children.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	94,478
State psychiatric hospital residents at the start of the year	873
State population	4,833,722

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	17.77
Children, overall	25.45
Adults in community mental health	17.62
Children in community mental health	25.44

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	3	0	3
Community Mental Health Providers	0	26	26
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility.

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	No Responsibility
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA

Agency	Location
Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Alabama's three state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30–90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	15	No
Supported Housing	Statewide	27	No
Supported Employment	Pilot Program	2	Yes
Consumer Operated Services	Parts of the State	13	No
Child/Adolescent EBPs			
Multisystemic Therapy	Not Implementing	NA	NA
Incredible Years	Not Implementing	NA	NA
Coping Power	Planning to Implement	No Response	No Response

Mental Health Integration with Physical Health Care

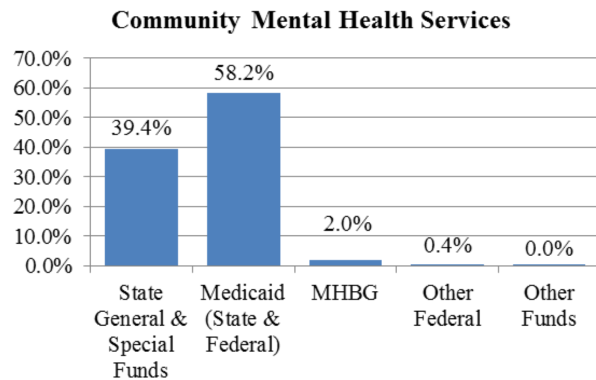
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of

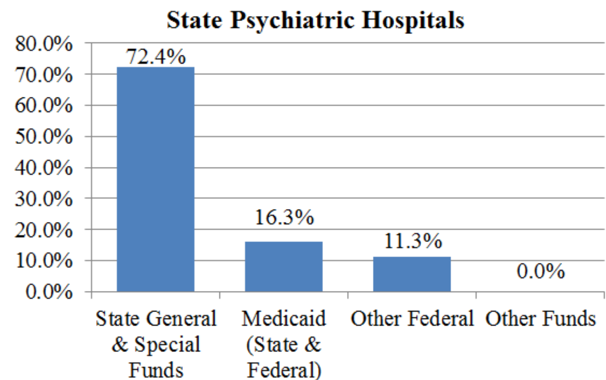
mental health providers in primary care. The SMHA screens or assesses mental health individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$360.7 million
Expenditures for Community Mental Health Services	$253.3 million
Expenditures for State Psychiatric Hospital Inpatient Care	$99.6 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$7.8 million
Per Capita State Mental Health Expenditures	$74.62

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanism Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through fee-for-services only. Mental health services are administered through a Medicaid 1915(i) state plan amendment.

Electronic Health Records

Electronic health records (EHRs) are implemented in 21 community mental health centers (CMHCs) and 1 state psychiatric hospital. Agreements allow the sharing of EHR client data between state hospitals within the state, community providers and state hospitals, community providers, and through a health information exchange (HIE).

This page intentionally left blank

Alaska Mental Health 2015

Division of Behavioral Health, Department of Health and Social Services

http://dhss.alaska.gov/dbh/Pages/default.aspx

Eligibility Criteria for State Mental Health Services

There is no income cap for individuals to be eligible for state mental health agency (SMHA) funded or operated services, however, there is an illness severity requirement.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	22,284
State psychiatric hospital residents at the start of the year	79
State population	735,132

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	28.17
Children, overall	35.19
Adults in community mental health	25.56
Children in community mental health	28.77

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	80	80
Private Psychiatric Hospitals	NA	1	1
General Hospitals With Separate Psychiatric Units	0	3	3
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	No Response
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 11,513
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- Number of individuals served by the SMHA with private insurance: 1,651

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Alaska's state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	1	Yes
Supported Housing	Parts of the State	3	Yes
Supported Employment	Parts of the State	3	No
Consumer Operated Services	Parts of the State	5	No
Illness Self-Management and Recovery	Parts of the State	3	No
Child/Adolescent EBPs			
Therapeutic Foster Care	Parts of the State	11	No
Brief Strategic Family Therapy	Parts of the State	9	Yes
Attachment, Self-Regulation, and Competency (ARC) Model: Treating Traumatic Stress in Children & Adolescents	Parts of the State	8	No

Mental Health Integration with Physical Health Care

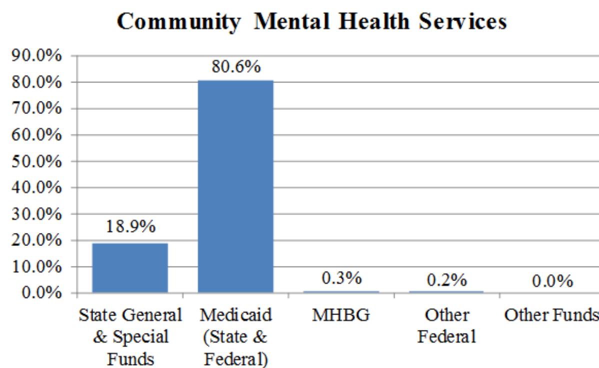
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of

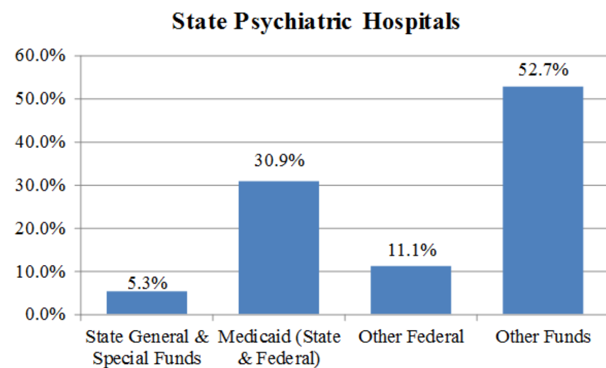
mental health providers in primary care. The SMHA screens or assesses mental health individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$226.5 million
Expenditures for Community Mental Health Services	$192.9 million
Expenditures for State Psychiatric Hospital Inpatient Care	$27.2 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$6.4 million
Per Capita State Mental Health Expenditures	$316.98

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanism Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through fee for services only. Mental health services are administered through 1915(i) option.

Electronic Health Records

Electronic health records (EHRs) are implemented in 45 community mental health centers (CMHCs) and the state psychiatric hospital. A single EHR system is used by the state psychiatric hospital and the CMHCs. There are agreements that allow the sharing of EHR client data between CMHCs.

This page intentionally left blank

Arizona Mental Health 2015

Division of Behavioral Health Services, Department of Health Services
http://www.hs.state.az.us/bhs

Eligibility Criteria for State Mental Health Services

Only adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds. All children and adults with any mental illness are eligible for mental health services funded by Medicaid. There is neither an income cap nor an illness severity requirement for individuals to be eligible for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	158,045
State psychiatric hospital residents at the start of the year	243
State population	6,626,624

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	20.76
Children, overall	33.42
Adults in community mental health	19.29
Children in community mental health	30.86

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	No Response	No Response	No Response
Community Mental Health Providers	No Response	No Response	No Response
Private Psychiatric Hospitals	NA	No Response	No Response
General Hospitals With Separate Psychiatric Units	No Response	No Response	No Response
Nursing Homes and Other ICF-MI and SNF Providers	No Response	No Response	No Response
Residential Treatment Facilities (RTCs)	No Response	No Response	No Response

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	No Response
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA

Agency	Location
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	SMHA part of State Public Health Agency
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The state data system does not allow the SMHA to determine the number of individuals served with expanded Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with private insurance.

The SMHA has Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for evidence-based practices, including supported housing, supported employment, assertive community treatment, and peer supports.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. One state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	No	No	No
Intermediate inpatient (30-90 days)	No	No	No	No	No
Long-term inpatient (more than 90 days)	No	No	No	No	No

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	19	Yes
Supported Housing	Parts of the State	No Response	No Response
Supported Employment	Parts of the State	7	No Response
Consumer Operated Services	Parts of the State	No Response	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	No Response	No Response	No Response
Incredible Years	No Response	No Response	No Response

Mental Health Integration with Physical Health Care

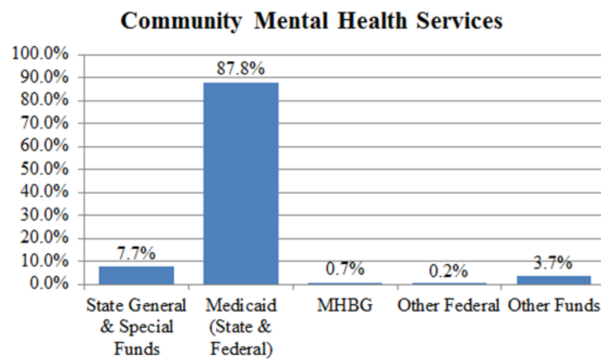
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of

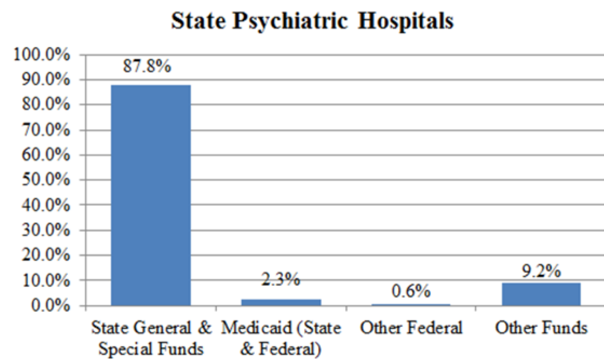
mental health providers in primary care. The SMHA screens or assesses mental health individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$1455.6 million
Expenditures for Community Mental Health Services	$1365.1 million
Expenditures for State Psychiatric Hospital Inpatient Care	$72.3 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$18.2 million
Per Capita State Mental Health Expenditures	$216.87

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanism Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Mental health services are administered through a Medicaid 1115 waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in one state psychiatric hospital. There are agreements that allow the sharing of EHR client data between community providers and the state hospital and between community providers.

This page intentionally left blank

Arkansas Mental Health 2015

Division of Behavioral Health Services, Department of Human Services
http://humanservices.arkansas.gov/dbhs/Pages/default.aspx

Eligibility Criteria for State Mental Health Services

Only adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds and Medicaid. There is an income cap for individuals to be eligible for state mental health agency (SMHA)-funded and operated services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	67,641
State psychiatric hospital residents at the start of the year	209
State population	2,959,373

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	21.06
Children, overall	28.55
Adults in community mental health	20.80
Children in community mental health	28.47

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	14	14
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	No Response
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Part of the SMHA
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability, and Child Welfare

Agency	Location
Substance Use Services Agency	Combined with SMHA

Agency	Location
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA
Child Welfare	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with state Medicaid agency on what mental health benefits will be included in alternative benefits plan. The SMHA did not provided information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Arkansas' state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	4	No
Supported Housing	Parts of the State	6	No
Supported Employment	Parts of the State	3	No
Family Psychoeducation	Parts of the State	3	No
Integrated Treatment for Co-Occurring Disorders	Parts of the State	4	No
Illness Self-Management and Recovery	Parts of the State	6	No
Child/Adolescent EBPs			
Therapeutic Foster Care	Parts of the State	7	No
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	No Response	No

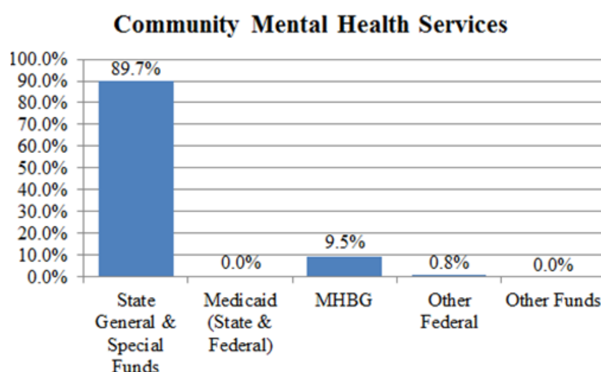
Mental Health Integration with Physical Health Care

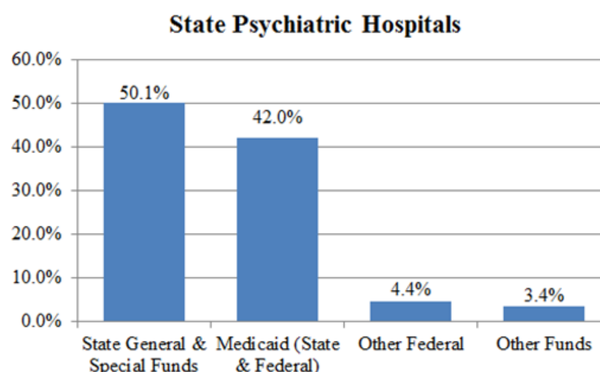
The SMHA does not have initiatives to improve the integration of mental health with primary health care, support the colocation of primary care in mental health programs, or support the colocation of mental health providers in primary care. The SMHA does not screen or assesses mental health individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$127.2 million
Expenditures for Community Mental Health Services	$38.1 million
Expenditures for State Psychiatric Hospital Inpatient Care	$84.8 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$4.3 million
Per Capita State Mental Health Expenditures	$42.98

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanism Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through fee-for-services only.

Electronic Health Records

Electronic health records (EHRs) are implemented in 13 community mental health centers (CMHCs). EHRs have not been implemented in the state psychiatric hospital. The SMHA does not have agreements that allow the sharing of EHR client data between providers.

This page intentionally left blank

California Mental Health 2015

Mental Health Services Division, Department of Health Care Services

http://www.dhcs.ca.gov/services/Pages/MentalHealthPrograms-Svcs.aspx

Eligibility Criteria for State Mental Health Services

The state mental health agency (SMHA) did not provide the criteria used to determine eligibility for mental health services funded by state general or special funds and Medicaid for adults and children. The SMHA did not provide information on whether or not there is an income cap below which individuals are eligible for SMHA services. The SMHA did not indicate whether or not there is an illness severity requirement for SMHA services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	695,885
State psychiatric hospital residents at the start of the year	6,213
State population	38,332,521

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	15.65
Children, overall	25.93
Adults in community mental health	15.26
Children in community mental health	25.92

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	No Response	No Response	No Response
Community Mental Health Providers	No Response	No Response	No Response
Private Psychiatric Hospitals	NA	No Response	No Response
General Hospitals With Separate Psychiatric Units	No Response	No Response	No Response
Nursing Homes and Other ICF-MI and SNF Providers	No Response	No Response	No Response
Residential Treatment Facilities (RTCs)	No Response	No Response	No Response

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	No Response
Older Adult Mental Health Services	No Response
State Psychiatric Hospitals	No Response
Traumatic Brain Injury Services	No Response
Alzheimer's Disease	No Response
Organic Brain Syndrome Services	No Response
Court Evaluation of Mental Health Status	No Response
Services to Individuals with Mental Illness in Prison/Jail	No Response
Sex Offender Services	No Response

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	No Response

Intellectual Disability/Developmental Disability Agency/Services	No Response

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	No Response
State Public Health Agency	No Response
State Housing Agency	No Response

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefits plan. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The SMHA has not indicated whether or not the responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. The SMHA has not indicated how many state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	**Adolescents (13—17 years)**	**Adults (18—64 years)**	**Older Adults (65+ years)**	**Forensic**
Acute inpatient (less than 30 days)	No Response	No Response	No Response	No Response	No Response
Intermediate inpatient (30-90 days)	No Response	No Response	No Response	No Response	No Response
Long-term inpatient (more than 90 days)	No Response	No Response	No Response	No Response	No Response

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	No Response	No Response	No Response
Supported Housing	No Response	No Response	No Response
Supported Employment	No Response	No Response	No Response
Consumer Operated Services	No Response	No Response	No Response
Child/Adolescent EBPs			
Multisystemic Therapy	No Response	No Response	No Response
Therapeutic Foster Care	No Response	No Response	No Response

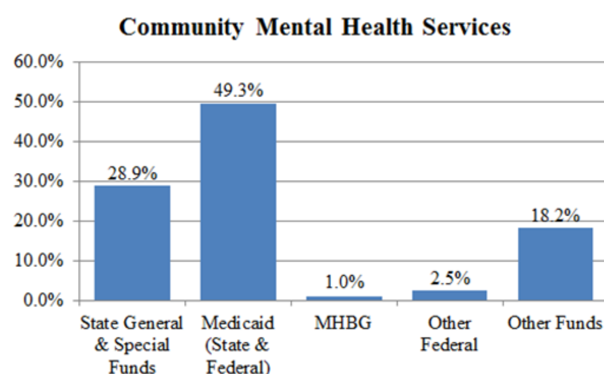
Mental Health Integration with Physical Health Care

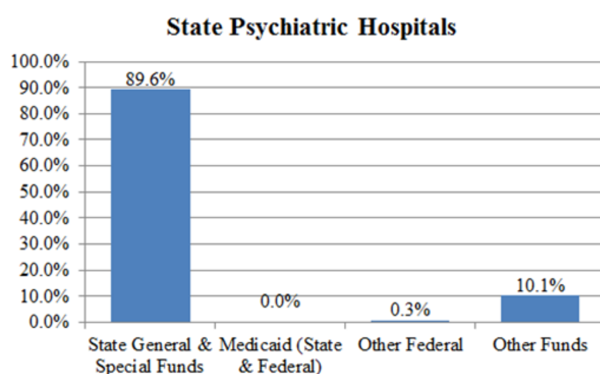
The SMHA did not indicate whether or not it has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, or supports the colocation of mental health providers with primary care. The SMHA did not indicate whether or not it screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$6762.8 million
Expenditures for Community Mental Health Services	$5479.8 million
Expenditures for State Psychiatric Hospital Inpatient Care	$1246.3 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$36.7 million
Per Capita State Mental Health Expenditures	$174.98

SMHA-Controlled Revenues: FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA did not indicate the primary mechanism used in delivering mental health services.

Medicaid

The SMHA did not indicate how mental health services are paid for through Medicaid and if it is using any Medicaid waivers for mental health services.

Electronic Health Records (EHRs)

The SMHA did not indicate the number of community mental health centers (CMHCs) and state psychiatric hospitals that are implementing electronic health records (EHRs). The SMHA did not indicate whether or not a single EHR system is used by just state psychiatric hospitals, CMHCs, or both state psychiatric hospitals and CMHCs. The SMHA has not indicated if there are agreements that allow the sharing of EHR client data between providers.

This page intentionally left blank

Colorado Mental Health 2015

Office of Behavioral Health, Department of Human Services

https://sites.google.com/a/state.co.us/cdhs-behavioral-health/home/about-us

Eligibility Criteria for State Mental Health Services

Only adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds, whereas all adults and children with a mental illness are eligible for services funded by Medicaid. Individuals below 300 percent of the federal poverty line are eligible for state mental health agency (SMHA)-funded or operated mental health services. The SMHA provides services to individuals with an illness severity rating of five or above on a nine-point symptom severity rating scale.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	113,269
State psychiatric hospital residents at the start of the year	480
State population	5,268,367

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	18.73
Children, overall	30.51
Adults in community mental health	18.39
Children in community mental health	29.00

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	19	19
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location

Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	No Response
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 46,611
- The state data system does not allow the SMHA to determine the number of individuals served with expanded Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency to determine what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Colorado's two state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	No	No
Intermediate inpatient (30-90 days)	No	No	Yes	No	No
Long-term inpatient (more than 90 days)	No	No	Yes	No	No

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	17	Yes
Supported Employment	Parts of the State	11	Yes
Consumer Operated Services	Parts of the State	Unknown	No
Medication Algorithms (Schizophrenia)	Parts of the State	Unknown	No
Medication Algorithms (Bipolar Disorders)	Parts of the State	Unknown	No
Family Psychoeducation	Parts of the State	3	No
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	2	No
Functional Family Therapy	Parts of the State	4	No
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	Unknown	No Response

Mental Health Integration with Physical Health Care

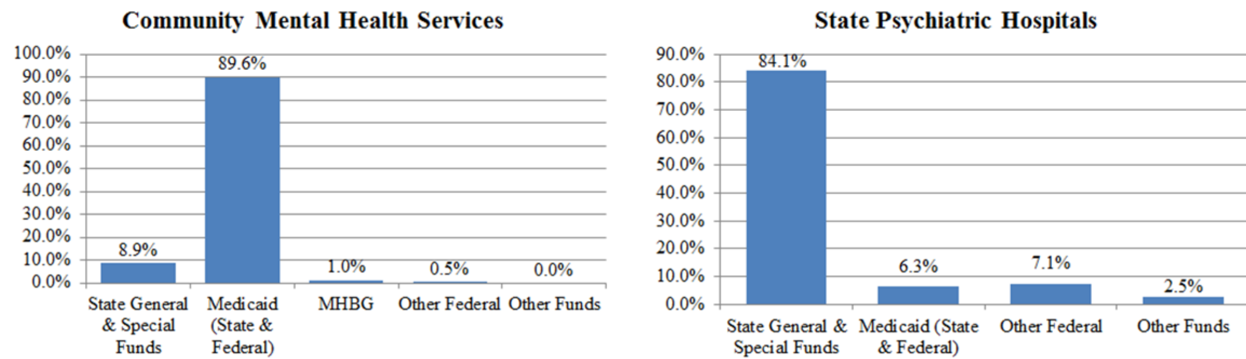
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of

mental health providers in primary care. The SMHA screens or assesses mental health individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$648.5 million
Expenditures for Community Mental Health Services	$522.1 million
Expenditures for State Psychiatric Hospital Inpatient Care	$120.9 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$5.4 million
Per Capita State Mental Health Expenditures	$121.9

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services
The SMHA directly funds, but does not operate local community-based agencies.

Medicaid
Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Mental health services are administered through a Medicaid 1915(b) waiver.

Electronic Health Records
Electronic health records (EHRs) are implemented in 17 community mental health centers (CMHCs). There are agreements that allow the sharing of EHR client data between state hospitals within the state, health maintenance organizations (HMOs), other managed care firms, and the SMHA.

This page intentionally left blank

Connecticut Mental Health 2015

Department of Mental Health and Addiction Services

http://www.ct.gov/dmhas

Eligibility Criteria for State Mental Health Services

Only adults with a serious mental illness (SMI) are eligible for mental health services funded by state general or special funds; however, all adults and children with any mental illness are eligible for mental health services funded by Medicaid. For an individual to receive services, the individual has to have a severe and persistent psychiatric illness as evidenced by one or more of the disorders indicated as defined by the current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association that is of sufficient severity to cause serious functional impairment in any of the following domains: occupation, social relationships, education, housing, and ability to manage tasks of daily living, e.g., bathing, dressing, managing bills, obtaining adequate food, and maintaining an adequate living environment. Eligible primary diagnoses include the following DSM diagnostic codes: 294.0 to 297.1, 298.9, 299.80, 300.3, 300.4, 301.0 to 301.22, 301.83, 301.9, 307.1, 307.51, 309.81, 312.30, and 312.34.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	92,857
State psychiatric hospital residents at the start of the year	713
State population	3,596,080

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	21.28
Children, overall	41.88
Adults in community mental health	20.96
Children in community mental health	41.66

Number of Mental Health Providers the State Mental Health Agency (SMHA) Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	9	94	103
Private Psychiatric Hospitals	NA	NA	NA
General Hospitals With Separate Psychiatric Units	0	13	13
Nursing Homes and Other ICF-MI and SNF Providers	0	1	1
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA

Services Arena	Responsibility
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 34,463
- The state data system does not allow the SMHA to determine the number of individuals served with expanded Medicaid coverage.
- Number of individuals served by the SMHA with private insurance: 6,707

The SMHA is not working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, and peer support services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Three state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	Yes	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	15	Yes
Supported Housing	Statewide	42	Yes
Supported Employment	Statewide	30	Yes
Consumer Operated Services	Statewide	3	No
Family Psychoeducation	Statewide	Not available	Yes
Integrated Treatment for Co-Occurring Disorders	Statewide	13	No

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Illness Self-Management and Recovery	Parts of the State	Not available	No
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	6	Yes
Therapeutic Foster Care	Statewide	16	No
Functional Family Therapy	Parts of the State	5	Yes
Cognitive Behavioral Intervention for Trauma in Schools	Parts of the State	4	Yes
Trauma-Focused Cognitive Behavior Therapy	Statewide	30	Yes
Modular Approach to Therapy for Children	Parts of the State	4	Yes
Triple P (Level 4): Positive Parenting Program	Statewide	29	Yes
Multidimensional Treatment Foster Care	Parts of the State	1	Yes
Multidimensional Family Therapy	Statewide	13 agencies; 27 teams	Yes
Multisystemic Therapy - Family Integrated	Parts of the State	1 agency; 2 teams	Yes

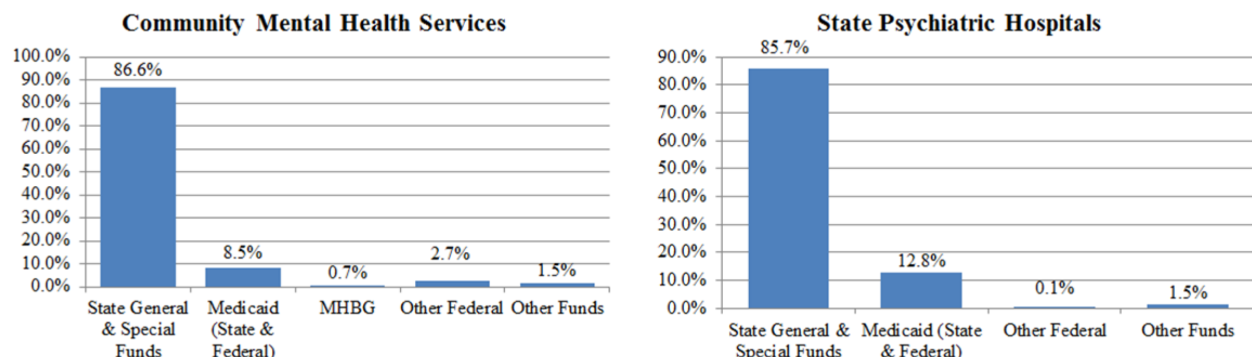
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses some mental health individuals for physical health issues in some community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$803.0 million
Expenditures for Community Mental Health Services	$538.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$211.4 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$53.0 million
Per Capita State Mental Health Expenditures	$223.73

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds local provider agencies and also directly operates community-based programs. In addition, the SMHA funds county or city mental health authorities which, in turn, fund local provider agencies or directly provide mental health services statewide.

Medicaid
Medicaid is paying for mental health services through fee for service (FFS). FFS Medicaid payments are made through the Department of Social Services' Medicaid Management Information System (MMIS). Behavioral health services are administered through a Medicaid 1915(c) waiver.

Electronic Health Records (EHRs)
Electronic health records (EHRs) are implemented in six community mental health centers (CMHCs) and one state psychiatric hospital. A single EHR system is used by the state psychiatric hospital and the CMHCs.

This page intentionally left blank

Delaware Mental Health 2015

Division of Substance Abuse and Mental Health, Department of Health and Social Services
http://dhss.delaware.gov/dsamh/

Eligibility Criteria for State Mental Health Services

The state mental health agency (SMHA) did not provide the criteria used to determine eligibility for mental health services funded by state general or special funds and Medicaid for adults and children. The SMHA did not provide information on whether or not there is an income cap below which individuals are eligible for SMHA services. The SMHA did not indicate whether or not there is an illness severity requirement for SMHA services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	9,830
State psychiatric hospital residents at the start of the year	127
State population	925,749

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	9.61
Children, overall	14.13
Adults in community mental health	8.90
Children in community mental health	8.09

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	3	1	4
Private Psychiatric Hospitals	NA	3	3
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	1	1

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	No Responsibility
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Responsibility
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 3,931
- The state data system does not allow the SMHA to determine the number of individuals served with expanded Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with private insurance.

The SMHA is not working with the state Medicaid agency on what mental health benefits will be included in alternative benefits plan. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for evidence-based practices, including supported housing, supported employment, assertive community treatment, peer supports, and medication-assisted treatment.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Delaware's state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	No
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	No Response	No Response
Supported Housing	Statewide	1	No Response
Supported Employment	Statewide	No Response	No
Consumer Operated Services	Statewide	No Response	No
Integrated Treatment for Co-Occurring Disorders	Statewide	No Response	Yes
Child/Adolescent EBPs			
Incredible Years	Parts of the State	No Response	No Response
Parent-Child Interaction Therapy	Statewide	1	Yes
Trauma-Focused Cognitive Behavior Therapy	Statewide	State program trains community clinicians and maintains a roster	Yes

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
		of 50+ graduates on its state webpage.	
Triple P (Level 4): Positive Parenting Program	Planning to Implement	No Response	No Response
Unspecified	Planning to Implement	No Response	No Response

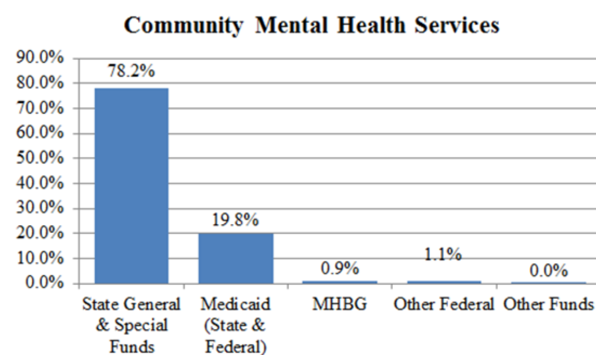
Mental Health Integration with Physical Health Care

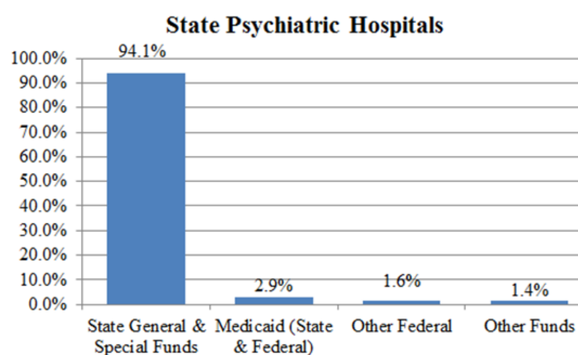
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$88.3 million
Expenditures for Community Mental Health Services	$53.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$32.1 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$2.6 million
Per Capita State Mental Health Expenditures	$94.73

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

SMHA did not indicate the primary mechanism used in delivering mental health services.

Medicaid

The SMHA did not indicate how mental health services are paid for through Medicaid and if it is using any Medicaid waivers for mental health services.

Electronic Health Records

Electronic health records (EHRs) have not yet been implemented in community mental health centers (CMHCs) and state psychiatric hospitals.

This page intentionally left blank

District of Columbia Mental Health 2015

Department of Behavioral Health

http://dbh.dc.gov/

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. Adults below 200 percent of the federal poverty level (FPL) and children below 300 percent of FPL are eligible for state mental health agency (SMHA) services. There is no illness severity requirement to be eligible for SMHA services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	23,872
State psychiatric hospital residents at the start of the year	250
State population	646,449

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	36.31
Children, overall	39.87
Adults in community mental health	34.78
Children in community mental health	38.10

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	2	35	37
Private Psychiatric Hospitals	NA	1	1
General Hospitals With Separate Psychiatric Units	0	4	4
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Part of the SMHA
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	Part of the SMHA
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 5,525
- The state's data system does allow them to determine whether or not an individual is in the Medicaid Expansion population.
- Number of individuals served by the SMHA with private insurance: 178

The SMHA is working with their Medicaid Agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. The SMHA oversees the care coordination of discharge planning between the hospital and the community providers; community providers are required to be involved in discharge planning and local funding is available to reimburse providers for their services prior to the person's discharge form the hospital.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No Response	No Response	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No Response	No Response	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No Response	No Response	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

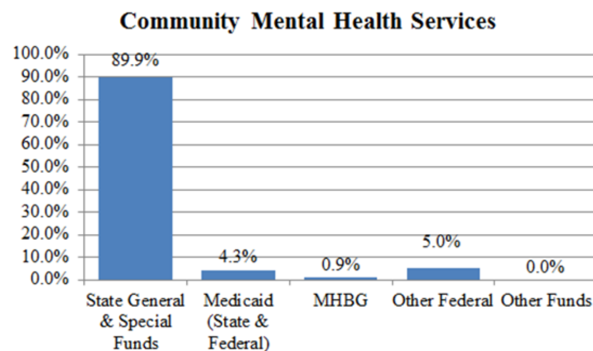
Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	No Response	Yes
Supported Housing	Statewide	No Response	No
Supported Employment	Statewide	No Response	Yes
Consumer Operated Services		No Response	No Response
Child/Adolescent EBPs			
Multisystemic Therapy	Statewide	No Response	Yes
Therapeutic Foster Care	Statewide	No Response	No Response
Functional Family Therapy	Statewide	No Response	Yes
Parent-Child Interaction Therapy	Statewide	No Response	No Response
Trauma-Focused Cognitive Behavior Therapy	Statewide	No Response	Yes
Multisystemic Therapy for Problem Sexual Behavioral	Statewide	No Response	No Response
Parent Child Interaction Therapy	Statewide	No Response	Yes

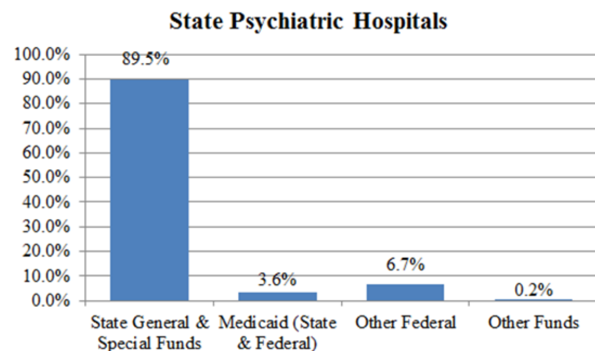
Mental Health Integration with Physical Health Care
The SMHA has initiatives to improve the integration of mental health with primary health care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$219.7 million
Expenditures for Community Mental Health Services	$84.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$87.0 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$48.1 million
Per Capita State Mental Health Expenditures	$335.16

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services
The SMHA directly funds, but does not operate local community-based agencies. The SMHA also directly operates community-based programs.

Medicaid
Medicaid is paying for mental health services through a combination of fee-for-service and managed care.

Electronic Health Records
Electronic health records (EHRs) are implemented in 30 community mental health centers (CMHCs) and 1 state psychiatric hospital. There are agreements that allow the sharing of EHR client data between community providers and the state hospital, health maintenance organizations (HMOs), other managed care firms, and the SMHA.

This page intentionally left blank

Florida Mental Health 2015

Substance Abuse and Mental Health, Department of Children & Families
http://www.dcf.state.fl.us/programs/samh/substanceabuse

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. Individuals below 138 percent of the federal poverty line are eligible for state mental health agency (SMHA)-funded or SMHA-operated services. There is an illness severity requirement for individuals to be eligible for SMHA services (*refer to the Florida Mental Health Act, Chapter 394 Florida Statutes*).

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	231,792
State psychiatric hospital residents at the start of the year	2,592
State population	19,552,860

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	12.05
Children, overall	11.10
Adults in community mental health	12.05
Children in community mental health	11.10

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	3	4	7
Community Mental Health Providers	*	*	*
Private Psychiatric Hospitals	NA	*	*
General Hospitals With Separate Psychiatric Units	*	*	*
Nursing Homes and Other ICF-MI and SNF Providers	*	*	*
Residential Treatment Facilities (RTCs)	*	*	*

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

*The SMHA contracts for the delivery of the majority of community-based behavioral health services with seven managing entities (MEs). MEs were legislatively authorized to create a management structure that places the responsibility for publicly financed behavioral health treatment and prevention services within a single private, non-profit entity at the local level. The SMHA can provide a catalogue of care that names all the subcontracts the MEs have with community-based providers and the services purchased, if requested.

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders, and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 428,468
- The SMHA is unable to determine the number of individuals served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative mental health benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, and peer supports.

State Psychiatric Hospital

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	No	No	No
Intermediate inpatient (30-90 days)	No	No	No	No	No
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	32	Yes
Supported Housing	Parts of the State	No Response	Yes
Supported Employment	Parts of the State	No Response	No
Consumer Operated Services	Parts of the State	No Response	No
Family Psychoeducation	Parts of the State	No Response	No
Integrated Treatment for Co-Occurring Disorders	Parts of the State	No Response	No Response
Illness Self-Management and Recovery	Parts of the State	No Response	No
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	No Response	No
Incredible Years	Parts of the State	No Response	No Response
Therapeutic Foster Care	Statewide	No Response	No
Functional Family Therapy	Parts of the State	No Response	No Response

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Second Steps	Parts of the State	No Response	No Response
Cognitive Behavioral Intervention for Trauma in Schools	Parts of the State	No Response	No Response
Parent-Child Interaction Therapy	Parts of the State	No Response	No Response
Brief Strategic Family Therapy	Parts of the State	No Response	No Response
Cognitive Behavior Therapy for Depression	Parts of the State	No Response	No Response
Cognitive Behavior Therapy for Anxiety	Parts of the State	No Response	No Response
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	No Response	No Response
Triple P (Level 4): Positive Parenting Program	Parts of the State	No Response	No Response
Wraparound	Parts of the State	No Response	Yes

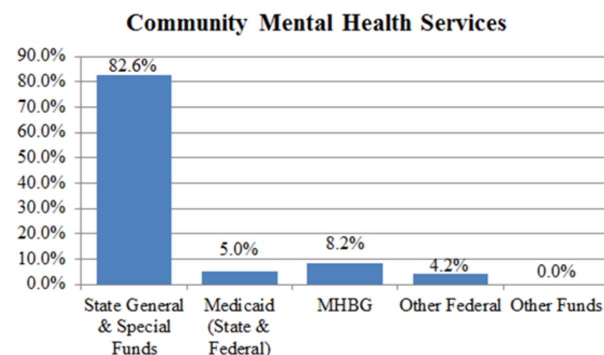
Mental Health Integration with Physical Health Care

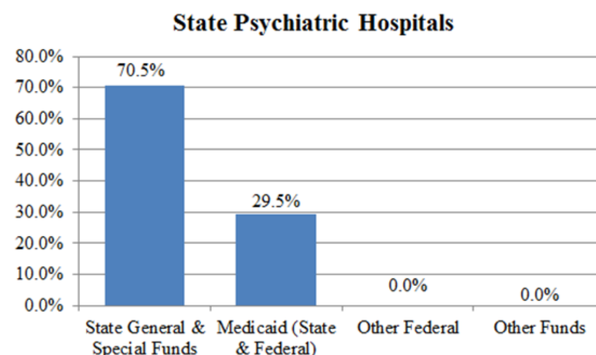
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$714.7 million
Expenditures for Community Mental Health Services	$366.7 million
Expenditures for State Psychiatric Hospital Inpatient Care	$326.3 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$21.7 million
Per Capita State Mental Health Expenditures	$36.05

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide. The SMHA also directly funds, but does not operate, local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through Medicaid 1915 and 1915(i) waivers.

Electronic Health Records

Electronic health records (EHRs) have not been implemented in state psychiatric hospitals. Implementation status of EHRs in community mental health centers (CMHCs) is not available.

This page intentionally left blank

Georgia Mental Health 2015

Department of Behavioral Health and Developmental Disabilities

http://dbhdd.georgia.gov/

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	163,570
State psychiatric hospital residents at the start of the year	910
State population	9,992,167

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	17.88
Children, overall	11.82
Adults in community mental health	17.88
Children in community mental health	11.82

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	5	0	5
Community Mental Health Providers	0	256	256
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Response

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Combined with SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The state did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The state did not provide the number of individuals served by the SMHA with private insurance.

The SMHA is working with the state Medicaid Agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay supported housing, supported employment, assertive community treatment, peer supports and medication assisted treatment.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Georgia's five state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	28	Yes
Supported Housing	Statewide	5	No
Supported Employment	Statewide	21	Yes
Consumer Operated Services	Parts of the State	No Response	No
Family Psychoeducation	Statewide	184	No
Illness Self-Management and Recovery	Statewide	No Response	No
Child/Adolescent EBPs			
Brief Strategic Family Therapy	Parts of the State	Not Available	No
Cognitive Behavior Therapy for Depression	Parts of the State	Not Available	No
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	Not Available	No
Combined Parent-Child Cognitive Behavioral Therapy	Parts of the State	Not Available	Not Available

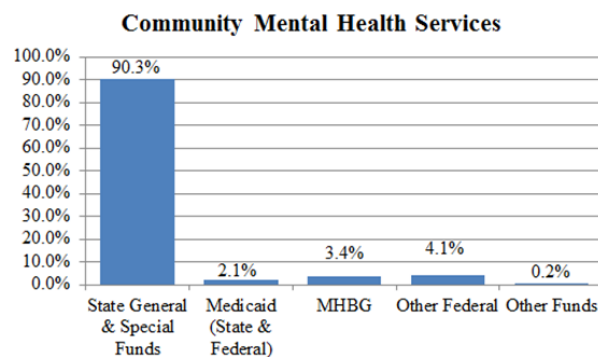
Mental Health Integration with Physical Health Care

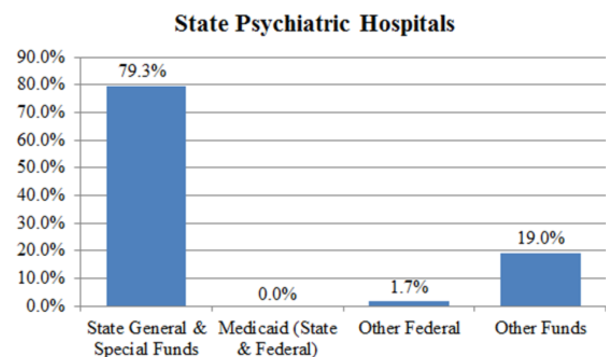
The SMHA has initiatives to improve the integration of mental health with primary health care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$603.4 million
Expenditures for Community Mental Health Services	$373.0 million
Expenditures for State Psychiatric Hospital Inpatient Care	$230.3 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$0
Per Capita State Mental Health Expenditures	$60.15

SMHA-Controlled Revenues: FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies. The SMHA also funds county or city mental health authorities which, in turn, fund local provider agencies or directly provide mental health services in parts of the state.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. The SMHA pays for aged, blind, and disabled individuals and the state Medicaid authority pays for foster care or adoption assistance youth, CHIP and low income Medicaid populations.

Electronic Health Records

Electronic health records (EHRs) are implemented in all five state psychiatric hospitals. The SMHA does not know details of the scope of EHRs the various community providers may have implemented as it differs from provider to provider. A single EHR system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state psychiatric hospitals within the state; community providers and state psychiatric hospitals; state psychiatric hospitals, private psychiatric hospitals, and general hospitals; and through a health information exchange (HIE).

This page intentionally left blank

Hawaii Mental Health 2015

Behavioral Health Administration, Department of Health

http://hawaii.gov/health/mental-health

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds and Medicaid. Individuals below 138 percent of the federal poverty line are eligible for state mental health agency (SMHA)-funded or SMHA-operated services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	12,725
State psychiatric hospital residents at the start of the year	198
State population	1,404,054

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	9.76
Children, overall	6.56
Adults in community mental health	9.50
Children in community mental health	6.56

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	16	72	88
Private Psychiatric Hospitals	NA	1	1
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	25	25
Residential Treatment Facilities (RTCs)	1	8	9

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 3,444
- Number of individuals served by the SMHA with expanded Medicaid coverage: 2,477
- Number of individuals served by the SMHA with private insurance: 1,144

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, peer supports, and medication-assisted treatment.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Hawaii's state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Supported Housing	Statewide	6	Yes
Supported Employment	Statewide	4	No
Family Psychoeducation	Statewide	5	Yes
Integrated Treatment for Co-Occurring Disorders	Statewide	18	No
Illness Self-Management and Recovery	Statewide	8	No
Wellness Recovery Action Plan	Statewide	18	No
Seeking Safety	Parts of the State	2	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	Statewide	6	Yes
Therapeutic Foster Care	Statewide	12	No
Functional Family Therapy	Parts of the State	3	Yes
Parent-Child Interaction Therapy	Pilot Program	1	No
Trauma-Focused Cognitive Behavior Therapy	Statewide	2	No
Modular Approach to Therapy for Children	Statewide	Not available	No

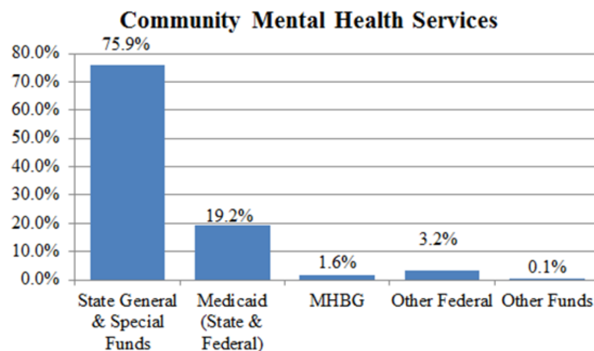
Mental Health Integration with Physical Health Care

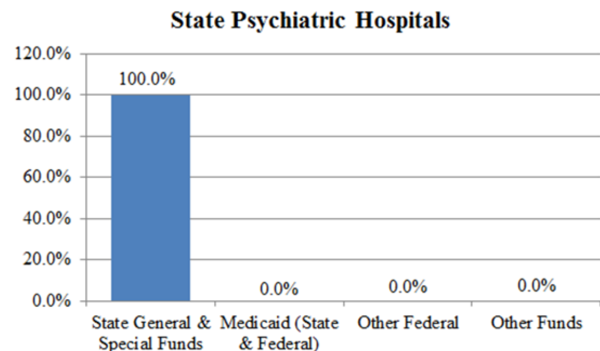
The SMHA has initiatives to improve the integration of mental health with primary health care and supports the colocation of primary care in mental health programs. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$188.1 million
Expenditures for Community Mental Health Services	$111.5 million
Expenditures for State Psychiatric Hospital Inpatient Care	$69.1 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$7.5 million
Per Capita State Mental Health Expenditures	$137.04

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Note: “Other” funds provided 0.1% revenue toward community mental health services; Medicaid, “other federal,” and “other” funds provided 0% revenue toward state psychiatric hospitals.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are provided through an 1115 waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in 20 community mental health centers (CMHCs) and the state psychiatric hospital. There are agreements that allow the sharing of EHR client data between community providers and through a health information exchange (HIE).

This page intentionally left blank

Idaho Mental Health 2015

Division of Behavioral Health, Department of Health and Welfare
http://healthandwelfare.idaho.gov/Medical/MentalHealth/tabid/103/Default.aspx

Eligibility Criteria for State Mental Health Services

Only adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds and Medicaid. There is no income cap for state mental health agency (SMHA) services; however, there is an illness severity requirement for individuals to be eligible for SMHA-operated or SMHA-funded mental health services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	14,106
State psychiatric hospital residents at the start of the year	145
State population	1,612,136

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	10.34
Children, overall	4.32
Adults in community mental health	9.82
Children in community mental health	4.31

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	7	0	7
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA has Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding and delivery of community-based mental health services. One state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	7	Yes
Supported Housing	Parts of the State	No Response	No
Supported Employment	Statewide	7	No
Integrated Treatment for Co-Occurring Disorders	Statewide	7	No
Child/Adolescent EBPs			
Therapeutic Foster Care	Statewide	7	No
Functional Family Therapy	Parts of the State	1	No
Parenting with Love and Limits	Statewide	7	Yes

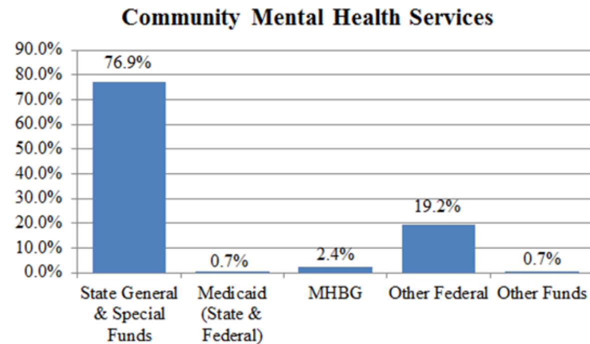
Mental Health Integration with Physical Health Care

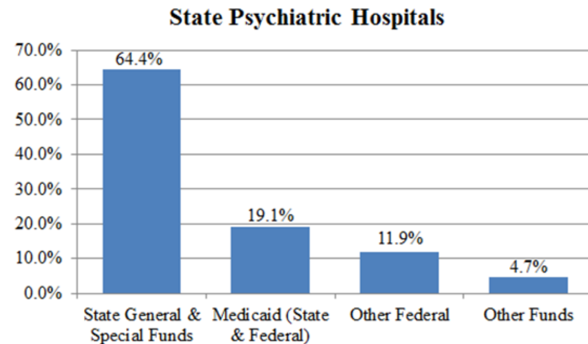
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$59.2 million
Expenditures for Community Mental Health Services	$28.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$27.8 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$2.8 million
Per Capita State Mental Health Expenditures	$36.31

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly operates community-based programs.

Medicaid

Medicaid is paying for mental health services through managed care only. Behavioral health services are provided through a 1915(b) waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in seven community mental health centers (CMHCs) and two state psychiatric hospitals. A single EHR system is used by the state psychiatric hospitals and the CMHCs. There are agreements that allow the sharing of EHR client data between state hospitals within the state and community providers and state hospitals.

This page intentionally left blank

Illinois Mental Health 2015

Division of Mental Health, Department of Human Services

http://www.dhs.state.il.us/page.aspx?item=29763

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is an income cap below which individuals are eligible for state mental health agency (SMHA) services. The cap is based on combined household income and federal poverty level above 400 percent. There is no illness severity requirement for SMHA services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	135,197
State psychiatric hospital residents at the start of the year	1,185
State population	12,882,135

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	9.95
Children, overall	12.27
Adults in community mental health	9.95
Children in community mental health	12.27

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	7	0	7
Community Mental Health Providers	0	180	180
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of SMHA
Older Adult Mental Health Services	Part of SMHA
State Psychiatric Hospitals	Part of SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of SMHA
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	Part of SMHA

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability, and Rehabilitation Services

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA

Agency	Location
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA
Rehabilitation Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 103,303
- The state's data system does not allow the SMHA to determine whether or not an individual is in the expanded Medicaid population.
- The number of individuals served by the SMHA with private insurance is not available.

The SMHA is not working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing and supported employment services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Illinois' seven state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	No
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	21	Yes
Supported Housing	Statewide	*	No
Supported Employment	Statewide	41	Yes
Child/Adolescent EBPs			
Practicewise	Statewide	Not Applicable	No

*The SMHA does not use programs for its supported housing initiatives

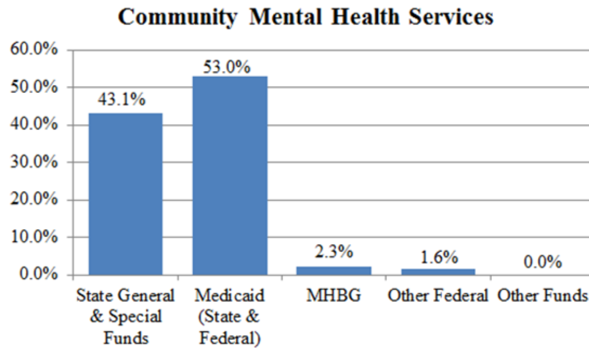
Mental Health Integration with Physical Health Care

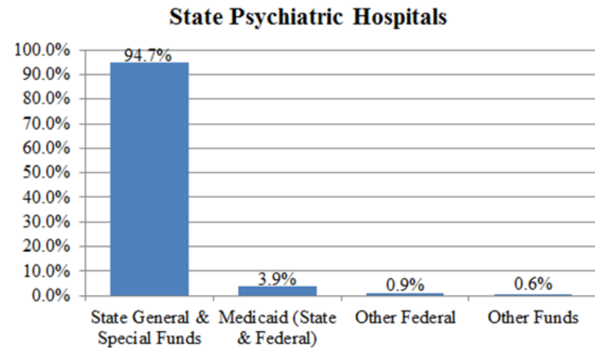
The SMHA has initiatives to improve the integration of mental health with primary health care. The SMHA does not screen or assesses individuals for physical health issues in community mental health programs.

SMHA-Controlled Expenditures for Mental Health

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$857.0 million
Expenditures for Community Mental Health Services	$606.1 million
Expenditures for State Psychiatric Hospital Inpatient Care	$232.4 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$18.5 million
Per Capita State Mental Health Expenditures	$66.67

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies. The SMHA also funds county or city mental health authorities which, in turn, fund local provider agencies or directly provide mental health services in parts of the state.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-services and managed care. Providers submit claims for each service provided. These claims are adjudicated by the state Medicaid agency.

Electronic Health Records

Electronic health records (EHRs) have not yet been the state psychiatric hospitals. Although some community mental health centers (CMHCs) have moved forward to establish and utilize an EHR system, the SMHA currently does not fund nor oversee the operation of these independent systems.

This page intentionally left blank

Indiana Mental Health 2015

Division of Mental Health and Addiction, Family and Social Services Administration
http://www.in.gov/fssa

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds. All adults and children with any mental illness are eligible for mental health services funded by Medicaid. Individuals below 200 percent of the federal poverty line are eligible for state mental health agency (SMHA)-funded or SMHA-operated mental health services. Adults must have functional impairment in at least two areas and / or adolescents must have functional impairments in at least one area (activities of daily living, interpersonal functioning, concentration, persistence, and pace, or adaptation to change) and the duration of mental illness has been, or is expected to be, in excess of 12 months.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	128,192
State psychiatric hospital residents at the start of the year	733
State population	6,570,902

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	15.52
Children, overall	32.04
Adults in community mental health	15.39
Children in community mental health	32.02

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	0	25	25
Private Psychiatric Hospitals	NA	NA	NA
General Hospitals With Separate Psychiatric Units	NA	NA	NA
Nursing Homes and Other ICF-MI and SNF Providers	NA	NA	NA
Residential Treatment Facilities (RTCs)	NA	NA	NA

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability, and Child Welfare

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA
Child Welfare	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 103,400
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- Number of individuals served by the SMHA with private insurance: 35,372

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Community mental health centers (CMHCs) are responsible for managing who is admitted and discharged from the state hospitals for all groups except persons with forensic commitments and persons with primary intellectual disabilities. Indiana's six state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0–12 years)	Adolescents (13–17 years)	Adults (18–64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	No	No	No
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	No
Long-term inpatient (more than 90 days)	Yes	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	3	No
Supported Housing	Parts of the State	Unknown	No
Supported Employment	Parts of the State	Unknown	No
Consumer Operated Services	Parts of the State	7	No
Integrated Treatment for Co-Occurring Disorders	Parts of the State	Unknown	No
Illness Self-Management and Recovery	Parts of the State	Unknown	No

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Child/Adolescent EBPs			
Incredible Years	Planning to Implement	No Response	No Response
Therapeutic Foster Care	Parts of the State	Unknown	No
Functional Family Therapy	Planning to Implement	Not applicable	Not applicable
Cognitive Behavioral Intervention for Trauma in Schools	Planning to Implement	Not applicable	Not applicable
Parent-Child Interaction Therapy	Planning to Implement	Not applicable	Not applicable
Trauma-Focused Cognitive Behavior Therapy	Planning to Implement	Not applicable	Not applicable

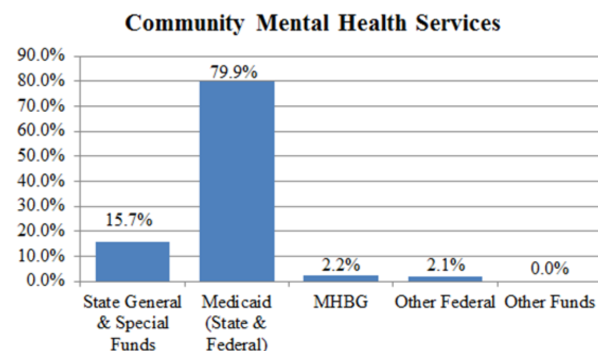
Mental Health Integration with Physical Health Care

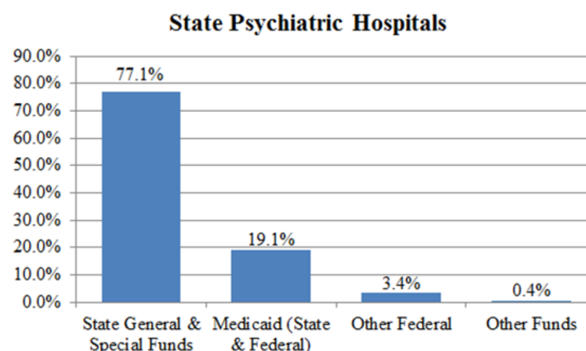
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$486.5 million
Expenditures for Community Mental Health Services	$323.9 million
Expenditures for State Psychiatric Hospital Inpatient Care	$156.9 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$5.7 million
Per Capita State Mental Health Expenditures	$73.78

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administrated through 1915(b), 1915(c), and 1915(i) waivers.

Electronic Health Records

Electronic health records (EHRs) are implemented in 25 CMHCs and 6 state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals.

This page intentionally left blank

Iowa Mental Health 2015

Division of Mental Health and Disability Services, Department of Human Services
http://dhs.iowa.gov/mhds

Eligibility Criteria for State Mental Health Services

The SMHA did not provide the criteria used to determine eligibility for mental health services funded by state general or special funds and Medicaid for adults and children. The state mental health agency (SMHA) did not provide information on whether or not there is an income cap below which individuals are eligible for SMHA services. The SMHA did not indicate whether or not there is an illness severity requirement for SMHA services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	111,351
State psychiatric hospital residents at the start of the year	118
State population	3,090,416

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	29.61
Children, overall	57.00
Adults in community mental health	29.45
Children in community mental health	56.84

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	26	26
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	31	31
Nursing Homes and Other ICF-MI and SNF Providers	0	3	3
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	No Responsibility
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Different state department
Intellectual Disability/Developmental Disability Agency/Services	Combined with SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefits plan. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Iowa's two state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No Response	No Response	No Response	No Response	No Response
Intermediate inpatient (30-90 days)	No Response	No Response	No Response	No Response	No Response
Long-term inpatient (more than 90 days)	No Response	No Response	No Response	No Response	No Response

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	No Response	No Response	No Response
Supported Housing	No Response	No Response	No Response
Supported Employment	No Response	No Response	No Response
Consumer Operated Services	No Response	No Response	No Response
Child/Adolescent EBPs			
Multisystemic Therapy	No Response	No Response	No Response
Incredible Years	No Response	No Response	No Response

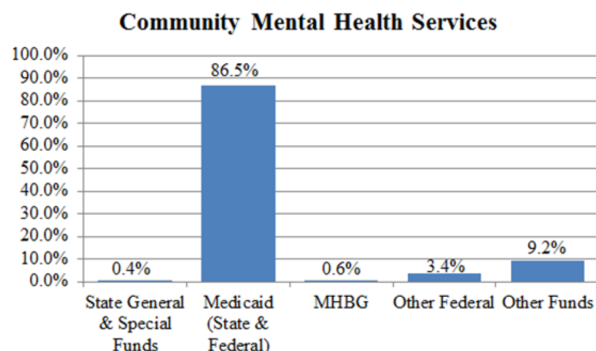
Mental Health Integration with Physical Health Care

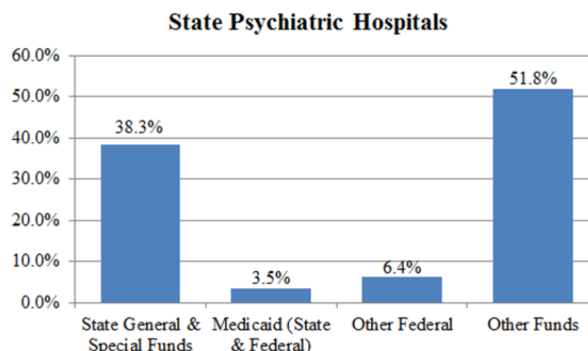
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$479.1 million
Expenditures for Community Mental Health Services	$409.9 million
Expenditures for State Psychiatric Hospital Inpatient Care	$57.9 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$11.3 million
Per Capita State Mental Health Expenditures	$154.27

SMHA-Controlled Revenues: FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide. The SMHA also directly funds, but does not operate, local community-based agencies.

Medicaid

The SMHA did not indicate how mental health services are paid for through Medicaid and if it is using any Medicaid waivers for mental health services.

Electronic Health Records

The SMHA did not indicate the number of community mental health centers (CMHCs) and state psychiatric hospitals that are implementing electronic health records (EHRs). The SMHA did not indicate whether or not a single EHR system is used by just hospitals, CMHCs, or both hospitals and CMHCs. The SMHA has not indicated if there are agreements that allow the sharing of EHR client data between providers.

This page intentionally left blank

Kansas Mental Health 2015

Behavioral Health Services, Community Services and Programs Commission, Department for Aging and Disability Services

https://www.kdads.ks.gov/commissions/behavioral-health

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds and Medicaid.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	131,963
State psychiatric hospital residents at the start of the year	756
State population	2,893,957

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	43.57
Children, overall	50.16
Adults in community mental health	43.57
Children in community mental health	50.16

Number of Mental Health Providers the State Mental Health Agency (SMHA) Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	26	26
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	No Responsibility
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Response
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Part of the SMHA

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 51,818
- Number of individuals served by the SMHA with private insurance: 48,419

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Kansas' two state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	No Response
Intermediate inpatient (30-90 days)	No	No	No	No	No Response
Long-term inpatient (more than 90 days)	No	No	No	No	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Supported Employment	Parts of the State	12	Yes
Consumer Operated Services	Not Implementing	NA	NA
Family Psychoeducation	Parts of the State	4	Yes
Integrated Treatment for Co-Occurring Disorders	Parts of the State	13	Yes
Illness Self-Management and Recovery	Parts of the State	3	Yes
Strengths Model Case Management	Parts of the State	14	Yes
Common Ground	Parts of the State	6	No Response
Child/Adolescent EBPs			
Positive Behavior Supports	Statewide	No Response	Yes
Coordinated Specialty Care for First Episode Psychosis	Pilot Program	No Response	No

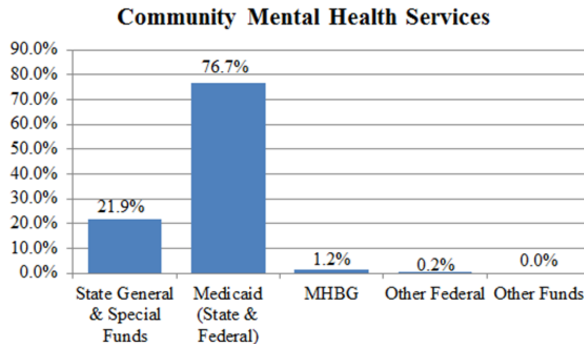
Mental Health Integration with Physical Health Care

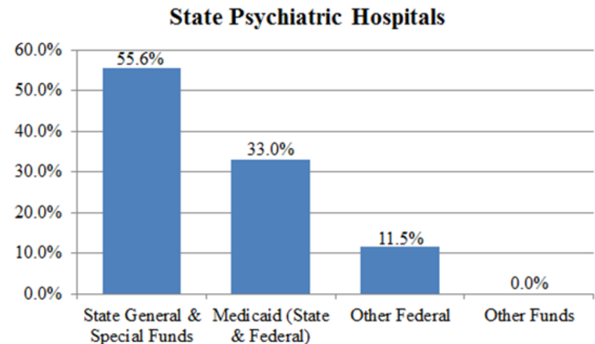
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$357.6 million
Expenditures for Community Mental Health Services	$266.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$89.8 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$1.2 million
Per Capita State Mental Health Expenditures	$124.11

SMHA-Controlled Revenues: FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

The SMHA did not indicate how mental health services are paid for through Medicaid and if it is using any Medicaid waivers for mental health services.

Electronic Health Records

Electronic health records (EHRs) are implemented in 26 community mental health centers (CMHCs) and 2 state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state.

This page intentionally left blank

Kentucky Mental Health 2015

Department for Behavioral Health, Developmental and Intellectual Disabilities

http://chfs.ky.gov/dbhdid/

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds; whereas all adults and children with mental illness are eligible for services funded by Medicaid. There is neither an income cap nor an illness severity requirement for individuals to be eligible for state mental health agency (SMHA)-funded or operated services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	158,084
State psychiatric hospital residents at the start of the year	446
State population	4,395,295

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	29.46
Children, overall	57.65
Adults in community mental health	28.93
Children in community mental health	57.65

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	1	3
Community Mental Health Providers	0	14	14
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	1	1
Nursing Homes and Other ICF-MI and SNF Providers	2	0	2
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	No Responsibility
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Combined with SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	No Response

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefits plan. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Two state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	No	No	No

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	16	Yes
Supported Housing	Statewide	13	Yes
Supported Employment	Statewide	16	Yes
Consumer Operated Services	Parts of the State	8	Yes
Integrated Treatment for Co-Occurring Disorders	Planning to Implement	Not applicable	Not applicable
Illness Self-Management and Recovery	Parts of the State	37	No
Peer Support	Statewide	12	No
Child/Adolescent EBPs			
Incredible Years	Parts of the State	Unknown	No
Parent-Child Interaction Therapy	Parts of the State	12	No
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	10	Yes
High Fidelity Wraparound	Statewide	14	Yes

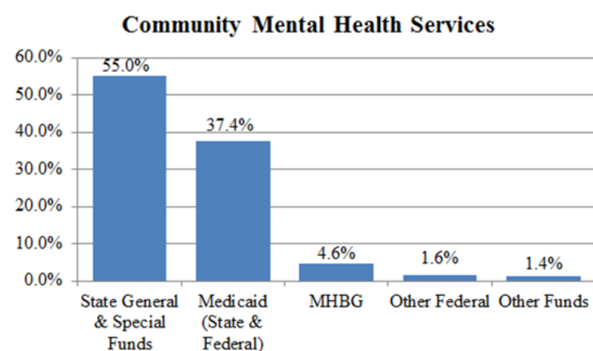
Mental Health Integration with Physical Health Care

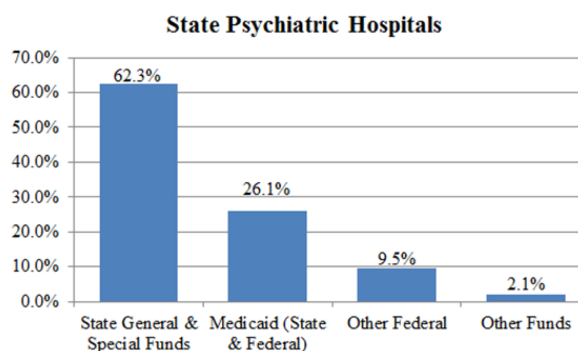
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$259.4 million
Expenditures for Community Mental Health Services	$121.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$128.2 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$9.6 million
Per Capita State Mental Health Expenditures	$59.03

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administrated through 1115, 1915(b), and 1915(c) waivers.

Electronic Health Records

Electronic health records (EHRs) are implemented in 14 community mental health centers (CMHCs). EHRs have not yet been implemented in state psychiatric hospitals.

This page intentionally left blank

Louisiana Mental Health 2015

Office of Behavioral Health, Department of Health and Hospitals
http://dhh.louisiana.gov/index.cfm/subhome/10

Eligibility Criteria for State Mental Health Services

The state mental health agency (SMHA) did not provide the criteria used to determine eligibility for mental health services funded by state general or special funds and Medicaid for adults and children. The SMHA did not provide information on whether or not there is an income cap below which individuals are eligible for SMHA services. The SMHA did not indicate whether or not there is an illness severity requirement for SMHA services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	48,828
State psychiatric hospital residents at the start of the year	584
State population	4,625,470

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	11.61
Children, overall	6.85
Adults in community mental health	11.22
Children in community mental health	6.85

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	1,673	1,673
Private Psychiatric Hospitals	NA	3	3
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	56	56

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Part of another agency
Alzheimer's Disease	Part of another agency
Organic Brain Syndrome Services	Part of another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Part of the SMHA
Sex Offender Services	Part of the SMHA

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Disorders	Combined with SMHA

Agency	Location
Intellectual Disability/Developmental Disability Agency/Services (Office of Citizens with Intellectual and Developmental Disabilities)	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: In FY14 there was 1,253,529 unduplicated Louisiana Behavioral Health Partnership (LBHP) members.
- Number of individuals served by the SMHA with private insurance is not available.

Louisiana does not have an alternative benefits plan. Though the SMHA has had discussions with Medicaid regarding the implementation of health homes, none have been implemented to date. The SMHA has no information on private insurers' payment of evidence based practices.

State Psychiatric Hospitals

The SMHA has oversight of the state psychiatric hospitals, Central Louisiana State Hospital and East Louisiana Mental Health System (which is comprised of an acute unit, a forensic unit and a civil intermediate unit). Both of the state run and operated psychiatric hospitals are accredited by the Joint Commission. In addition, the SMHA currently has cooperative endeavor agreements with three private psychiatric hospitals which fund acute care beds for the indigent population.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Yes	16	Yes
Supported Housing	Yes	13	Yes
Supported Employment	NA	NA	NA
Consumer Operated Services	Yes	1	No
Child/Adolescent EBPs			
Multisystemic Therapy	Yes	29	Yes
Incredible Years	NA	NA	NA
Functional Family Therapy	Yes	24	Yes
Homebuilders	Yes	11	Yes

Mental Health Integration with Physical Health Care

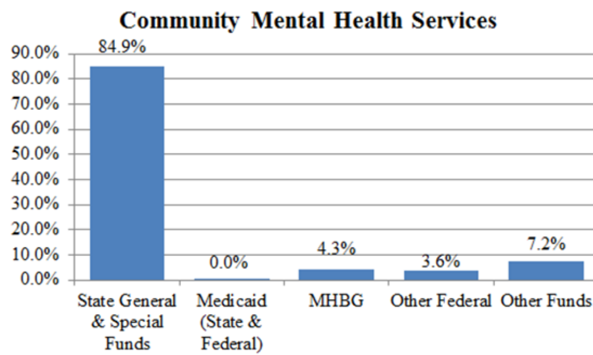
The SMHA has worked collaboratively with the Medicaid agency to support the integration of physical and behavioral health services. Effective December 1, 2015, the Bayou Health managed care organization (MCO) will be responsible for the following functions to support integration:

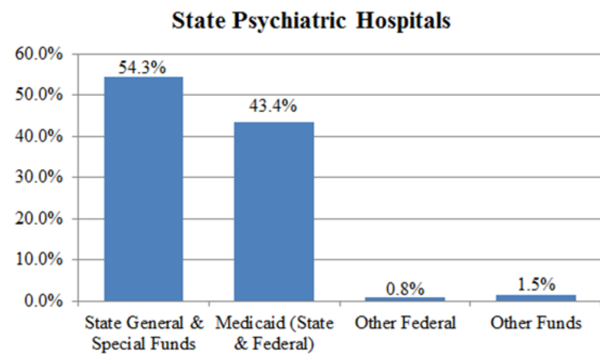
- Use of an assessment tool by the MCO and network providers,
- Training on integrated care, including but not limited to the appropriate utilization of basic behavioral health screenings in the primary care setting and basic physical health screenings in the behavioral health setting,
- Integrated data, quality, and claims systems, and
- Develop capacity for enhanced rates or incentives to behavioral health clinics to employ a primary care provider (physician, physician's assistant, nurse practitioner, or nurse) part- or full-time in a psychiatric specialty setting to monitor the physical health of patients.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$223.7 million
Expenditures for Community Mental Health Services	$94.3 million
Expenditures for State Psychiatric Hospital Inpatient Care	$129.4 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$0.0
Per Capita State Mental Health Expenditures	$48.31

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds some community-based programs. The SMHA also directly funds to local governing entities which, in turn, fund local provider agencies or directly provide mental health services region wide.

Medicaid

The SMHA contracts with a Prepaid Inpatient Health Plan (PIHP) to manage the delivery of Medicaid-funded specialized behavioral health services, inclusive of Medicaid State Plan services, 1915(c) waiver services, 1915(b) (3) services, and 1915(i) services.

Electronic Health Records

State psychiatric hospitals continue to use a legacy Electronic Medical Record (EMR) and have not adopted a formal Electronic Health Record (EHR). At this time, nine of ten Local Governing Entities have contracted with EHR vendors (i.e., ICANotes, CareLogic-Qualifacts, SuccessEHS, and E-Clinical Works) with the remaining engaging in efforts to secure a contract.

This page intentionally left blank

Maine Mental Health 2015

Substance Abuse and Mental Health Services, Department of Health and Human Services
http://www.maine.gov/dhhs/samhs/

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is no income cap for individuals to be eligible for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	68,116
State psychiatric hospital residents at the start of the year	169
State population	1,328,302

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	42.19
Children, overall	88.42
Adults in community mental health	42.08
Children in community mental health	88.30

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	179	179
Private Psychiatric Hospitals	NA	2	2
General Hospitals With Separate Psychiatric Units	9	No Response	9
Nursing Homes and Other ICF-MI and SNF Providers	0	3	3
Residential Treatment Facilities (RTCs)	0	8	8

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Part of the SMHA
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 94,871
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is not working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA has Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for the supported housing, supported employment, assertive community treatment, peer supports, and medication-assisted treatment.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	11	Yes
Supported Housing	Parts of the State	3	No
Supported Employment	Parts of the State	No Response	No
Consumer Operated Services	Parts of the State	16	No
Family Psychoeducation	Parts of the State	No Response	No
Integrated Treatment for Co-Occurring Disorders	Statewide	4	No
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	10	Yes
Incredible Years	Parts of the State	2	Yes
Therapeutic Foster Care	Statewide	10	No
Functional Family Therapy	Parts of the State	2	Yes
Trauma-Focused Cognitive Behavior Therapy	Planning to Implement	No Response	No Response
Modular Approach to Therapy for Children	Planning to Implement	No Response	No Response
Multidimensional Treatment Foster Care	Parts of the State	1	Yes

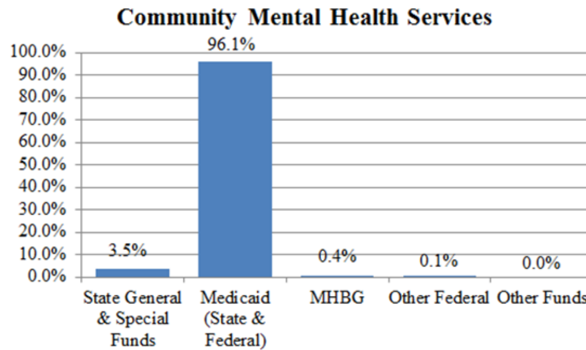
Mental Health Integration with Physical Health Care

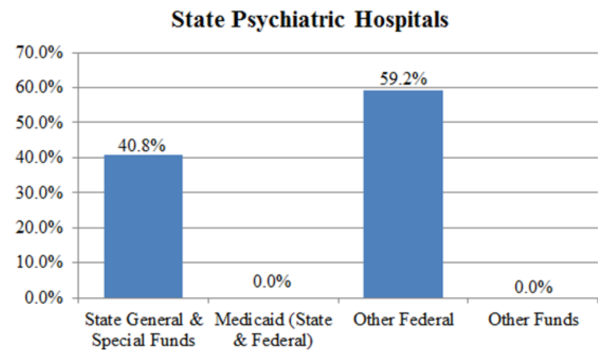
The SMHA supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$482.0 million
Expenditures for Community Mental Health Services	$417.3 million
Expenditures for State Psychiatric Hospital Inpatient Care	$52.3 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$12.4 million
Per Capita State Mental Health Expenditures	$362.75

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through fee-for-services only.

Electronic Health Records

Electronic health records (EHRs) are implemented in two state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state and through a health information exchange (HIE).

This page intentionally left blank

Maryland Mental Health 2015

Mental Hygiene Administration, Department of Health and Mental Hygiene
http://www.dhmh.state.md.us

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. Individuals below 138 percent of the federal poverty line are eligible for state mental health agency (SMHA)-funded or SMHA-operated mental health services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	165,346
State psychiatric hospital residents at the start of the year	957
State population	5,928,814

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	23.30
Children, overall	43.55
Adults in community mental health	22.98
Children in community mental health	43.35

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	No Response	5	5
Community Mental Health Providers	No Response	488	488
Private Psychiatric Hospitals	NA	3	3
General Hospitals With Separate Psychiatric Units	No Response	28	28
Nursing Homes and Other ICF-MI and SNF Providers	No Response	0	0
Residential Treatment Facilities (RTCs)	2	8	10

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Part of the SMHA
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 155,431
- Number of individuals served by the SMHA with expanded Medicaid coverage: 26,075
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits are included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Five state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

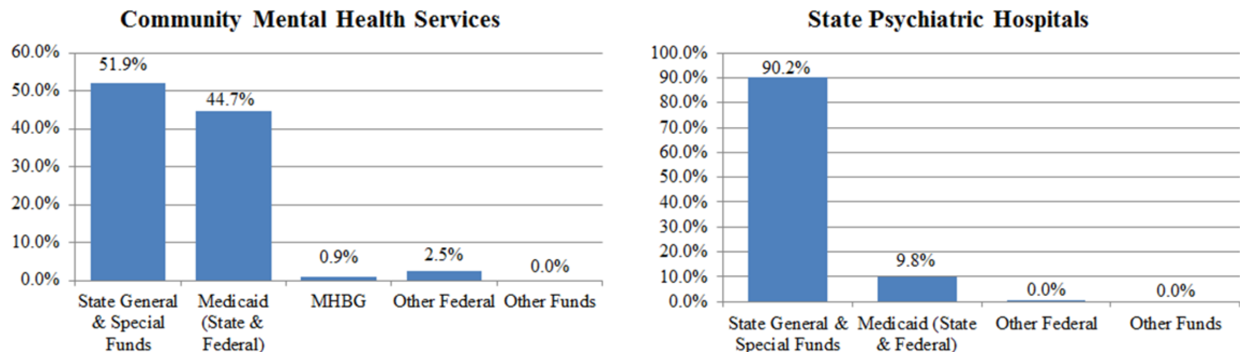
Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	20	Yes
Supported Housing	Statewide	112	No
Supported Employment	Statewide	26	Yes
Consumer Operated Services	Statewide	26	No
Family Psychoeducation	Parts of the State	3	Yes
Integrated Treatment for Co-Occurring Disorders	Parts of the State	3	Yes
Illness Self-Management and Recovery	Pilot Program	2	Yes
Coordinated Specially Care for First Episode Psychosis	Parts of the State	No Response	No Response
Older Adult EBP to be determined	Planning to Implement	No Response	Yes
Child/Adolescent EBPs			
Incredible Years	Planning to Implement	No Response	No Response
Functional Family Therapy	Planning to Implement	No Response	No Response
Parent-Child Interaction Therapy	Planning to Implement	No Response	No Response

Mental Health Integration with Physical Health Care
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$1138.6 million
Expenditures for Community Mental Health Services	$834.5 million
Expenditures for State Psychiatric Hospital Inpatient Care	$272.9 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$31.2 million
Per Capita State Mental Health Expenditures	$191.45

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services
The SMHA directly funds, but does not operate local community-based agencies. The SMHA also funds county or city mental health authorities which, in turn, fund local provider agencies or directly provide mental health services statewide.

Medicaid
Medicaid is paying for mental health services through fee-for-services only. Behavioral health services are administered through 1115, 1915(c), and 1915(i) waivers.

Electronic Health Records
Electronic health records (EHRs) are implemented in one state psychiatric hospital. There are agreements that allow the sharing of EHR client data between state hospitals within the state.

This page intentionally left blank

Massachusetts Mental Health 2015

Department of Mental Health

http://www.mass.gov/eohhs/gov/departments/dmh/

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for state mental health agency (SMHA) services funded by state general or special funds. There is no income cap for SMHA service eligibility; however, there is an illness severity requirement. Individuals must meet qualifying DSM criteria for SMI and functioning must be substantially impaired by the disorder in one or more major life activities with an expected duration of a year or more.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	32,046
State psychiatric hospital residents at the start of the year	536
State population	6,692,824

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	5.17
Children, overall	3.32
Adults in community mental health	5.07
Children in community mental health	3.29

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	5	140	145
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	2	1	3
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	6	No Response	6

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Four state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	21	No
Supported Housing	Statewide	52	No
Supported Employment	Statewide	52	No
Consumer Operated Services	Statewide	6	No
Child/Adolescent EBPs			
Therapeutic Foster Care	Statewide	13	No
Triple P (Level 4): Positive Parenting Program	Parts of the State	Unknown	Yes

Mental Health Integration with Physical Health Care

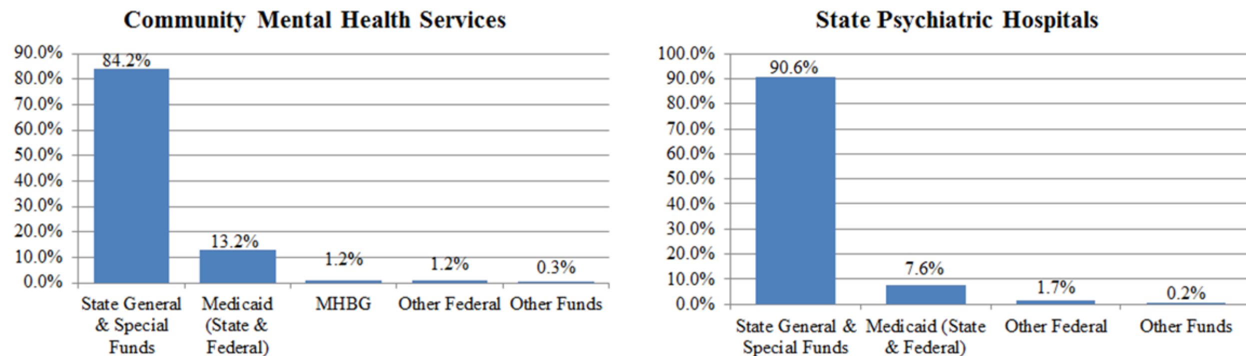
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of

mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$763.4 million
Expenditures for Community Mental Health Services	$632.0 million
Expenditures for State Psychiatric Hospital Inpatient Care	$107.7 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$23.7 million
Per Capita State Mental Health Expenditures	$113.27

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds and also directly operates community-based programs.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through 1115 and 1915(b) waivers.

Electronic Health Records

Electronic health records (EHRs) are implemented in five community mental health centers (CMHCs) and two state psychiatric hospitals. A single EHR system is used by the state psychiatric hospitals and the CMHCs. There are agreements that allow the sharing of EHR client data between state hospitals within the state and community providers and state hospitals.

This page intentionally left blank

Michigan Mental Health 2015

Behavioral Health and Developmental Administration, Department of Health & Human Services
http://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941-146590--,00.html

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds and Medicaid. There is an illness severity requirement for individuals to be eligible for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	251,019
State psychiatric hospital residents at the start of the year	257
State population	9,895,622

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	25.84
Children, overall	23.76
Adults in community mental health	25.84
Children in community mental health	23.76

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	5	0	5
Community Mental Health Providers	0	46	46
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	60	60
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Combined with SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 174,842
- Number of individuals served by the SMHA with expanded Medicaid coverage: 36,294
- Number of individuals served by the SMHA with private insurance: 25,357

The SMHA is working with the state Medicaid agency on what mental health benefits are included in alternative benefit plans. The SMHA has Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, and peer supports.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Five state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	No
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	No
Long-term inpatient (more than 90 days)	Yes	Yes	Yes	Yes	No

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	90	Yes
Supported Housing	Statewide	117	Yes
Supported Employment	Parts of the State	20	Yes
Consumer Operated Services	Parts of the State	3	No
Family Psychoeducation	Statewide	Varies due to county participation and need	Yes
Integrated Treatment for Co-Occurring Disorders	Statewide	66	Yes
Illness Self-Management and Recovery	Statewide	Unknown	No Response
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	11	Yes
Incredible Years	Pilot Program	1	Yes
Therapeutic Foster Care	Parts of the State	2	Yes
Parent-Child Interaction Therapy	Parts of the State	3 or more	Yes
Parent Management Training - Oregon	Parts of the State	No Response	Yes
Brief Strategic Family Therapy	Parts of the State	Unknown	Yes
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	39	Yes

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Triple P (Level 4): Positive Parenting Program	Pilot Program	1	Yes
Nurturing Families	Parts of the State	3	Yes
Parenting with Love and Limits	Pilot Program	1	Yes

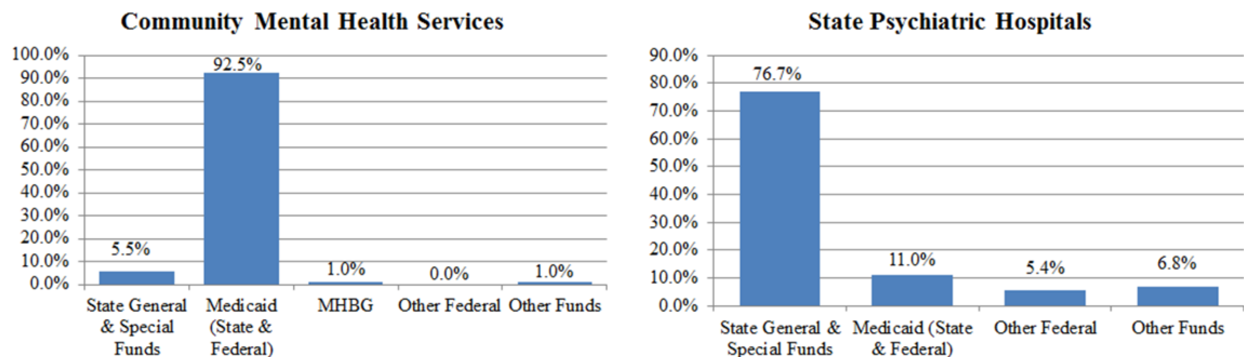
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$1232.6 million
Expenditures for Community Mental Health Services	$974.9 million
Expenditures for State Psychiatric Hospital Inpatient Care	$251.1 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$6.6 million
Per Capita State Mental Health Expenditures	$124.43

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly operates and funds community-based programs. The SMHA also directly funds county or city mental health authorities which, in turn, fund local provider agencies or directly provide mental health services statewide.

Medicaid

Behavioral health services are administered through 1115, 1915(b), 1915(c), and 1915(i) waivers.

Electronic Health Records

Electronic health records (EHRs) are implemented in 46 community mental health centers (CMHCs) and in three of the five state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state, health maintenance organizations (HMOs), other

managed care firms, and the SMHA, community providers, and through a health information exchange (HIE).

This page intentionally left blank

Minnesota Mental Health 2015

Adult Mental Health Division, Department of Human Services
http://mn.gov/dhs/people-we-serve/adults/

Eligibility Criteria for State Mental Health Services

The state mental health agency (SMHA) did not provide the criteria used to determine eligibility for mental health services funded by state general or special funds and Medicaid for adults and children. The SMHA did not provide information on whether or not there is an income cap below which individuals are eligible for SMHA services. The SMHA did not indicate whether or not there is an illness severity requirement for SMHA services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	200,568
State psychiatric hospital residents at the start of the year	207
State population	5,420,380

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	35.37
Children, overall	42.28
Children in community mental health	39.23

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	8	0	8
Community Mental Health Providers	0	600	600
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	33	33
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Part of the SMHA

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA is unable to determine the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA is unable to determine the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA is unable to determine the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, and peer supports.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Six state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No Response	No Response	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No Response	No Response	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No Response	No Response	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	27	Yes
Supported Housing	Parts of the State	No Response	No Response
Supported Employment	Pilot Program	17	Yes
Consumer Operated Services	Parts of the State	No Response	No Response
Integrated Treatment for Co-Occurring Disorders	Pilot Program	No Response	No Response
Illness Self-Management and Recovery	Statewide	approximately 170	No Response
Child/Adolescent EBPs			
Parent-Child Interaction Therapy	Parts of the State	22	No Response
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	69	No Response
Managing and Adapting Practice	Parts of the State	35	No Response
Trauma Informed Child Parent Psychotherapy	Parts of the State	22	No Response

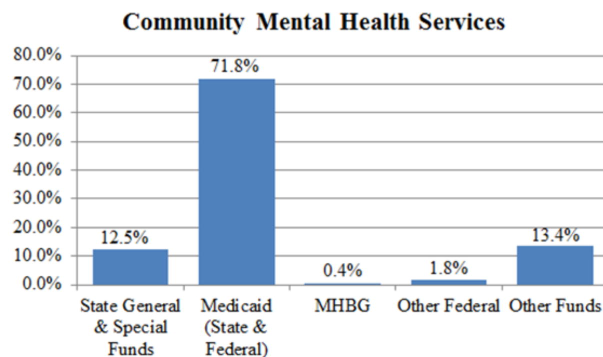
Mental Health Integration with Physical Health Care

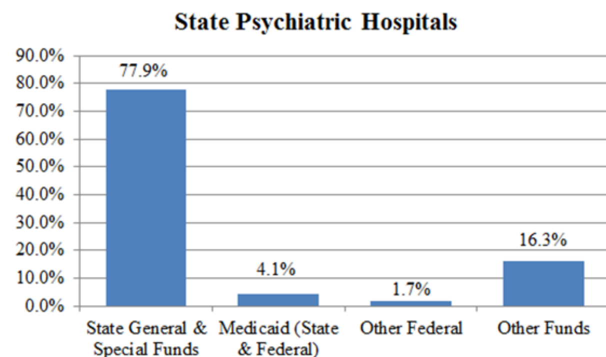
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$1064.1 million
Expenditures for Community Mental Health Services	$920.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$135.8 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$7.7 million
Per Capita State Mental Health Expenditures	$195.09

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanism(s) Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies. The SMHA also directly funds county or city mental health authorities which, in turn, fund local provider agencies or directly provide mental health services statewide or in parts of the state.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a 1915(c) waiver.

Electronic Health Records

A single electronic health record (HER) system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state.

This page intentionally left blank

Mississippi Mental Health 2015

Department of Mental Health

http://www.dmh.ms.gov

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds, however, only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by Medicaid.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	91,818
State psychiatric hospital residents at the start of the year	1,824
State population	2,991,207

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	27.06
Children, overall	41.80
Adults in community mental health	26.61
Children in community mental health	41.58

Number of Mental Health Providers the State Mental Health Agency (SMHA) Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	0	18	18
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	7	0	7
Residential Treatment Facilities (RTCs)	1	0	1

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Part of SMHA

Intellectual Disability/Developmental Disability Agency/Services	Part of SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 27,885
- Number of individuals served by the SMHA with private insurance: 2,226

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, intensive outpatient services, and residential services including crisis services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Four state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	Yes	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	8	Yes
Supported Housing	Parts of the State	13	No
Supported Employment	Pilot Program	4	Yes
Consumer Operated Services	Statewide	4	No
Family Psychoeducation	Parts of the State	4	No
Integrated Treatment for Co-Occurring Disorders	Statewide	12	Yes
Illness Self-Management and Recovery	Parts of the State	60	No
Sober Living Home Model (Oxford House)	Parts of the State	10	Yes
WRAP	Statewide	26	Yes
Child/Adolescent EBPs			
Incredible Years	Parts of the State	1	No
Therapeutic Foster Care	Statewide	6	Yes
Second Steps	Parts of the State	3	No
Trauma-Focused Cognitive Behavior Therapy	Statewide	16	Yes
High Fidelity	Statewide	8	Yes
Skillstreaming	Statewide	14	No

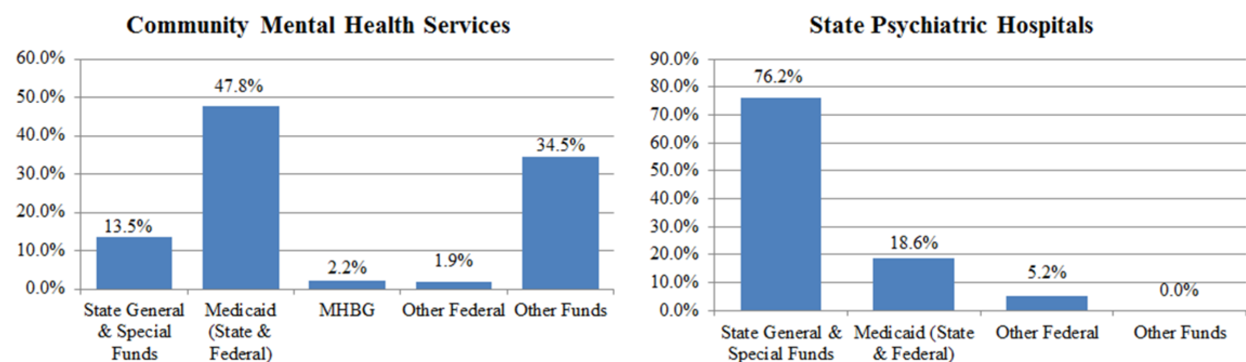
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$294.7 million
Expenditures for Community Mental Health Services	$170.9 million
Expenditures for State Psychiatric Hospital Inpatient Care	$119.8 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$4.0 million
Per Capita State Mental Health Expenditures	$98.93

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide. The SMHA also directly funds, but does not operate, local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care.

Electronic Health Records

Electronic health records (EHRs) are implemented in 14 community mental health centers (CMHCs) and two state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state, community providers, and through a health information exchange (HIE).

This page intentionally left blank

Missouri Mental Health 2015

Department of Mental Health

http://dmh.mo.gov/

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds, however, only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by Medicaid. Individuals in Medicaid funded programs are assessed to be eligible based on diagnosis, disability, and duration of illness. Additionally, a functional tool, the Daily Living Activities 20, can be used to determine eligibility.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	74,670
State psychiatric hospital residents at the start of the year	1,095
State population	6,044,171

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	12.77
Children, overall	10.96
Adults in community mental health	12.51
Children in community mental health	10.95

Number of Mental Health Providers the State Mental Health Agency (SMHA) Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	0	30	30
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Part of the SMHA

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 42,005
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA has Medicaid health homes currently providing mental health services and the SMHA had documented improved outcomes for individuals served by health home.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Six state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	No	No	Yes
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	12	Yes
Supported Employment	Statewide	11	Yes
Consumer Operated Services	Statewide	10	Yes
Integrated Treatment for Co-Occurring Disorders	Statewide	19	Yes
Illness Self-Management and Recovery	Parts of the State	Unknown	No
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	1	No
Incredible Years	Parts of the State	1	No
Cognitive Behavioral Intervention for Trauma in Schools	Parts of the State	1	No
Parent-Child Interaction Therapy	Parts of the State	4	No
Parent Management Training - Oregon	Parts of the State	1	No
Cognitive Behavior Therapy for Depression	Parts of the State	6	No
Cognitive Behavior Therapy for Anxiety	Parts of the State	10	No Response
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	10	No
Triple P (Level 4): Positive Parenting Program	Parts of the State	1	No

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Motivational Interviewing	Parts of the State	5	No
Dialectical Behavioral Therapy	Parts of the State	5	No

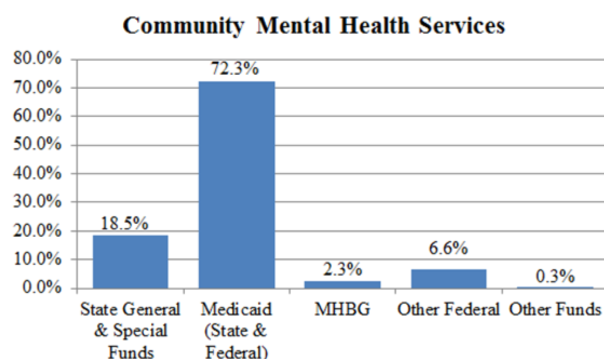
Mental Health Integration with Physical Health Care

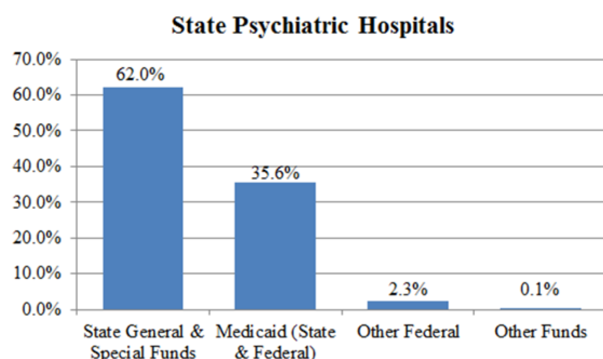
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$628.4 million
Expenditures for Community Mental Health Services	$333.7 million
Expenditures for State Psychiatric Hospital Inpatient Care	$274.8 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$19.9 million
Per Capita State Mental Health Expenditures	$103.94

SMHA-Controlled Revenues: FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care.

Electronic Health Records

Electronic health records (EHRs) are implemented in 30 community mental health centers (CMHCs) and three state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state.

This page intentionally left blank

Montana Mental Health 2015

Addictive and Mental Disorders Division

http://dphhs.mt.gov/amdd.aspx

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds and Medicaid. Individuals must be below 150 percent of the federal poverty line (FPL) for mental health services funded by state general funds, and below 100 percent of FPL for Medicaid funded mental health services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	39,634
State psychiatric hospital residents at the start of the year	126
State population	1,015,165

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	28.94
Children, overall	74.72
Adults in community mental health	28.41
Children in community mental health	74.42

Number of Mental Health Providers the State Mental Health Agency (SMHA) Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	10	10
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	5	5
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 34,494
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is not working with the Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	No
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	4	No
Supported Housing	Not Implementing	NA	NA
Supported Employment	Parts of the State	No Response	No
Consumer Operated Services	Parts of the State	6	No
Family Psychoeducation	Parts of the State	No Response	No
Integrated Treatment for Co-Occurring Disorders	Parts of the State	1	No
Illness Self-Management and Recovery	Statewide	No Response	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	Not Implementing	NA	NA
Incredible Years	Not Implementing	NA	NA
Therapeutic Foster Care	Parts of the State	No Response	No Response

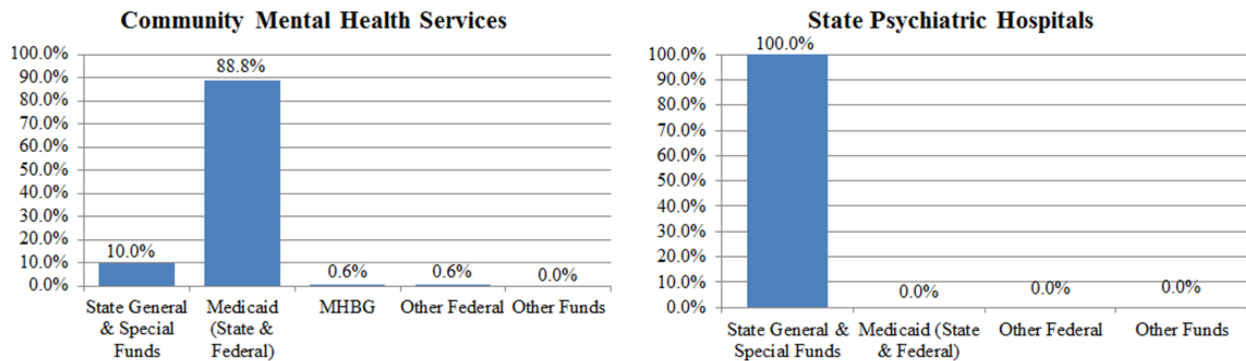
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$229.8 million
Expenditures for Community Mental Health Services	$193.1 million
Expenditures for State Psychiatric Hospital Inpatient Care	$34.1 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$2.7 million
Per Capita State Mental Health Expenditures	$225.38

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through fee-for-services only. Behavioral health services are administered through 1115 and 1915 (c) waivers.

Electronic Health Records

Electronic health records (EHRs) are implemented in six community mental health centers (CMHCs) and one state psychiatric hospital. A single EHR system is used by the state psychiatric hospitals and the CMHCs. The SMHA does not have agreements that allow the sharing of EHR client data between providers.

This page intentionally left blank

Nebraska Mental Heath 2015

Division of Behavioral Health, Department of Health and Human Services

http://dhhs.ne.gov/behavioral_health/Pages/behavioral_health_index.aspx

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds. There is an eligibility policy that determines financial eligibility qualifications for consumers. It utilizes the federal poverty level as well as ability to pay and sliding scale determinations. There is an illness severity requirement for individuals to be eligible for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	22,579
State psychiatric hospital residents at the start of the year	284
State population	1,868,516

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	14.50
Children, overall	4.76
Adults in community mental health	13.21
Children in community mental health	4.44

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	2	4
Community Mental Health Providers	0	53	53
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	7	7
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	1	0	1

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Part of the SMHA

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA

Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 5,744
- Number of individuals served by the SMHA with private insurance: 1,883

The SMHA is not working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, and peer supports.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. One state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	3	Yes
Supported Housing	Statewide	6	Yes
Supported Employment	Statewide	6	Yes
Consumer Operated Services	Parts of the State	4	No Response
Integrated Treatment for Co-Occurring Disorders	Statewide	6	Yes
International Center for Clubhouse Development (ICCD) Certified Clubhouse Model	Parts of the State	1	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	1	Yes
Functional Family Therapy	Planning to Implement	Not applicable	Not applicable

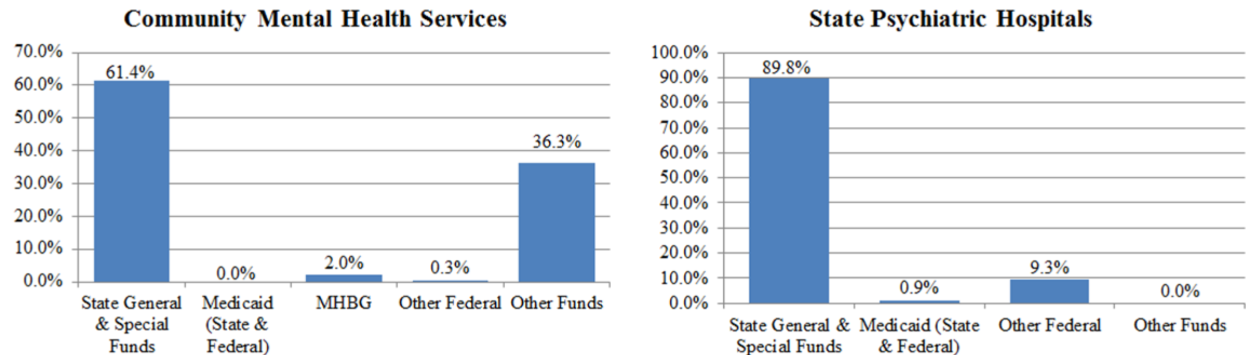
Mental Health Integration with Physical Health Care

The SMHA supports the colocation of primary care in mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$140.1 million
Expenditures for Community Mental Health Services	$87.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$50.0 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$2.6 million
Per Capita State Mental Health Expenditures	$74.76

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide. The SMHA also directly funds, but does not operate, local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a 1915(b) waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in 11 community mental health centers (CMHCs) and two state psychiatric hospitals. A single EHR system is used for the two state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state.

This page intentionally left blank

Nevada Mental Health 2015

Division of Public and Behavioral Health, Department of Health and Human Services
http://dpbh.nv.gov/

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement to be eligible for state mental health agency (SMHA) mental health services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	30,358
State psychiatric hospital residents at the start of the year	219
State population	2,790,136

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	12.60
Children, overall	5.31
Adults in community mental health	11.42
Children in community mental health	5.14

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	24	0	24
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	1	0	1

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 7,019
- The state did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- Number of individuals served by the SMHA with private insurance: 1,725

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, assertive community treatment, peer supports, and medication-assisted treatment.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Three state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	No	No Response
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	No	No Response
Long-term inpatient (more than 90 days)	Yes	Yes	No Response	No	No Response

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	2	No
Supported Housing	Statewide	27	Yes
Supported Employment	Parts of the State	6	Yes
Family Psychoeducation	Parts of the State	3	No Response
Integrated Treatment for Co-Occurring Disorders	Parts of the State	3	Yes
Illness Self-Management and Recovery	Statewide	6	No
Wellness Recovery Action Plan	Parts of the State	7	No
Assisted Outpatient Treatment	Pilot Program	1	No
Child/Adolescent EBPs			
Therapeutic Foster Care	Pilot Program	1	No
Functional Family Therapy	Parts of the State	3	No
Parent-Child Interaction Therapy	Parts of the State	1	Yes
Problem-Solving Skills Training	Planning to Implement	7	Yes
Cognitive Behavior Therapy for Depression	Statewide	9	No

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Cognitive Behavior Therapy for Anxiety	Statewide	9	No
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	6	No
Interpersonal Therapy for Depression	Planning to Implement	No Response	No Response
Eye Movement Desensitization and Reprocessing	Parts of the State	2	No
Dialectical Behavior Therapy	Statewide	5	No

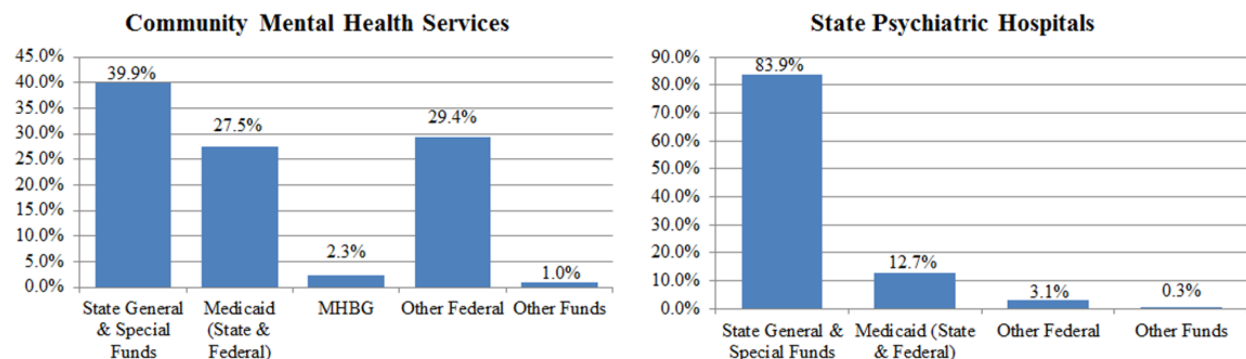
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$255.7 million
Expenditures for Community Mental Health Services	$177.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$70.6 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$7.5 million
Per Capita State Mental Health Expenditures	$90.44

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly operates and funds community-based programs.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a 1915(i) waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in 24 community mental health centers (CMHCs) and 4 state psychiatric hospitals. A single EHR system is used by the state psychiatric hospitals and the CMHCs. There are agreements that allow the sharing of EHR client data between state hospitals within the state, community providers and state hospitals, and community providers.

This page intentionally left blank

New Hampshire Mental Health 2015

Bureau of Behavioral Health, Department of Health and Human Services

http://www.dhhs.nh.gov/dcbcs/bbh/

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) are eligible for mental health services funded by state general or special funds and Medicaid.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	46,749
State psychiatric hospital residents at the start of the year	155
State population	1,323,459

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	32.20
Children, overall	47.45
Adults in community mental health	32.20
Children in community mental health	47.45

Number of Mental Health Providers the State Mental Health Agency (SMHA) Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	0	0	1
Community Mental Health Providers	0	10	10
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	No Responsibility
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	No Responsibility
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability, and Vocational Rehabilitation

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA

Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA
Vocational Rehabilitation	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of persons served by the SMHA with Medicaid coverage: 0
- The state data system does allow the SMHA to determine the number of individual served with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding or delivery of community-based mental health services. One state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	10	Yes
Supported Housing	Statewide	10	No
Supported Employment	Statewide	10	No
Consumer Operated Services	Not Implementing	NA	NA
Illness Self-Management and Recovery	Statewide	10	No
Child/Adolescent EBPs			
Multisystemic Therapy	Not Implementing	NA	NA
Incredible Years	Not Implementing	NA	NA
Assertive Community Treatment	Parts of the State	2	No

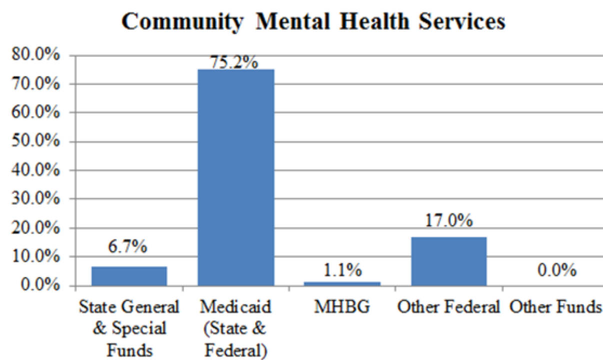
Mental Health Integration with Physical Health Care

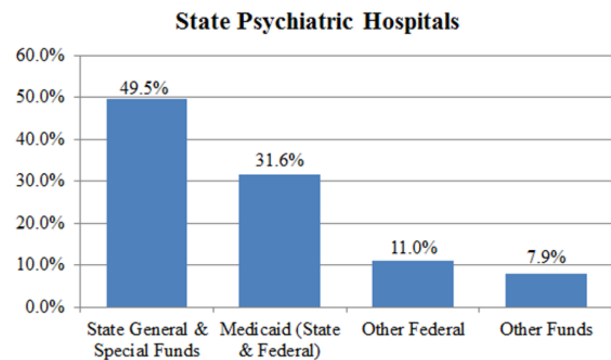
The SMHA supports the colocation of primary care in mental health programs and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$195.4 million
Expenditures for Community Mental Health Services	$122.1 million
Expenditures for State Psychiatric Hospital Inpatient Care	$71.5 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$1.8 million
Per Capita State Mental Health Expenditures	$147.46

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care.

Electronic Health Records

Electronic health records (EHRs) are implemented in 10 community mental health centers (CMHCs) and one state psychiatric hospital. The SMHA does not have agreements that allow the sharing of EHR client data between providers.

This page intentionally left blank

New Jersey Mental Health 2015

Division of Mental Health and Addiction Services, Department of Human Services
http://www.nj.gov/humanservices/dmhas/home/

Eligibility Criteria for State Mental Health Services

All adults with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement for individuals to be eligible for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	347,245
State psychiatric hospital residents at the start of the year	1,615
State population	8,899,339

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	46.74
Children, overall	12.08
Adults in community mental health	43.89
Children in community mental health	11.77

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	0	115	115
Private Psychiatric Hospitals	NA	No Response	No Response
General Hospitals With Separate Psychiatric Units	No Response	No Response	No Response
Nursing Homes and Other ICF-MI and SNF Providers	No Response	No Response	No Response
Residential Treatment Facilities (RTCs)	No Response	No Response	No Response

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability, and Children and Families

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Children and Families	Located in a different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Different state department
State Housing Agency	Located in a different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 15,630
- The state data system does allow the SMHA to determine the number of individual served with expanded Medicaid coverage.
- Number of individuals served by the SMHA with private insurance: 9,778

The SMHA has Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Four state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	31	No
Supported Housing	Statewide	48	No Response
Supported Employment	Statewide	21	No
Consumer Operated Services	Statewide	35	No Response
Family Psychoeducation	Statewide	21	Yes
Integrated Treatment for Co-Occurring Disorders	Statewide	21	No
Illness Self-Management and Recovery	Statewide	No Response	No
Child/Adolescent EBPs			
Multisystemic Therapy	No Response	No Response	No Response
Incredible Years	No Response	No Response	No Response

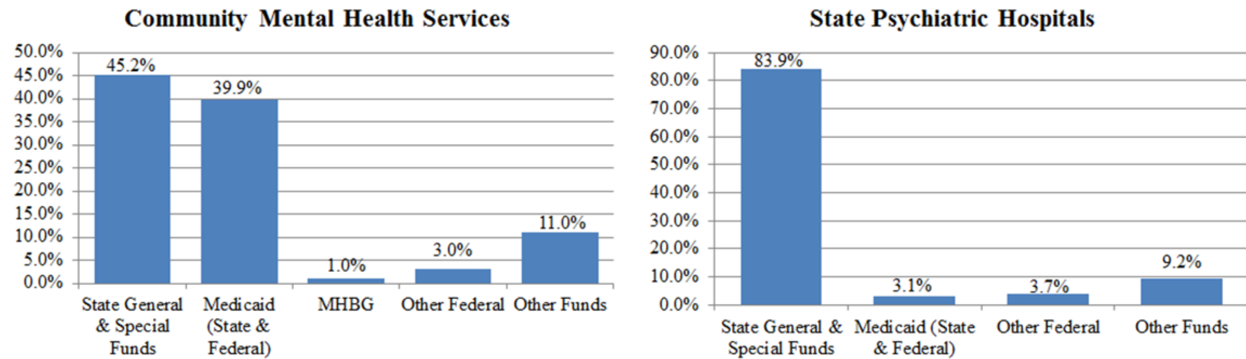
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$1902.9 million
Expenditures for Community Mental Health Services	$1346.3 million
Expenditures for State Psychiatric Hospital Inpatient Care	$530.7 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$25.9 million
Per Capita State Mental Health Expenditures	$213.12

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through an 1115 waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in 10 community mental health centers (CMHCs).

This page intentionally left blank

New Mexico Mental Health 2015

Behavioral Health Collaborative, Human Services Department

http://www.hsd.state.nm.us

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by state general or special funds; however, all adults and children with any mental illness are eligible for mental health services funded by Medicaid. There is neither an income cap nor an illness severity requirement for individuals to be eligible for state mental health agency (SMHA)-funded or -operated mental health services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	93,300
State psychiatric hospital residents at the start of the year	75
State population	2,085,287

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	32.05
Children, overall	84.20
Adults in community mental health	31.38
Children in community mental health	84.12

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	0	0	1
Community Mental Health Providers	0	No Response	No Response
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	No Responsibility
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA

Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding or delivery of community-based mental health services. One state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No Response	No Response	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No Response	No Response	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No Response	No Response	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	No Response	No
Supported Housing	Statewide	No Response	No Response
Supported Employment	Parts of the State	No Response	No
Consumer Operated Services		No Response	No Response
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	10	Yes
Therapeutic Foster Care	Statewide	11	Yes
Parent-Child Interaction Therapy	Parts of the State	1	Yes
Problem-Solving Skills Training	Parts of the State	No Response	Yes
Cognitive Behavior Therapy for Depression	Parts of the State	2	No Response
Cognitive Behavior Therapy for Anxiety	Parts of the State	2	No Response
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	6	No
Interpersonal Therapy for Depression	Parts of the State	8	No

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Modular Approach to Therapy for Children	Parts of the State	5	No
Triple P (Level 4): Positive Parenting Program	Parts of the State	1	No Response
Circles of Security	Parts of the State	19	Yes
Child-Parent Psychotherapy	Parts of the State	13	No Response

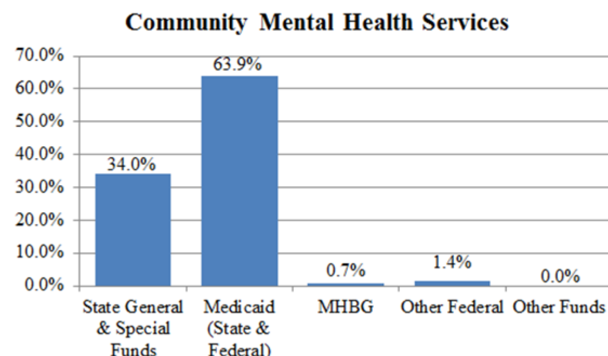
Mental Health Integration with Physical Health Care

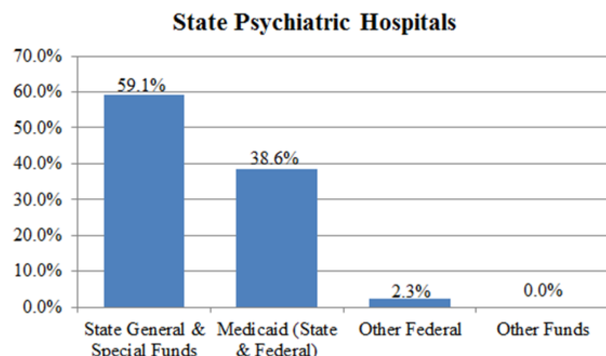
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$300.8 million
Expenditures for Community Mental Health Services	$253.1 million
Expenditures for State Psychiatric Hospital Inpatient Care	$47.7 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$0.0
Per Capita State Mental Health Expenditures	$145.11

SMHA-Controlled Revenues: FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through an 1115.

Electronic Health Records

Electronic health records (EHRs) are implemented in 26 community mental health centers (CMHCs) and one state psychiatric hospital.

This page intentionally left blank

New York Mental Health 2015

Office of Mental Health

http://www.omh.ny.gov

Eligibility Criteria for State Mental Health Services

The state mental health agency (SMHA) did not provide the criteria used to determine eligibility for mental health services funded by state general or special funds and Medicaid for adults and children. The SMHA did not provide information on whether or not there is an income cap below which individuals are eligible for SMHA services. The SMHA did not indicate whether or not there is an illness severity requirement for SMHA services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	729,421
State psychiatric hospital residents at the start of the year	4,355
State population	19,651,127

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	37.18
Children, overall	36.86
Adults in community mental health	35.10
Children in community mental health	35.04

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	25	No Response	25
Community Mental Health Providers	No Response	714	714
Private Psychiatric Hospitals	NA	6	6
General Hospitals With Separate Psychiatric Units	No Response	102	102
Nursing Homes and Other ICF-MI and SNF Providers	No Response	No Response	No Response
Residential Treatment Facilities (RTCs)	No Response	18	18

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Part of the SMHA
Sex Offender Services	Part of the SMHA

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability, and Office of Alcoholism and Substance Abuse Services

Agency	Location
Substance Use Services Agency	Different state department
Intellectual Disability/Developmental Disability Agency/Services	Different state department
Office of Alcoholism and Substance Abuse Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Twenty-three state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No Response	No Response	No Response	No Response	No Response
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No Response	No Response	No Response	No Response	No Response

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment (ACT)	Statewide	80	Yes
Supported Housing	Statewide	161	No
Supported Employment	Statewide	90	Yes
Child/Adolescent EBPs			
Multisystemic Therapy (MST)	Not Implementing	NA	NA
Incredible Years	Not Implementing	NA	NA
Managing and Adapting Practice	Parts of the State	Approximately 50	Yes
ParentCorps	Parts of the State	9	Yes

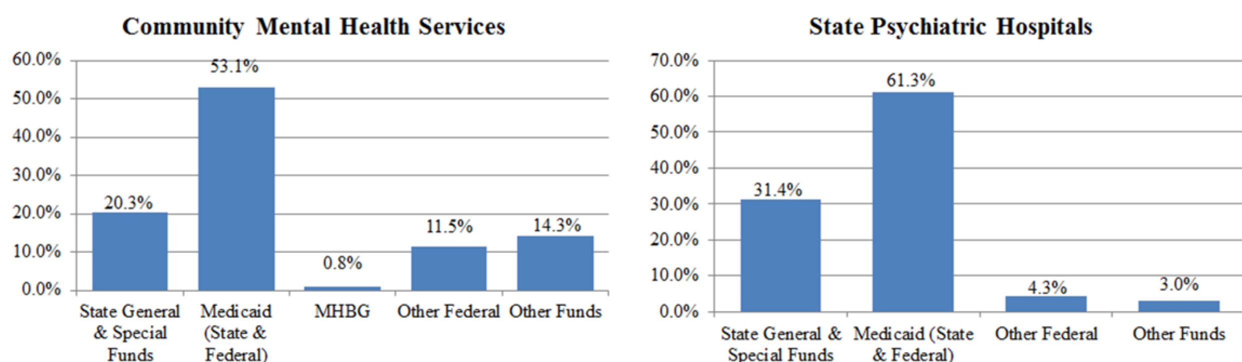
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$4952.1 million
Expenditures for Community Mental Health Services	$2953.0 million
Expenditures for State Psychiatric Hospital Inpatient Care	$1768.7 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$230.4 million
Per Capita State Mental Health Expenditures	$251.12

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide. The SMHA also directly funds, but does not operate local community-based agencies and directly operates community-based programs.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through 1115, 1915(c), and 1915(i) waivers.

Electronic Health Records

Electronic health records (EHRs) are implemented in 24 state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state, community providers and state hospitals; health maintenance organizations (HMOs), other managed care firms, and the SMHA, and community providers.

This page intentionally left blank

North Carolina Mental Health 2015

Division of Mental Health, Developmental Disabilities and Substance Abuse Services,
Department of Health and Human Services
http://www.dhhs.state.nc.us/mhddsas

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance are eligible for mental health services funded by state general or special funds. There is neither an income cap nor an illness severity requirement for individual to be eligible for state mental health agency (SMHA)-funded or SMHA-operated services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	219,448
State psychiatric hospital residents at the start of the year	618
State population	9,848,060

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	21.17
Children, overall	25.97
Adults in community mental health	21.00
Children in community mental health	25.81

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	3	0	3
Community Mental Health Providers	0	0	0
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	21	21
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	No Responsibility
Traumatic Brain Injury Services	Part of the SMHA
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Combined with SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is not working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, peer supports, and medication-assisted treatment.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding or delivery of community-based mental health. Three state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	Yes	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	77	Yes
Supported Housing	Parts of the State	1	No
Supported Employment	Parts of the State	No Response	Yes
Consumer Operated Services	Parts of the State	Unknown	No
Family Psychoeducation	Parts of the State	Unknown	No Response
Integrated Treatment for Co-Occurring Disorders	Planning to Implement	1	No
Illness Self-Management and Recovery	Parts of the State	Unknown	No
Child/Adolescent EBPs			
Multisystemic Therapy	Statewide	45	Yes
Incredible Years	Parts of the State	No Response	No Response
Therapeutic Foster Care	Statewide	Unknown	Yes
Functional Family Therapy	Parts of the State	No Response	Yes

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Parent-Child Interaction Therapy	Parts of the State	No Response	Yes
Cognitive Behavior Therapy for Depression	Parts of the State	No Response	No Response
Cognitive Behavior Therapy for Anxiety	Parts of the State	No Response	No Response
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	No Response	No Response
Triple P (Level 4): Positive Parenting Program	Parts of the State	No Response	No Response
Child Parent Psychotherapy	Parts of the State	3	Yes

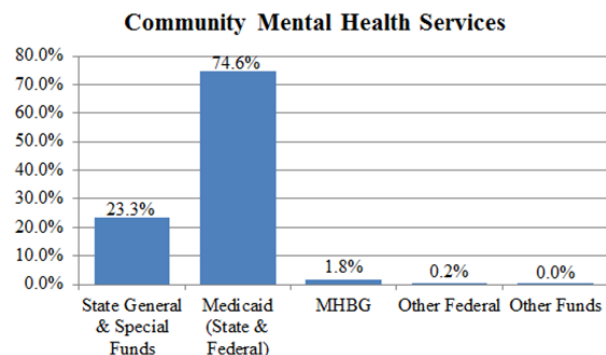
Mental Health Integration with Physical Health Care

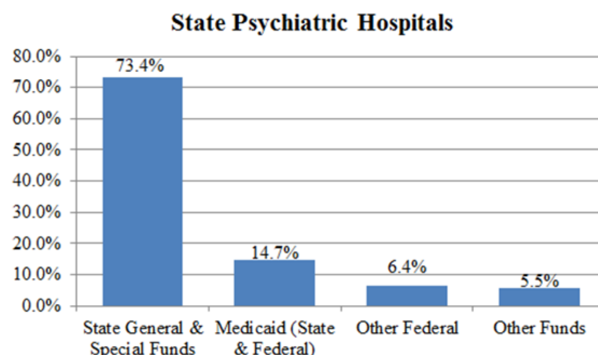
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$989.6 million
Expenditures for Community Mental Health Services	$618.7 million
Expenditures for State Psychiatric Hospital Inpatient Care	$359.0 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$11.9 million
Per Capita State Mental Health Expenditures	$100.59

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a 1915(b) waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in nine community mental health centers (CMHCs) and one state psychiatric hospital. There are agreements that allow the sharing of EHR client data between state hospitals within the state and health maintenance organizations (HMOs), other managed care firms, and the SMHA.

This page intentionally left blank

North Dakota Mental Health 2015

Division of Mental Health and Substance Abuse, Department of Human Services

http://www.nd.gov/dhs/?OpenDocument

Eligibility Criteria for State Mental Health Services

The state mental health agency (SMHA) did not provide the criteria used to determine eligibility for mental health services funded by state general or special funds and Medicaid for adults and children. The SMHA did not provide information on whether or not there is an income cap below which individuals are eligible for SMHA services. The SMHA did not indicate whether or not there is an illness severity requirement for SMHA services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	17,322
State psychiatric hospital residents at the start of the year	159
State population	723,393

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	24.58
Children, overall	19.36
Adults in community mental health	23.40
Children in community mental health	18.85

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	0	1	1
Community Mental Health Providers	0	8	8
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Part of the SMHA
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 4,447
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- Number of individuals served by the SMHA with private insurance: 3,161

The SMHA is not working with the state Medicaid agency on what mental health benefits are included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, and peer supports.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. One state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Not Implementing	NA	NA
Supported Housing	Not Implementing	NA	NA
Supported Employment	Parts of the State	3	Yes
Consumer Operated Services	Statewide	8	No Response
Family Psychoeducation	Parts of the State	2	Yes
Integrated Treatment for Co-Occurring Disorders	Statewide	8	Yes
Illness Self-Management and Recovery	Parts of the State	1	Yes
Motivational Interviewing	Statewide	8	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	Not Implementing	NA	NA
Incredible Years	Not Implementing	NA	NA
Therapeutic Foster Care	Statewide	312	No
Trauma-Focused Cognitive Behavior Therapy	Statewide	8	Yes

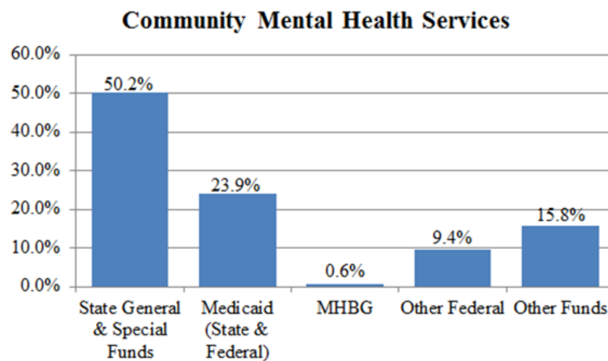
Mental Health Integration with Physical Health Care

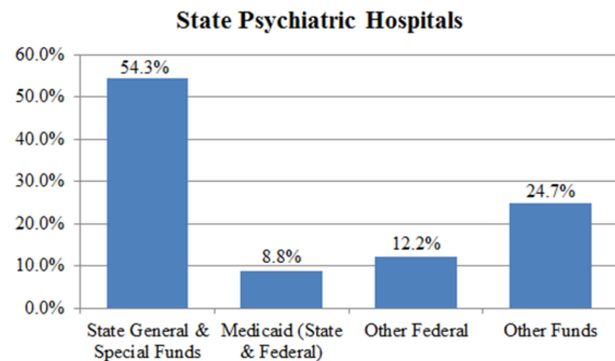
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$69.0 million
Expenditures for Community Mental Health Services	$44.8 million
Expenditures for State Psychiatric Hospital Inpatient Care	$24.1 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$0.1 million
Per Capita State Mental Health Expenditures	$94.23

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid pays for mental health services. If an individual does not have Medicaid or insurance the block grant assists in paying for services which is based on a sliding fee scale. We are in the process of developing a 1915i waiver but do not have one in place yet.

Electronic Health Records

Electronic health records (EHRs) are implemented in eight community mental health centers (CMHCs) and one state psychiatric hospital. A single EHR system is used by the state psychiatric hospitals and the CMHCs. There are agreements that allow the sharing of EHR client data between community providers and state hospitals.

This page intentionally left blank

Ohio Mental Health 2015

Mental Health and Addiction Services

http://mha.ohio.gov/

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement for individual to be eligible for state mental health agency (SMHA)-funded or SMHA-operated services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	398,720
State psychiatric hospital residents at the start of the year	1,046
State population	11,570,808

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	29.17
Children, overall	52.27
Adults in community mental health	29.06
Children in community mental health	52.27

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	3	410	413
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	41	41

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability, and Youth Correction

Agency	Location
Substance Use Services Agency	Combined with SMHA

Agency	Location
Intellectual Disability/Developmental Disability Agency/Services	Different state department
Youth Correction: Vocational Rehabilitation	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Six state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	No Response	Yes
Supported Housing	Parts of the State	NA	No
Supported Employment	Parts of the State	25	Yes
Consumer Operated Services	Parts of the State	60	No
Integrated Treatment for Co-Occurring Disorders	Parts of the State	No Response	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	NA	Yes
Incredible Years	Parts of the State	NA	No Response
Function Family Therapy	Parts of the State	NA	No Response

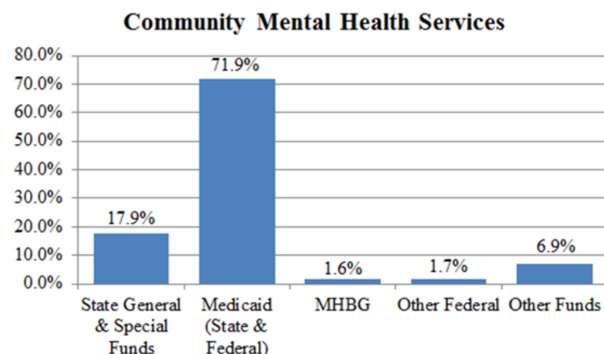
Mental Health Integration with Physical Health Care

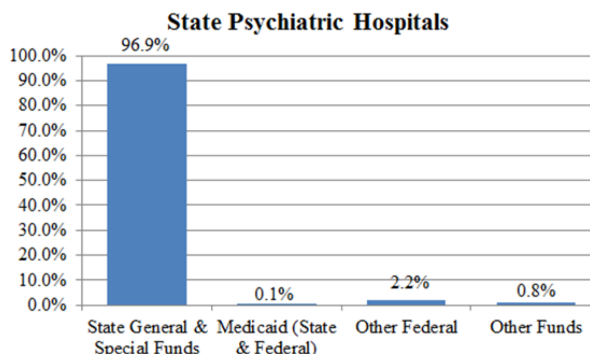
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$504.3 million
Expenditures for Community Mental Health Services	$241.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$223.6 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$39.1 million
Per Capita State Mental Health Expenditures	$43.53

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide. The SMHA also directly operates community-based programs.

Medicaid

Medicaid is paying for mental health services through fee-for-services only. Behavioral health services are administered through a 1915(i) waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in six state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state.

This page intentionally left blank

Oklahoma Mental Health 2015

Department of Mental Health and Substance Abuse Services

http://www.odmhsas.org

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. Adults must be below 200 percent of the federal poverty line to be eligible for state mental health agency (SMHA)-funded or SMHA-operated mental health services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	79,751
State psychiatric hospital residents at the start of the year	329
State population	3,850,568

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	21.11
Children, overall	19.48
Adults in community mental health	20.76
Children in community mental health	19.22

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	4	10	14
Private Psychiatric Hospitals	NA	No Response	No Response
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	No Response	No Response	No Response

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 23,070
- The state did not provide the number of individuals served by the SMHA with private insurance.

The SMHA is not working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA has Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, peer supports, and medication-assisted treatment.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. One state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	12	Yes
Supported Housing	Not Implementing	NA	NA
Supported Employment	Pilot Program	6	No Response
Consumer Operated Services	Parts of the State	7	No
Family Psychoeducation	Statewide	14	No
Integrated Treatment for Co-Occurring Disorders	Statewide	14	No
Illness Self-Management and Recovery	Parts of the State	2	No
Child/Adolescent EBPs			
Multisystemic Therapy	Not Implementing	NA	NA
Incredible Years	Not Implementing	NA	NA
Parent-Child Interaction Therapy	Parts of the State	1	No
Brief Strategic Family Therapy	Pilot Program	1	No
Trauma-Focused Cognitive Behavior Therapy	Statewide	19	Yes

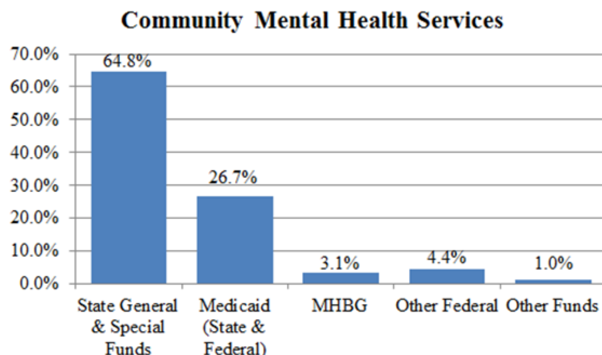
Mental Health Integration with Physical Health Care

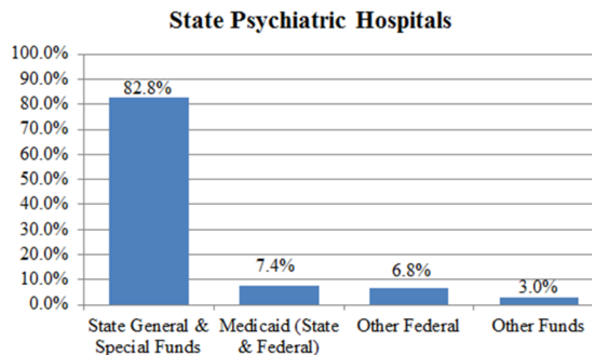
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$228.7 million
Expenditures for Community Mental Health Services	$170.7 million
Expenditures for State Psychiatric Hospital Inpatient Care	$43.7 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$14.4 million
Per Capita State Mental Health Expenditures	$59.29

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds and operates local community-based agencies.

Medicaid

Medicaid is paying for mental health services through fee-for-services only. A fixed fee-for-service is approved by the SMHA and the Medicaid agency. Medicaid reimburses providers at the fixed rates.

Electronic Health Records

Electronic health records (EHRs) are implemented in 14 community mental health centers (CMHCs) and two state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state, and through a health information exchange (HIE).

This page intentionally left blank

Oregon Mental Health 2015

Addictions and Mental Health Division, Oregon Health Authority
http://www.oregon.gov/oha/amh/pages/index.aspx

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement for individual to be eligible for state mental health agency (SMHA)-funded or SMHA-operated services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	120,566
State psychiatric hospital residents at the start of the year	424
State population	3,930,065

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	25.94
Children, overall	47.65
Adults in community mental health	25.45
Children in community mental health	47.60

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	35	35
Private Psychiatric Hospitals	0	0	0
General Hospitals With Separate Psychiatric Units	0	14	14
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	1	131	132

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of SMHA
Older Adult Mental Health Services	Part of SMHA
State Psychiatric Hospitals	Part of SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No responsibility
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 120,564
- The state's data system does allow them to determine whether or not an individual is in the Medicaid Expansion population.
- The SMHA is unable to determine the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency staff on what mental health benefits will be included in alternative benefit plans. The SMHA does provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services and there are currently 577 Patient-Centered Primary Care Homes (PCPCHs) in Oregon. Early psychosis services are not generally paid for by private health insurance, adding to the overall cost.

State Psychiatric Hospitals

The SMHA is responsible for the operation of state psychiatric hospitals and is within the same agency responsible for the funding or delivery of community-based mental health services. The SMHA has one state psychiatric hospitals accredited by The Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	No	No	No
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	20	Yes
Supported Housing	Statewide	Yes	No
Supported Employment	Statewide	30	Yes
Consumer Operated Services	Parts of the State	2	No
Family Psychoeducation	Statewide	100	No
Integrated Treatment for Co-Occurring Disorders	Parts of the State	4	No
Illness Self-Management and Recovery	Parts of the State	1	No
Child/Adolescent EBPs			
Multisystemic Therapy	Planning to Implement	0	NA
Incredible Years	Parts of the State	13	No
Cognitive Behavioral Intervention for Trauma in Schools	Parts of the State	3	No
Parent-Child Interaction Therapy	Parts of the State	45	Yes
Cognitive Behavior Therapy for Depression	Parts of the State	15	No

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Cognitive Behavior Therapy for Anxiety	Statewide	15	No
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	3	No
Modular Approach to Therapy for Children	Planning to Implement	0	NA
Multidimensional Treatment Foster Care	Parts of the State	1	No
Dialectical Behavioral Therapy	Statewide	36	No
Question, Persuade, and Refer	Statewide	20	Yes

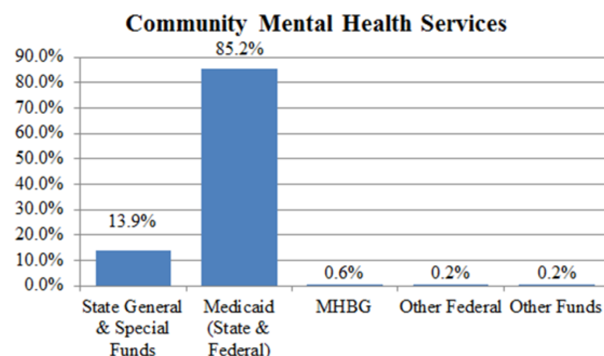
Mental Health Integration with Physical Health Care

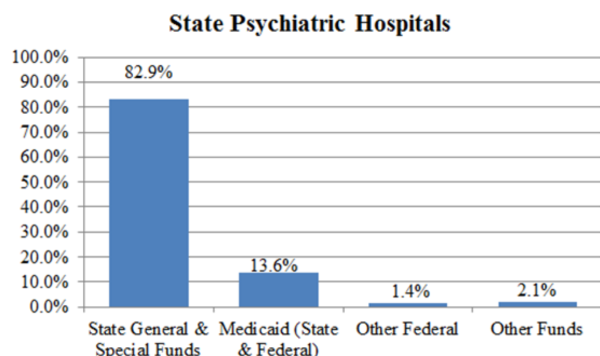
The SMHA has initiatives to improve the integration of mental health with primary health care. The SMHA does not routinely screen or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$931.8 million
Expenditures for Community Mental Health Services	$720.8 million
Expenditures for State Psychiatric Hospital Inpatient Care	$207.2 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$3.8 million
Per Capita State Mental Health Expenditures	$234.87

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA contracts with the county based community mental health system and coordinated care organizations (CCOs).

Medicaid

The SMHA is designated as the single state agency responsible for setting Medicaid rates for mental health and Medicaid options and controls Medicaid rates for mental health services in SMHA operated and funded programs. Oregon has an 1115 Waiver and an approved 1915(i) Option.

Electronic Health Records

Electronic health records (EHRs) are implemented in 36 community mental health centers (CMHCs). There are agreements that allow the sharing of EHR client data between state hospitals within the state, CCOs, other managed care firms, and the SMHA, and through a health information exchange (HIE).

This page intentionally left blank

Pennsylvania Mental Health 2015

Mental Health Services, Department of Human Services
http://www.dhs.pa.gov/citizens/mentalhealthservices/

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is no income cap for individuals to be eligible for state mental health agency (SMHA)-funded or SMHA-operated mental health services. However, there is an illness severity requirement for individuals to be eligible for SMHA Services. Individuals must meet the medical necessity criteria or program eligibility criteria for admission into SMHA-funded or SMHA-operated programs.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	615,570
State psychiatric hospital residents at the start of the year	2,495
State population	12,773,801

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	42.54
Children, overall	69.11
Adults in community mental health	42.54
Children in community mental health	69.11

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	6	0	6
Community Mental Health Providers	0	1,400	1,400
Private Psychiatric Hospitals	NA	33	33
General Hospitals With Separate Psychiatric Units	0	94	94
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1
Residential Treatment Facilities (RTCs)	No Response	No Response	No Response

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Different state department
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	SMHA part of State Medicaid Agency
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 2,300,000
- The SMHA did not provide the number of individuals served by the SMHA with expanded Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	41	Yes
Supported Housing	Statewide	59	No
Supported Employment	Planning to Implement	No Response	No Response
Consumer Operated Services	Parts of the State	78	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	Statewide	13	Yes
Incredible Years	Pilot Program	5	Yes
Functional Family Therapy	Statewide	9	Yes
Parent-Child Interaction Therapy	Statewide	100	No Response
Trauma-Focused Cognitive Behavior Therapy	Statewide	No Response	No
Triple P (Level 4): Positive Parenting Program	Pilot Program	3	Yes

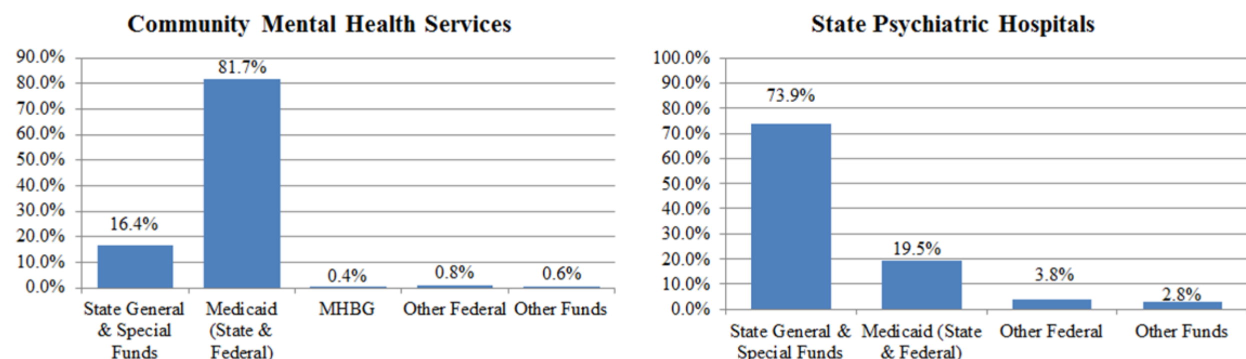
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA does not screen or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$3664.9 million
Expenditures for Community Mental Health Services	$3294.4 million
Expenditures for State Psychiatric Hospital Inpatient Care	$357.1 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$13.4 million
Per Capita State Mental Health Expenditures	$286.76

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a 1915(b) waiver.

Electronic Health Records

The SMHA is unable to report the number of community mental health centers (CMHCs) and state psychiatric hospitals that have implemented electronic health records (EHRs).

This page intentionally left blank

Rhode Island Mental Health 2015

Developmental Disabilities and Hospitals, Department of Behavioral Healthcare
http://www.bhddh.ri.gov

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement for state mental health agency (SMHA)-funded or SMHA-operated services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	32,100
State psychiatric hospital residents at the start of the year	140
State population	1,051,511

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	28.14
Children, overall	39.87
Adults in community mental health	27.91
Children in community mental health	39.87

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	0	0	0
Community Mental Health Providers	0	8	8
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	1	0	1
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	33	33

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	No Responsibility
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Combined with SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 25,901
- The state's data system does not allow them to determine whether or not an individual is in the Medicaid Expansion population.
- Number of individuals served by the SMHA with private insurance: 12,558

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA has Medicaid health homes currently providing mental health services and the SMHA has documented improved outcomes for individuals served by a health home. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, and peer supports.

State Psychiatric Hospitals

Rhode Island does not have a state psychiatric hospital.

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Supported Housing	Parts of the State	8	No
Supported Employment	Statewide	8	No
Consumer Operated Services	Parts of the State	1	No
Integrated Treatment for Co-Occurring Disorders	Statewide	6	No
Child/Adolescent EBPs			
Multisystemic Therapy)	No response	No Response	No Response
Incredible Years	No response	No Response	No Response

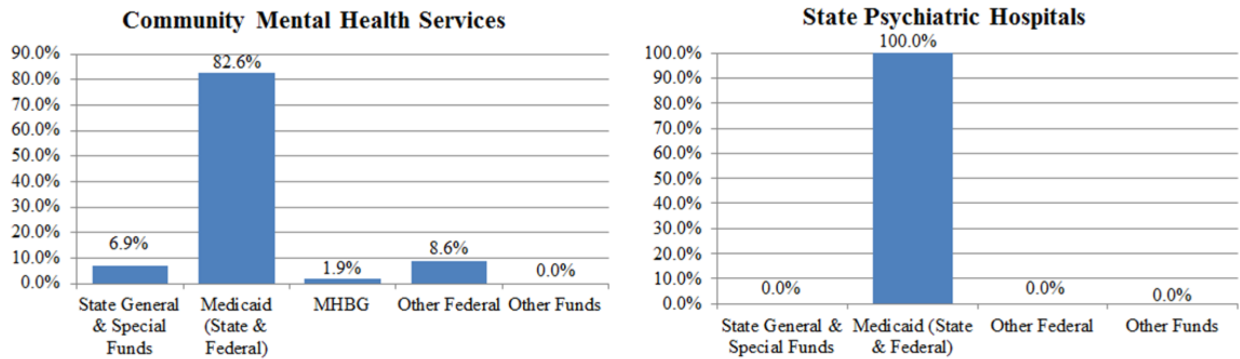
Mental Health Integration with Physical Health Care

The SMHA did not indicate if it has initiatives to improve the integration of mental health with primary health care, support the colocation of primary care in mental health programs, or support the colocation of mental health providers in primary care. The SMHA did not indicate whether or not it screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$111.1 million
Expenditures for Community Mental Health Services	$70.5 million
Expenditures for State Psychiatric Hospital Inpatient Care	$38.9 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$1.7 million
Per Capita State Mental Health Expenditures	$105.72

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a Medicaid 1115 waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in eight community mental health centers (CMHCs). There are agreements that allow the sharing of EHR client data between health maintenance organizations (HMOs), other managed care firms, and the SMHA; community providers; and through a health information exchange (HIE).

This page intentionally left blank

South Carolina Mental Health 2015

Department of Mental Health

http://www.state.sc.us/dmh

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement for individual to be eligible for state mental health agency (SMHA)-funded or SMHA-operated services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	80,864
State psychiatric hospital residents at the start of the year	617
State population	4,774,839

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	14.87
Children, overall	23.99
Adults in community mental health	14.66
Children in community mental health	23.94

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	17	0	17
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	2	2	4
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Different state department
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Three state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	No Response	Yes
Supported Employment	Parts of the State	No Response	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	3	Yes
Incredible Years	Not Implementing	NA	NA
Parent-Child Interaction Therapy	Parts of the State	5	Yes
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	17	No

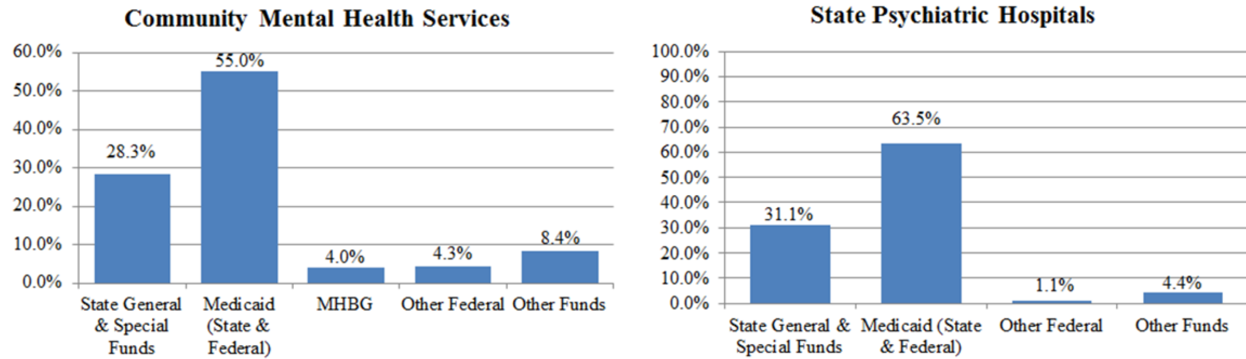
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care.

SMHA Controlled Expenditures for Mental Health

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$275.4 million
Expenditures for Community Mental Health Services	$150.9 million
Expenditures for State Psychiatric Hospital Inpatient Care	$111.6 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$12.9 million
Per Capita State Mental Health Expenditures	$57.49

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly operates community-based programs.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a 1915(i) waiver.

Electronic Health Records (EHRs)

Electronic health records (EHRs) are implemented in 17 community mental health centers (CMHCs). A single EHR system is used for all CMHCs. There are agreements that allow the sharing of EHR client data between community providers and state hospitals and community providers and telepsychiatry services in hospital emergency departments.

This page intentionally left blank

South Dakota Mental Health 2015

Division of Behavioral Health, Department of Social Services

http://dss.sd.gov/behavioralhealth

Eligibility Criteria for State Mental Health Services

All adults and all children are eligible for mental health services funded by state general or special funds and Medicaid.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	15,277
State psychiatric hospital residents at the start of the year	209
State population	844,877

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	16.05
Children, overall	24.31
Adults in community mental health	16.05
Children in community mental health	24.31

Number of Mental Health Providers the State Mental Health Agency (SMHA) Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	11	11
Private Psychiatric Hospitals	NA	No Response	No Response
General Hospitals With Separate Psychiatric Units	No Response	No Response	No Response
Nursing Homes and Other ICF-MI and SNF Providers	No Response	No Response	No Response
Residential Treatment Facilities (RTCs)	No Response	No Response	No Response

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	No Responsibility
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	No Responsibility
Services to Individuals with Mental Illness in Prison/Jail	Part of the SMHA
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- The SMHA did not provide the number of individuals served by the SMHA with Medicaid coverage.
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding or delivery of community-based mental health services.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	Yes	Yes	Yes	No
Long-term inpatient (more than 90 days)	No	Yes	Yes	Yes	No

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	4	Yes
Supported Housing	No Response	No Response	No Response
Supported Employment	No Response	No Response	No Response
Consumer Operated Services	No Response	No Response	No Response
Child/Adolescent EBPs			
Multisystemic Therapy	No Response	No Response	No Response
Incredible Years	No Response	No Response	No Response

Mental Health Integration with Physical Health Care

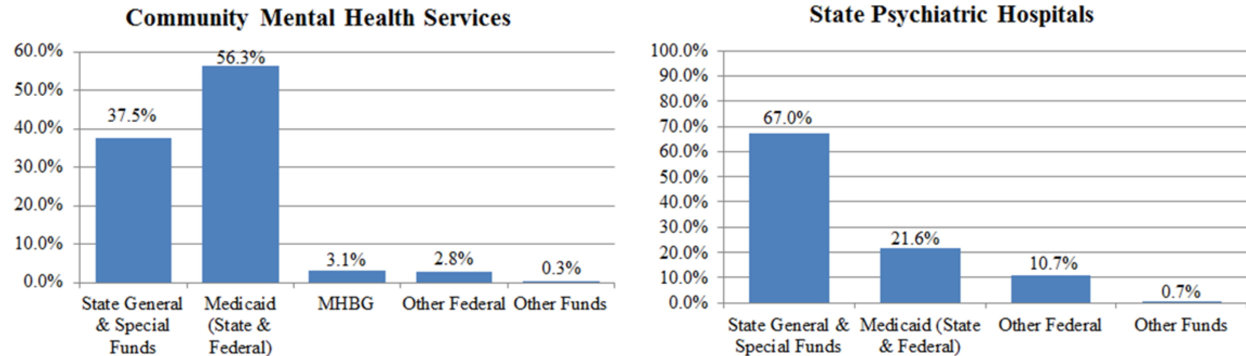
The SMHA has initiatives to improve the integration of mental health with primary health care and supports the colocation of mental health providers in primary care. The SMHA does not screen or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$73.7 million
Expenditures for Community Mental Health Services	$26.9 million

SMHA-Controlled Expenditures	Dollars
Expenditures for State Psychiatric Hospital Inpatient Care	$46.2 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$0.6 million
Per Capita State Mental Health Expenditures	$86.77

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through fee-for-services only.

Electronic Health Records

Electronic health records (EHRs) are implemented in five community mental health centers (CMHCs) and one state psychiatric hospital.

This page intentionally left blank

Tennessee Mental Health 2015

Department of Mental Health and Substance Abuse Services
http://www.state.tn.us/mental/index.html

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	249,308
State psychiatric hospital residents at the start of the year	531
State population	6,495,978

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	37.56
Children, overall	41.14
Adults in community mental health	35.33
Children in community mental health	40.90

Number of Mental Health Providers the State Mental Health Agency (SMHA) Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	4	0	4
Community Mental Health Providers	0	61	61
Private Psychiatric Hospitals	NA	3	3
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Different state department

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 181,821
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA has Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Four state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Supported Housing	Statewide	N/A	Yes
Supported Employment	Statewide	8	Yes
Consumer Operated Services	Statewide	45	Yes
Illness Self-Management and Recovery	Statewide	45	Yes
Child/Adolescent EBPs			
Regional Intervention Programs	Statewide	13	Yes
Project BASIC/Child Care Consultation	Statewide	40+	Yes

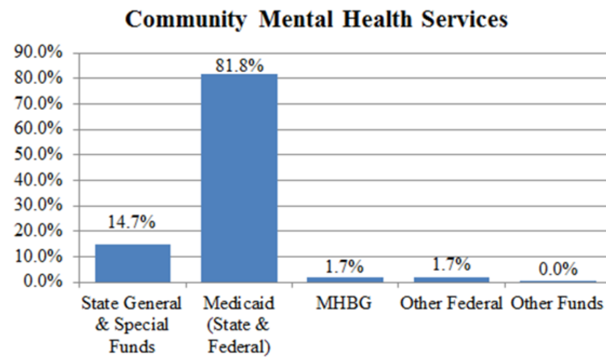
Mental Health Integration with Physical Health Care

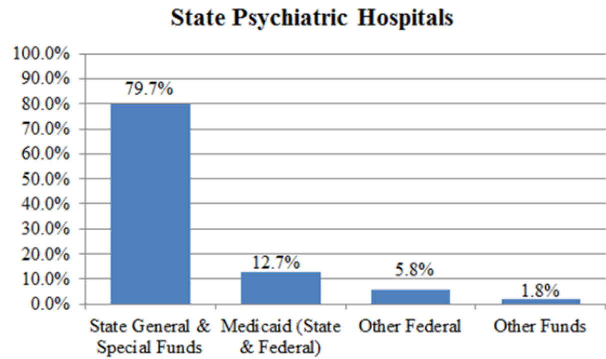
The SMHA supports the colocation of primary care in mental health programs and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$619.2 million
Expenditures for Community Mental Health Services	$475.7 million
Expenditures for State Psychiatric Hospital Inpatient Care	$128.7 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$14.8 million
Per Capita State Mental Health Expenditures	$94.86

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through managed care only. Behavioral health services are administered through an 1115 waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in some community mental health centers (CMHCs). The SMHA does not have a comprehensive EHR system for the state psychiatric hospitals.

This page intentionally left blank

Texas Mental Health 2015

Mental Health and Substance Abuse, Department of State Health Services
http://www.dshs.state.tx.us

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious mental illness (SED) are eligible for mental health services funded by state general or special funds and Medicaid. The adult mental health priority population consists of adults who have severe and persistent mental illnesses (diagnoses of schizophrenia, bipolar disorder, or major depressive disorder) and significant functional impairment. A system centered around child and family that fosters hope, resilience and recovery through an intensive service delivery model that utilizes evidence based practices based on the child needs and strengths falling in a continuum of care.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	324,439
State psychiatric hospital residents at the start of the year	2,386
State population	26,448,193

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	13.19
Children, overall	9.73
Adults in community mental health	13.08
Children in community mental health	9.69

Number of Mental Health Providers the State Mental Health Agency (SMHA) Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	9	2	11
Community Mental Health Providers	0	38	38
Private Psychiatric Hospitals	NA	5	5
General Hospitals With Separate Psychiatric Units	0	7	7
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	16	16

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	SMHA part of State Public Health Agency
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 114,016
- Number of individuals served by the SMHA with private insurance: 23,816

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Ten state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	Yes	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Statewide	90	Yes
Supported Housing	Statewide	45	Yes
Supported Employment	Statewide	45	Yes
Consumer Operated Services	Parts of the State	6	No
Family Psychoeducation	Statewide	45	No
Integrated Treatment for Co-Occurring Disorders	Statewide	45	No
Illness Self-Management and Recovery	Statewide	45	No
International Center for Clubhouse Development	Planning to Implement	Not applicable	Not applicable
Child/Adolescent EBPs			
Parent-Child Interaction Therapy	Parts of the State	4	No
Cognitive Behavior Therapy for Depression	Statewide	39	Yes
Cognitive Behavior Therapy for Anxiety	Statewide	39	Yes

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Trauma-Focused Cognitive Behavior Therapy	Statewide	39	Yes
Nurturing Parenting	Statewide	39	Yes
Seeking Safety	Statewide	39	Yes

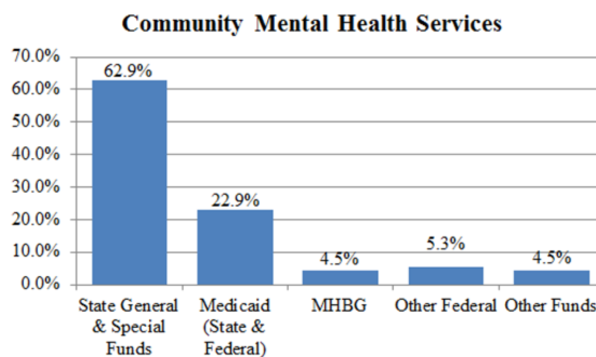
Mental Health Integration with Physical Health Care

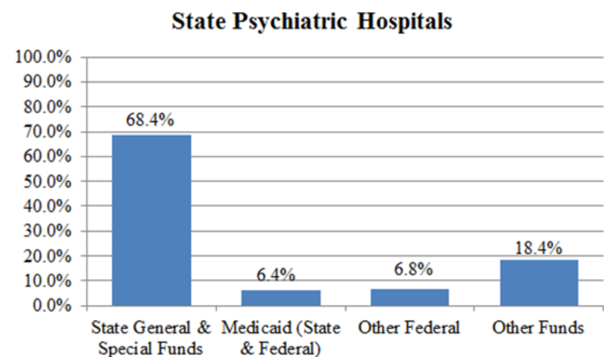
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$1213.5 million
Expenditures for Community Mental Health Services	$749.6 million
Expenditures for State Psychiatric Hospital Inpatient Care	$428.7 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$35.2 million
Per Capita State Mental Health Expenditures	$45.23

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide.

Medicaid

Medicaid is paying for mental health services through a combination of fee for service and managed care. Behavioral health services are administered through 1115, 1915(b), 1915(c), and 1915(i) waivers.

Electronic Health Records

Electronic health records (EHRs) are implemented in 38 community mental health centers (CMHCs) and 10 state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state, community providers and state hospitals, and community providers.

This page intentionally left blank

Utah Mental Health 2015

Division of Substance Abuse and Mental Health, Department of Human Services

http://www.hsmh.state.ut.us

Eligibility Criteria for State Mental Health Services

All adults and children with a mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is no income cap for individuals to be eligible for state mental health agency (SMHA)-funded or SMHA-operated mental health services; however, there is an illness severity requirement.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	48,567
State psychiatric hospital residents at the start of the year	284
State population	2,900,872

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	14.93
Children, overall	20.79
Adults in community mental health	14.77
Children in community mental health	20.67

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	13	13
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders, Intellectual Disability, and Child and Family Services, and Juvenile Justice Services

Agency	Location
Substance Use Services Agency	Combined with SMHA

Agency	Location
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA
Child and Family Services and Juvenile Justice Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 32,036
- Number of individuals served by the SMHA with private insurance: 2,517

The SMHA is not working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay for supported housing, supported employment, assertive community treatment, peer supports, and medication-assisted treatment.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. One state-operated psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	No
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	Yes	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	1	Yes
Supported Housing	Parts of the State	No Response	No
Supported Employment	Parts of the State	2	Yes
Consumer Operated Services	Not Implementing	NA	NA
Family Psychoeducation	Parts of the State	No Response	No
Integrated Treatment for Co-Occurring Disorders	Parts of the State	No Response	No
Illness Self-Management and Recovery	Parts of the State	No Response	No
Clubhouse	Parts of the State	3	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	No Response	No Response
Incredible Years	Not Implementing	NA	NA
Functional Family Therapy	Parts of the State	No Response	No

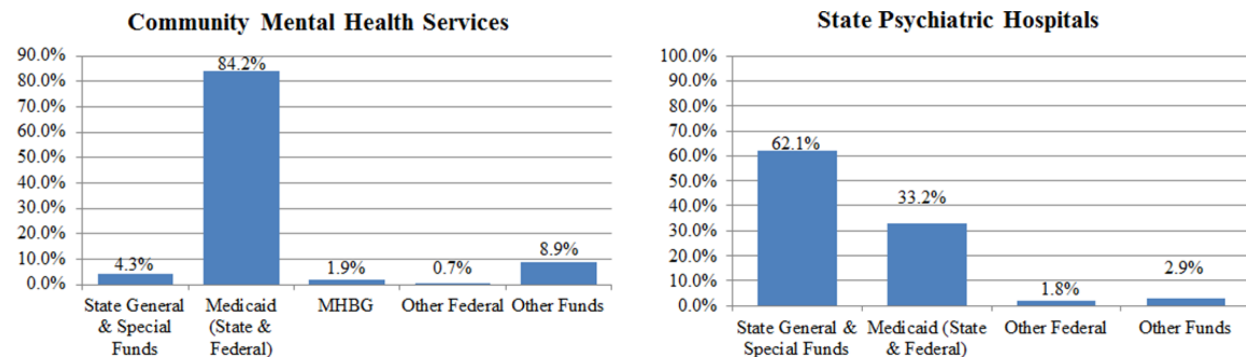
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care. All Patients are screened for physical health issues in all community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$213.2 million
Expenditures for Community Mental Health Services	$156.8 million
Expenditures for State Psychiatric Hospital Inpatient Care	$55.2 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$1.2 million
Per Capita State Mental Health Expenditures	$72.58

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide. The SMHA also directly funds, but does not operate, local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a 1915(b) waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in 13 community mental health centers (CMHCs) and one state psychiatric hospital. The SMHA does not have agreements that allow the sharing of EHR client data between providers.

This page intentionally left blank

Vermont Mental Health 2015

Department of Mental Health

http://mentalhealth.vermont.gov

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is no income cap for an individual to be eligible for state mental health agency (SMHA)-funded or SMHA-operated mental health services; however, there is an illness severity requirement for certain programs within the SMHA-funded services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	24,500
State psychiatric hospital residents at the start of the year	0
State population	626,630

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	28.85
Children, overall	80.81
Adults in community mental health	28.77
Children in community mental health	80.81

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	12	12
Private Psychiatric Hospitals	NA	1	1
General Hospitals With Separate Psychiatric Units	0	4	4
Nursing Homes and Other ICF-MI and SNF Providers	No Response	No Response	No Response
Residential Treatment Facilities (RTCs)	No Response	No Response	No Response

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	Shared with another agency
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Same umbrella department as the SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 19,050
- The state data system does allow the SMHA to determine the number of individuals served with expanded Medicaid coverage.
- Number of individuals served by the SMHA with private insurance: 4,937

The SMHA is not working with the state Medicaid agency on what mental health benefits are included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting insurance to pay for supported housing, supported employment, assertive community treatment, and peer supports.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Vermont continues to develop enhanced community alternatives to inpatient hospitalization and creating privately run inpatient units that can treat patients with high acuity. Vermont is also in the process of integrating all child and family services (Integrated Family Services) across all human services departments within the state government. One state psychiatric hospital is accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Supported Housing	Parts of the State	1	No
Supported Employment	Statewide	10	Yes
Consumer Operated Services	Parts of the State	9	No
Integrated Treatment for Co-Occurring Disorders	Statewide	9	No
Dialectical Behavior Therapy	Parts of the State	6	No
Child/Adolescent EBPs			
Therapeutic Foster Care	Statewide	Not available	No
Parent-Child Interaction Therapy	Parts of the State	Not available	No
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	Not available	No

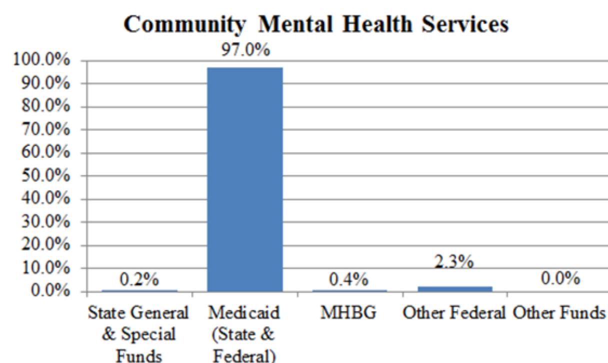
Mental Health Integration with Physical Health Care

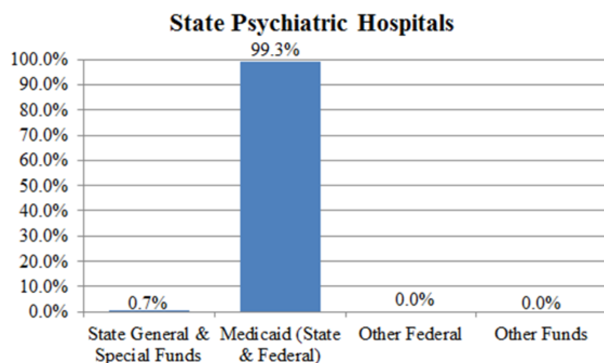
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$203.0 million
Expenditures for Community Mental Health Services	$182.2 million
Expenditures for State Psychiatric Hospital Inpatient Care	$14.0 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$6.8 million
Per Capita State Mental Health Expenditures	$324.28

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through managed care only. Behavioral health services are administered through an 1115 waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in 10 community mental health centers (CMHCs) and 1 state psychiatric hospital. The SMHA does not have agreements that allow the sharing of EHR client data between providers.

This page intentionally left blank

Virginia Mental Health 2015

Department of Behavioral Health and Developmental Services
http://www.dbhds.virginia.gov

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds; however, only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by Medicaid. There is neither an income cap nor an illness severity requirement for individuals to be eligible for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	112,944
State psychiatric hospital residents at the start of the year	1,225
State population	8,260,405

Utilization Rates, Fiscal Year (FY) 2014

Category	Resolved
Adults, overall	12.55
Children, overall	17.52
Adults in community mental health	12.39
Children in community mental health	17.38

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	9	0	9
Community Mental Health Providers	0	40	40
Private Psychiatric Hospitals	0	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	1	0	1
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Combined with SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 59,438
- The state's data system does allow them to determine whether or not an individual is in the Medicaid Expansion population.
- The state did not provide the number of individuals served by the SMHA with private insurance**.**

The SMHA is working with the state Medicaid agency on what mental health benefits are included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Nine state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	Yes	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	17	Yes
Supported Housing	Parts of the State	9	Yes
Supported Employment	Parts of the State	8	Yes
Consumer Operated Services	Parts of the State	8	No
Family Psychoeducation	Parts of the State	4	Yes
Integrated Treatment for Co-Occurring Disorders	Parts of the State	7	Yes
Illness Self-Management and Recovery	Parts of the State	8	Yes
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	3	Yes
Incredible Years	None	0	N/A
Therapeutic Foster Care	Parts of the State	2	Yes
Function Family Therapy	None	0	N/A

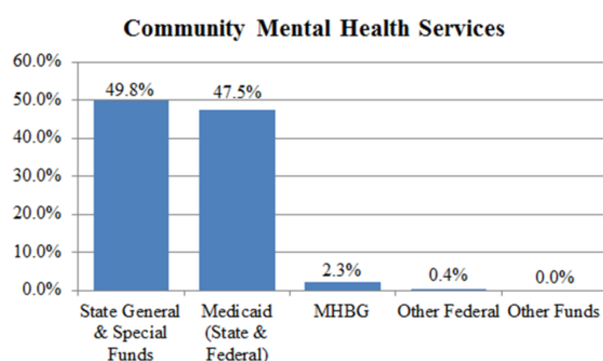
Mental Health Integration with Physical Health Care

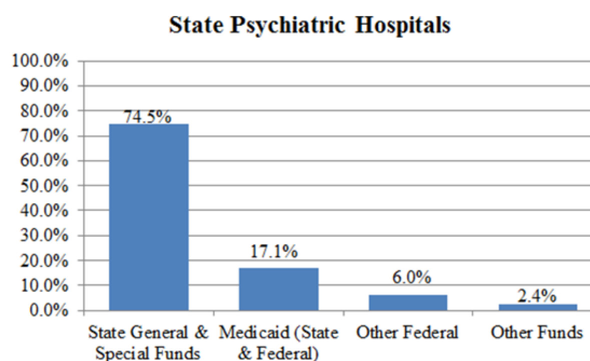
The SMHA has initiatives to improve the integration of mental health with primary health care and supports the colocation of primary care in mental health programs. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$764.3 million
Expenditures for Community Mental Health Services	$388.3 million
Expenditures for State Psychiatric Hospital Inpatient Care	$344.7 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$31.3 million
Per Capita State Mental Health Expenditures	$93.08

SMHA-Controlled Revenues, FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies. The SMHA also funds county or city mental health authorities which, in turn, fund local provider agencies or directly provide mental health services statewide and in parts of the state.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a 1915(c) waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in 40 community mental health centers (CMHCs) and two state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. There are agreements that allow the sharing of EHR client data between state hospitals within the state, community providers and state hospitals, and through a health information exchange (HIE).

This page intentionally left blank

Washington Mental Health 2015

Division of Behavioral Health and Recovery, Department of Social and Health Services
http://www.wa.gov/dshs

Eligibility Criteria for State Mental Health Services

Only adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) are eligible for mental health services funded by state general funds and Medicaid. There is an income cap and illness severity requirements for individuals to be eligible for state mental health agency (SMHA)-funded or SMHA-operated mental health services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	151,618
State psychiatric hospital residents at the start of the year	1,179
State population	6,971,406

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	19.77
Children, overall	28.37
Adults in community mental health	19.47
Children in community mental health	28.30

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	No Response	No Response	3
Community Mental Health Providers	No Response	206	206
Private Psychiatric Hospitals	NA	4	4
General Hospitals With Separate Psychiatric Units	No Response	18	18
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	No Response	17	17

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	No Responsibility
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	No Responsibility
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Different state department
State Public Health Agency	Different state department
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 135,620
- Number of individuals served by the SMHA with expanded Medicaid coverage: 38,086
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA has Medicaid health homes currently providing mental health services.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is not within the same agency responsible for the funding or delivery of community-based mental health services. Three state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	No	No	Yes
Intermediate inpatient (30-90 days)	Yes	Yes	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	Yes	Yes	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	13	Yes
Supported Housing	Parts of the State	8	Yes
Supported Employment	Parts of the State	10	Yes
Consumer Operated Services	Parts of the State	1	Yes
Child/Adolescent EBPs			
Cognitive Behavior Therapy for Depression	Statewide	No Response	No
Cognitive Behavior Therapy for Anxiety	Statewide	No Response	No Response
Trauma-Focused Cognitive Behavior Therapy	Statewide	No Response	No
Triple P (Level 4): Positive Parenting Program	Pilot Program	3	No

Mental Health Integration with Physical Health Care

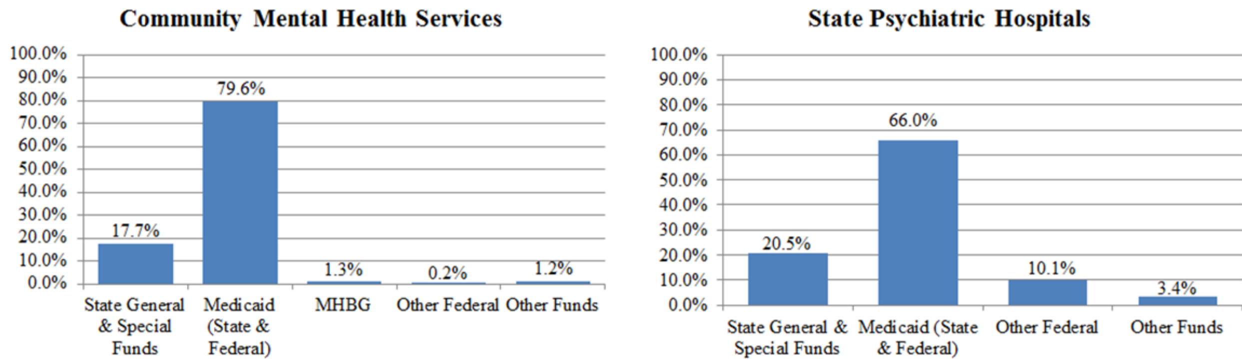
The SMHA supports the colocation of primary care in mental health programs and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$900.3 million

SMHA-Controlled Expenditures	Dollars
Expenditures for Community Mental Health Services	$642.8 million
Expenditures for State Psychiatric Hospital Inpatient Care	$239.2 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$18.3 million
Per Capita State Mental Health Expenditures	$128.46

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide. The SMHA also directly funds, but does not operate, local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through a 1915(b) waiver.

Electronic Health Records

The SMHA is unable to report the number of community mental health centers (CMHCs) and state psychiatric hospitals that have implemented electronic health records (EHRs).

This page intentionally left blank

West Virginia Mental Health 2015

Bureau for Behavioral Health and Health Facilities, Department of Health and Human Resources
http://www.dhhr.wv.gov/bhhf/Pages/default.aspx

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement for individuals to be eligible for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	57,811
State psychiatric hospital residents at the start of the year	263
State population	1,854,304

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	32.11
Children, overall	27.57
Adults in community mental health	31.41
Children in community mental health	27.56

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	0	13	13
Private Psychiatric Hospitals	NA	3	3
General Hospitals With Separate Psychiatric Units	0	13	13
Nursing Homes and Other ICF-MI and SNF Providers	5	0	5
Residential Treatment Facilities (RTCs)	0	2	2

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Shared with another agency
Alzheimer's Disease	Shared with another agency
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	No Responsibility
Sex Offender Services	No Responsibility

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Combined with SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 51,291
- Number of individuals served by the SMHA with expanded Medicaid coverage: 12,956
- The SMHA is unable to determine the number of individuals served by the SMHA with private insurance.

The SMHA did not provide information on whether or not the SMHA is working with the state Medicaid agency on what mental health benefits will be included in alternative benefit plans. The SMHA did not provide information on whether or not the SMHA has Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Two state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	10	No
Supported Housing	Parts of the State	Unknown	No
Supported Employment	Parts of the State	2	No
Consumer Operated Services	Parts of the State	7	Yes
Family Psychoeducation	Parts of the State	Unknown	No
Illness Self-Management and Recovery	Parts of the State	13	No
Child/Adolescent EBPs			
Incredible Years	Parts of the State	Unknown	No
Therapeutic Foster Care	Parts of the State	Unknown	No
Functional Family Therapy	Statewide	13	No
Second Steps	Parts of the State	Unknown	No
Parent-Child Interaction Therapy	Parts of the State	Unknown	No
Cognitive Behavior Therapy for Depression	Parts of the State	Unknown	No
Cognitive Behavior Therapy for Anxiety	Parts of the State	Unknown	No

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Child/Adolescent EBPs			
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	Unknown	No
Interpersonal Therapy for Depression	Parts of the State	Unknown	No
Triple P (Level 4): Positive Parenting Program	Parts of the State	Unknown	No
Prolonged Exposure Therapy for Adolescents	Parts of the State	Unknown	No
Multidimensional Treatment Foster Care	Parts of the State	Unknown	No

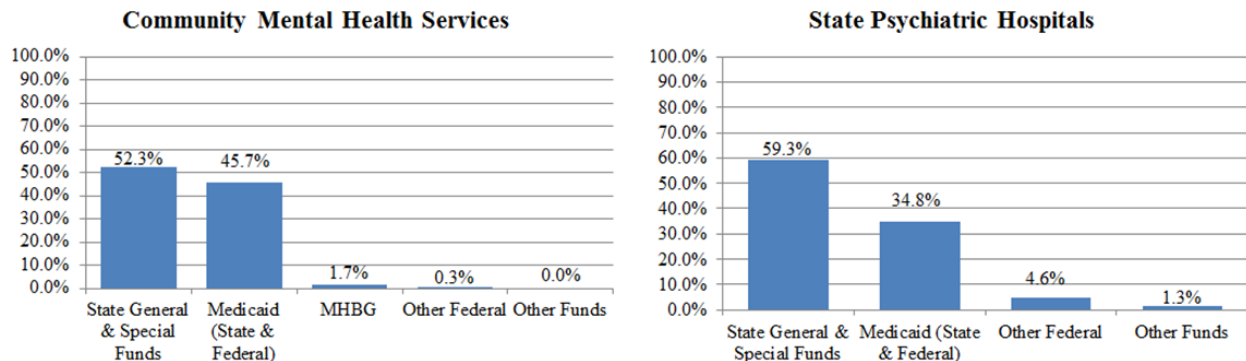
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. Some Patients are screened for physical health issues in some SMHA-funded or operated community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$170.8 million
Expenditures for Community Mental Health Services	$116.2 million
Expenditures for State Psychiatric Hospital Inpatient Care	$54.1 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$0.5 million
Per Capita State Mental Health Expenditures	$92.37

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through fee-for-services only. Providers submit claims using assigned procedure codes. Services are priced using state specific rates or fee schedules.

Electronic Health Records

Electronic health records (EHRs) are implemented in 13 community mental health centers (CMHCs) and two state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. The SMHA does not have agreements that allow the sharing of EHR client data between providers.

This page intentionally left blank

Wisconsin Mental Health 2015

Division of Mental Health and Substance Abuse Services, Department of Health Services

https://www.dhs.wisconsin.gov/

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement for individuals to be eligible for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	100,901
State psychiatric hospital residents at the start of the year	1,064
State population	5,742,713

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	19.97
Children, overall	9.42
Adults in community mental health	19.54
Children in community mental health	8.80

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	2	0	2
Community Mental Health Providers	1	67	68
Private Psychiatric Hospitals	NA	0	0
General Hospitals With Separate Psychiatric Units	0	0	0
Nursing Homes and Other ICF-MI and SNF Providers	0	0	0
Residential Treatment Facilities (RTCs)	0	0	0

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Shared with another agency
Older Adult Mental Health Services	Shared with another agency
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	No Responsibility
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	No Responsibility
Court Evaluation of Mental Health Status	Part of the SMHA
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Part of the SMHA

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Same umbrella department as the SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	Different state department

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 120,759
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is working with the state Medicaid agency on what mental health benefits are included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA is experiencing difficulties getting private insurance to pay supported housing, supported employment, assertive community treatment, and peer supports.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services. Two state psychiatric hospitals are accredited by the Joint Commission.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	Yes	Yes	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	No	No	No
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Assertive Community Treatment	Parts of the State	41	No Response
Supported Housing	Parts of the State	29	No Response
Supported Employment	Parts of the State	37	No Response
Consumer Operated Services	Parts of the State	No Response	No Response
Family Psychoeducation	Parts of the State	23	No Response
Integrated Treatment for Co-Occurring Disorders	Parts of the State	38	No Response
Illness Self-Management and Recovery	Parts of the State	34	No Response
MedTeam	Parts of the State	22	No Response
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	Unknown	No Response
Therapeutic Foster Care	Parts of the State	Unknown	No Response
Functional Family Therapy	Parts of the State	No Response	No Response
Cognitive Behavioral Intervention for Trauma in Schools	Parts of the State	Unknown	No Response
Problem-Solving Skills Training	Parts of the State	Unknown	No Response
Cognitive Behavior Therapy for Depression	Parts of the State	Unknown	No Response
Cognitive Behavior Therapy for Anxiety	Parts of the State	Unknown	No Response

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	Unknown	No Response
Interpersonal Therapy for Depression	Parts of the State	Unknown	No Response

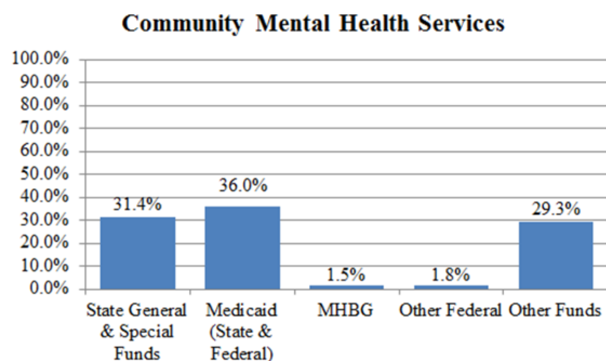
Mental Health Integration with Physical Health Care

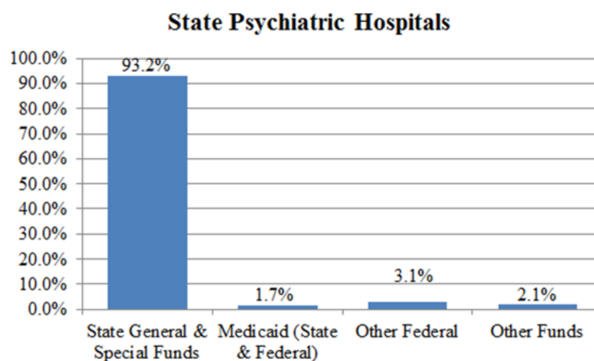
The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures FY 2014	Dollars
Total Mental Health Agency Controlled Expenditures	$644.8 million
Expenditures for Community Mental Health Services	$431.7 million
Expenditures for State Psychiatric Hospital Inpatient Care	$211.8 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$1.3 million
Per Capita State Mental Health Expenditures	$112.05

SMHA-Controlled Revenues: FY 2014





Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA funds county or city mental health authorities statewide. The SMHA also directly funds, but does not operate, local community-based agencies.

Medicaid

Medicaid is paying for mental health services through a combination of fee-for-service and managed care. Behavioral health services are administered through 1115, 1915(b), 1915(c), and 1915(i) waiver.

Electronic Health Records

Electronic health records (EHRs) are partially implemented two state psychiatric hospitals. A single EHR system is used for all state psychiatric hospitals. The SMHA does not have agreements that allow the sharing of EHR client data between providers.

This page intentionally left blank

Wyoming Mental Health 2015

Behavioral Health Division, Department of Health

http://www.health.wyo.gov/mhsa/index.html

Eligibility Criteria for State Mental Health Services

All adults and children with mental illness are eligible for mental health services funded by state general or special funds and Medicaid. There is neither an income cap nor an illness severity requirement for individuals to be eligible for state mental health agency (SMHA) services.

Numbers of Clients, Fiscal Year (FY) 2014

Category	Number
Individuals served	17,491
State psychiatric hospital residents at the start of the year	141
State population	582,658

Utilization Rates, Fiscal Year (FY) 2014

Category	Rate (per 1,000)
Adults, overall	28.43
Children, overall	35.15
Adults in community mental health	28.32
Children in community mental health	35.10

Number of Mental Health Providers the SMHA Operates or Funds

Mental Health Providers	SMHA-Operated	SMHA-Funded	Total
State Psychiatric Hospitals	1	0	1
Community Mental Health Providers	0	14	14
Private Psychiatric Hospitals	NA	No Response	No Response
General Hospitals With Separate Psychiatric Units	No Response	No Response	No Response
Nursing Homes and Other ICF-MI and SNF Providers	No Response	No Response	No Response
Residential Treatment Facilities (RTCs)	No Response	No Response	No Response

Abbreviations: ICF-MI, intermediate care facilities for persons with mental illness; NA, not applicable; SNF, skilled nursing facility

Responsibilities of the SMHA in Administering Specific Mental Health Services

Services Arena	Responsibility
Children and Youth Mental Health Services	Part of the SMHA
Older Adult Mental Health Services	Part of the SMHA
State Psychiatric Hospitals	Part of the SMHA
Traumatic Brain Injury Services	Part of the SMHA
Alzheimer's Disease	No Responsibility
Organic Brain Syndrome Services	Part of the SMHA
Court Evaluation of Mental Health Status	Shared with another agency
Services to Individuals with Mental Illness in Prison/Jail	Shared with another agency
Sex Offender Services	Shared with another agency

Responsibilities of the SMHA for Substance Use Disorders and Intellectual Disability

Agency	Location
Substance Use Services Agency	Combined with SMHA
Intellectual Disability/Developmental Disability Agency/Services	Combined with SMHA

Relationship of the SMHA to Other Major State Agencies

Agency	Location
State Medicaid Agency	Same umbrella department as the SMHA
State Public Health Agency	Same umbrella department as the SMHA
State Housing Agency	No Response

SMHA Role in Health Care Reform

- Number of individuals served by the SMHA with Medicaid coverage: 3,503
- The SMHA did not provide the number of persons served by the SMHA with private insurance.

The SMHA is not working with the state Medicaid agency on what mental health benefits are included in alternative benefit plans. The SMHA does not have Medicaid health homes currently providing mental health services. The SMHA did not indicate if it is experiencing difficulties getting private insurance to pay for evidence-based practices.

State Psychiatric Hospitals

The responsibility for the operation of state psychiatric hospitals is within the same agency responsible for the funding or delivery of community-based mental health services.

How the SMHA currently uses its State psychiatric hospital beds:

SMHA Psychiatric Hospital Inpatient Bed Use	Target Population				
	Children (0—12 years)	Adolescents (13—17 years)	Adults (18—64 years)	Older Adults (65+ years)	Forensic
Acute inpatient (less than 30 days)	No	No	Yes	Yes	Yes
Intermediate inpatient (30-90 days)	No	No	Yes	Yes	Yes
Long-term inpatient (more than 90 days)	No	No	Yes	Yes	Yes

Use of Evidence-Based Practices (EBPs)

Evidence-Based Practice	Implementation	Number of Programs	Fidelity is Assessed
Adult EBPs			
Supported Employment	Parts of the State	2	No
Consumer Operated Services	Parts of the State	2	No
Family Psychoeducation	Statewide	19	No
Integrated Treatment for Co-Occurring Disorders	Statewide	19	No
Illness Self-Management and Recovery	Parts of the State	9	No
Child/Adolescent EBPs			
Multisystemic Therapy	Parts of the State	3	No
Therapeutic Foster Care	Parts of the State	4	No
Functional Family Therapy	Parts of the State	2	No
Brief Strategic Family Therapy	Parts of the State	2	No
Trauma-Focused Cognitive Behavior Therapy	Parts of the State	6	No
High Fidelity Wraparound	Planning to Implement	2	Yes

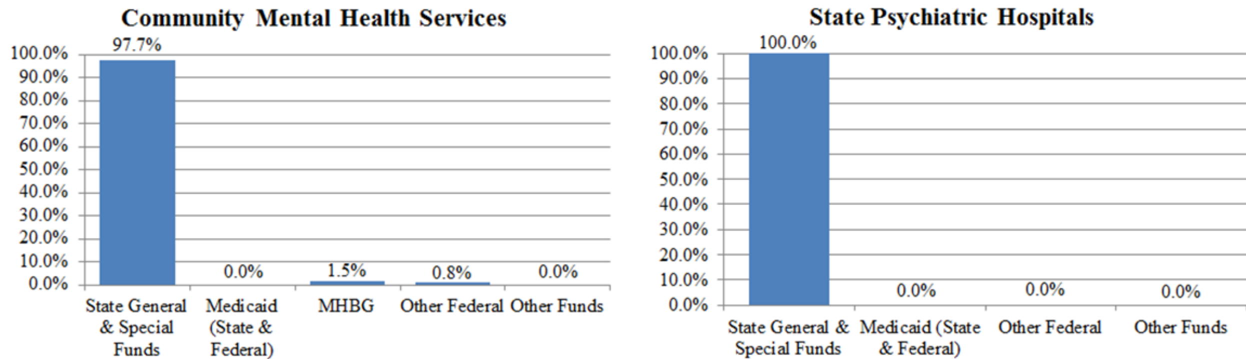
Mental Health Integration with Physical Health Care

The SMHA has initiatives to improve the integration of mental health with primary health care, supports the colocation of primary care in mental health programs, and supports the colocation of mental health providers in primary care. The SMHA screens or assesses individuals for physical health issues in community mental health programs.

SMHA Controlled Expenditures for Mental Health, FY 2014

SMHA-Controlled Expenditures	Dollars
Total Mental Health Agency Controlled Expenditures	$63.1 million
Expenditures for Community Mental Health Services	$30.3 million
Expenditures for State Psychiatric Hospital Inpatient Care	$32.0 million
Expenditures for SMHA Central Office, Research, Training, Prevention	$0.8 million
Per Capita State Mental Health Expenditures	$108.56

SMHA-Controlled Revenues, FY 2014



Abbreviation: MHBG, mental health block grant.

Mechanisms Used to Deliver Community Mental Health Services

The SMHA directly funds, but does not operate local community-based agencies.

Medicaid

Medicaid is paying for mental health services through fee-for-services only. Behavioral health services are administered through a 1915(c) waiver.

Electronic Health Records

Electronic health records (EHRs) are implemented in 13 community mental health centers (CMHCs) and one state psychiatric hospital. The SMHA does not have agreements that allow the sharing of EHR client data between providers.

Appendix B: Profiles of Single State Agency (SSA) Substance Abuse Services, 2015[1]

[1] Data were compiled in summer of 2015 from the most recent data reported by states, which generally was state fiscal year 2014 and for several it was fiscal year 2013. Please see Chapter 2 of the main report for a more complete description of methods, sources, and limitations.

Contents

Alabama Substance Abuse Profile 2015 .... B-1
Alaska Substance Abuse Profile 2015 .... B-4
Arizona Substance Abuse Profile 2015 .... B-7
Arkansas Substance Abuse Profile 2015 .... B-10
California Substance Abuse Profile 2015 .... B-13
Colorado Substance Abuse Profile 2015 .... B-16
Connecticut Substance Abuse Profile 2015 .... B-19
Delaware Substance Abuse Profile 2015 .... B-22
District of Columbia Substance Abuse Profile 2015 .... B-25
Florida Substance Abuse Profile 2015 .... B-28
Georgia Substance Abuse Profile 2015 .... B-30
Hawaii Substance Abuse Profile 2015 .... B-33
Idaho Substance Abuse Profile 2015 .... B-36
Illinois Substance Abuse Profile 2015 .... B-38
Indiana Substance Abuse Profile 2015 .... B-41
Iowa Substance Abuse Profile 2015 .... B-44
Kansas Substance Abuse Profile 2015 .... B-47
Kentucky Substance Abuse Profile 2015 .... B-50
Louisiana Substance Abuse Profile 2015 .... B-53
Maine Substance Abuse Profile 2015 .... B-56
Maryland Substance Abuse Profile 2015 .... B-59
Massachusetts Substance Abuse Profile 2015 .... B-62
Michigan Substance Abuse Profile 2015 .... B-65
Minnesota Substance Abuse Profile 2015 .... B-68
Mississippi Substance Abuse Profile 2015 .... B-70
Missouri Substance Abuse Profile 2015 .... B-73
Montana Substance Abuse Profile 2015 .... B-76
Nebraska Substance Abuse Profile 2015 .... B-79
Nevada Substance Abuse Profile 2015 .... B-82
New Hampshire Substance Abuse Profile 2015 .... B-85
New Jersey Substance Abuse Profile 2015 .... B-88
New Mexico Substance Abuse Profile 2015 .... B-91
New York Substance Abuse Profile 2015 .... B-94
North Carolina Substance Abuse Profile 2015 .... B-97
North Dakota Substance Abuse Profile 2015 .... B-100
Ohio Substance Abuse Profile 2015 .... B-103
Oklahoma Substance Abuse Profile 2015 .... B-106
Oregon Substance Abuse Profile 2015 .... B-109
Pennsylvania Substance Abuse Profile 2015 .... B-111
Rhode Island Substance Abuse Profile 2015 .... B-113
South Carolina Substance Abuse Profile 2015 .... B-116
South Dakota Substance Abuse Profile 2015 .... B-119
Tennessee Substance Abuse Profile 2015 .... B-122
Texas Substance Abuse Profile 2015 .... B-125
Utah Substance Abuse Profile 2015 .... B-128
Vermont Substance Abuse Profile 2015 .... B-131
Virginia Substance Abuse Profile 2015 .... B-134
Washington Substance Abuse Profile 2015 .... B-137
West Virginia Substance Abuse Profile 2015 .... B-139
Wisconsin Substance Abuse Profile 2015 .... B-142
Wyoming Substance Abuse Profile 2015 .... B-145

This page intentionally left blank

Alabama Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Substance Abuse Services Division

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	4,849,377	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.7
Alcohol SUD		6.2
Illicit drug SUD		2.6
Marijuana SUD		1.5
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		5.7
Young adults (18–25 years) with SUD		15.0
Adults with SUD (26 years or older)		6.7
Binge alcohol use past month		21.4
Illicit drug use past month		7.6

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	89,974
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	708,491
Providers funded by SSA to deliver SUD prevention	29

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.2
Illicit drug use (youth 12–17 years): past 30 days	7.7
Marijuana use (youth 12–17 years): past 30 days	4.8
Cigarette use (youth 12–17 years): past 30 days	6.2
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	80.3
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	76.0
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	90.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	54.1
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	94.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	18,792
Detoxification admissions (24-hour care)	705
Rehabilitation/residential admissions (24-hour care)	4,475
Ambulatory outpatient (regular plus intensive) admissions	13,665
Opioid replacement therapy admissions	1,922

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	81.2	
Rate of abstinence from illicit drugs at discharge (from outpatient)	58.0	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		96.2
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		83.8
Percentage of clients attending self-help programs at discharge (from outpatient)		68.3

SSA Financial Data

Characteristic	$ millions
Total annual budget	39.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	33.6
Expenditures on SUD primary prevention[a] services	3.9
Expenditures on infrastructure (e.g., workforce) and administration	1.9
State funding	12.4
SAMHSA SABG	18.7
Value of Medicaid funding managed by the SSA (if any)	6.3
Funding from other sources (e.g., federal capacity expansion grants, local governments)	2.1

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Alaska Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	736,732	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.1
Alcohol SUD		7.1
Illicit drug SUD		2.7
Marijuana SUD		2.3
Pain reliever SUD		0.5
Youth (12–17 years) with SUD		4.6
Young adults (18–25 years) with SUD		19.3
Adults with SUD (26 years or older)		7.8
Binge alcohol use past month		22.1
Illicit drug use past month		12.9

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	10,818
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	5,043
Providers funded by SSA to deliver SUD prevention	10

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	10.5
Illicit drug use (youth 12–17 years): past 30 days	9.7
Marijuana use (youth 12–17 years): past 30 days	8.7
Cigarette use (youth 12–17 years): past 30 days	6.4
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	76.1
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	68.1
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	86.3
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	59.2
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	50.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	7,512
Detoxification admissions (24-hour care)	1,355
Rehabilitation/residential admissions (24-hour care)	1,141
Ambulatory outpatient (regular plus intensive) admissions	3,903
Opioid replacement therapy admissions	38

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	69.7	
Rate of abstinence from illicit drugs at discharge (from outpatient)	64.9	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		92.7
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		95.4
Percentage of clients attending self-help programs at discharge (from outpatient)		35.9

SSA Financial Data

Characteristic	$ millions
Total annual budget	57.7
Expenditures on SUD treatment and prevention (other than primary prevention) services	38.0
Expenditures on SUD primary prevention[a] services	14.5
Expenditures on infrastructure (e.g., workforce) and administration	5.2
State funding	41.6
SAMHSA SABG	5.0
Value of Medicaid funding managed by the SSA (if any)	8.3
Funding from other sources (e.g., federal capacity expansion grants, local governments)	2.8

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	No
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR[b]
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	DK/NR
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Arizona Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	6,731,484	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.0
Alcohol SUD		7.2
Illicit drug SUD		3.0
Marijuana SUD		2.0
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		6.4
Young adults (18–25 years) with SUD		18.3
Adults with SUD (26 years or older)		7.7
Binge alcohol use past month		23.0
Illicit drug use past month		10.4

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	29,333
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	2,405,938
Providers funded by SSA to deliver SUD prevention	7

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.9
Illicit drug use (youth 12–17 years): past 30 days	11.0
Marijuana use (youth 12–17 years): past 30 days	8.3
Cigarette use (youth 12–17 years): past 30 days	5.5
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	77.6
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	69.2
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	89.9
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	57.6
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	94.2

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	128,392
Detoxification admissions (24-hour care)	1,876
Rehabilitation/residential admissions (24-hour care)	6,675
Ambulatory outpatient (regular plus intensive) admissions	62,229
Opioid replacement therapy admissions	4,995

National Outcome Measures

Characteristic	%
Rate of abstinence from alcohol at discharge (from outpatient)	77.2
Rate of abstinence from illicit drugs at discharge (from outpatient)	35.7
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)	87.4
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	76.2
Percentage of clients attending self-help programs at discharge (from outpatient)	45.9

SSA Financial Data

Characteristic	$ Millions
Total annual budget	155.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	140.2
Expenditures on SUD primary prevention[a] services	7.3
Expenditures on infrastructure (e.g., workforce) and administration	8.0
State funding	9.6
SAMHSA SABG	27.6
Value of Medicaid funding managed by the SSA (if any)	114.4
Funding from other sources (e.g., federal capacity expansion grants, local governments)	4.0

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	Yes

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Arkansas Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	2,966,369	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.7
Alcohol SUD		5.6
Illicit drug SUD		3.0
Marijuana SUD		1.8
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		5.7
Young adults (18–25 years) with SUD		17.2
Adults with SUD (26 years or older)		6.3
Binge alcohol use past month		21.0
Illicit drug use past month		8.0

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	90,187
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	116,830
Providers funded by SSA to deliver SUD prevention	30

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.0
Illicit drug use (youth 12–17 years): past 30 days	8.8
Marijuana use (youth 12–17 years): past 30 days	5.7
Cigarette use (youth 12–17 years): past 30 days	7.6
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	74.6
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	75.8
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	90.1
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	58.7
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	15.6

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	15,177
Detoxification admissions (24-hour care)	2,221
Rehabilitation/residential admissions (24-hour care)	2,934
Ambulatory outpatient (regular plus intensive) admissions	8,227
Opioid replacement therapy admissions	886

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	70.0	
Rate of abstinence from illicit drugs at discharge (from outpatient)	37.3	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		98.6
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		91.7
Percentage of clients attending self-help programs at discharge (from outpatient)		78.8

SSA Financial Data

Characteristic	$ Millions
Total annual budget	17.9
Expenditures on SUD treatment and prevention (other than primary prevention) services	14.4
Expenditures on SUD primary prevention[a] services	2.5
Expenditures on infrastructure (e.g., workforce) and administration	1.2
State funding	2.9
SAMHSA SABG	10.5
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	4.5

On Health Financing Reform

Characteristic	Response
Has the State expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes

Has state seen past year increase in heroin treatment admissions?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	DK/NR
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	DK/NR
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	DK/NR

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

California Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Alcohol & Drug Programs

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	38,802,500	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.8
Alcohol SUD		7.3
Illicit drug SUD		2.9
Marijuana SUD		1.9
Pain reliever SUD		0.6
Youth (12–17 years) with SUD		5.8
Young adults (18–25 years) with SUD		19.2
Adults with SUD (26 years or older)		7.2
Binge alcohol use past month		21.2
Illicit drug use past month		11.2

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	386,489
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	4,810,807
Providers funded by SSA to deliver SUD prevention	284

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.6
Illicit drug use (youth 12–17 years): past 30 days	9.8
Marijuana use (youth 12–17 years): past 30 days	7.8
Cigarette use (youth 12–17 years): past 30 days	4.3
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	79.0
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	70.4
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.2
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	59.1
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	7.3

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	237,352
Detoxification admissions (24-hour care)	23,708
Rehabilitation/residential admissions (24-hour care)	33,203
Ambulatory outpatient (regular plus intensive) admissions	93,147
Opioid replacement therapy admissions	17,090

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	86.9	
Rate of abstinence from illicit drugs at discharge (from outpatient)	77.2	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		93.9
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		66.1
Percentage of clients attending self-help programs at discharge (from outpatient)		86.9

SSA Financial Data

Characteristic	$ Millions
Total annual budget	482.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	406.9
Expenditures on SUD primary prevention[a] services	57.0
Expenditures on infrastructure (e.g., workforce) and administration	6.1
State funding	65.3
SAMHSA SABG	248.9
Value of Medicaid funding managed by the SSA (if any)	160.9
Funding from other sources (e.g., federal capacity expansion grants, local governments)	7.3

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Yes
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR[b]
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	Yes
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Colorado Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Behavioral Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	5,355,866	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.8
Alcohol SUD		7.5
Illicit drug SUD		3.1
Marijuana SUD		2.1
Pain reliever SUD		0.5
Youth (12–17 years) with SUD		6.7
Young adults (18–25 years) with SUD		21.5
Adults with SUD (26 years or older)		8.2
Binge alcohol use past month		25.5
Illicit drug use past month		14.9

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	198,382
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	1,717,506
Providers funded by SSA to deliver SUD prevention	35

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	13.1
Illicit drug use (youth 12–17 years): past 30 days	14.4
Marijuana use (youth 12–17 years): past 30 days	11.2
Cigarette use (youth 12–17 years): past 30 days	6.3
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	81.0
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	69.0
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.3
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	62.9
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	95.7

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	128,249
Detoxification admissions (24-hour care)	53,074
Rehabilitation/residential admissions (24-hour care)	10,778
Ambulatory outpatient (regular plus intensive) admissions	36,784
Opioid replacement therapy admissions	2,044

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	95.8	
Rate of abstinence from illicit drugs at discharge (from outpatient)	81.7	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		97.4
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		86.9
Percentage of clients attending self-help programs at discharge (from outpatient)		83.7

SSA Financial Data

Characteristic	$ Millions
Total annual budget	58.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	46.4
Expenditures on SUD primary prevention[a] services	10.2
Expenditures on infrastructure (e.g., workforce) and administration	1.6
State funding	22.1
SAMHSA SABG	27.2
Value of Medicaid funding managed by the SSA (if any)	1.2
Funding from other sources (e.g., federal capacity expansion grants, local governments)	7.7

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	Already Approved
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR[b]
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	Yes
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No

Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Connecticut Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Dept. of Mental Health & Addiction Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	3,596,677	
Population with a substance use disorder (SUD; alcohol, illicit drugs or both)		8.3
Alcohol SUD		7.0
Illicit drug SUD		2.5
Marijuana SUD		1.8
Pain reliever SUD		0.6
Youth (12–17 years) with SUD		5.3
Young adults (18–25 years) with SUD		18.9
Adults with SUD (26 years or older)		7.0
Binge alcohol use past month		24.0
Illicit drug use past month		9.9

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	4,281,660
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	14,887,432
Providers funded by SSA to deliver SUD prevention	36

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	14.2
Illicit drug use (youth 12–17 years): past 30 days	9.9
Marijuana use (youth 12–17 years): past 30 days	8.6
Cigarette use (youth 12–17 years): past 30 days	4.9
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.8
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	69.2
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.6
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	64.9
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	73.1

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	56,991
Detoxification admissions (24-hour care)	10,187
Rehabilitation/residential admissions (24-hour care)	5,806
Ambulatory outpatient (regular plus intensive) admissions	15,947
Opioid replacement therapy admissions	5,363

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	70.1	
Rate of abstinence from illicit drugs at discharge (from outpatient)	52.7	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		92.4
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		80.8
Percentage of clients attending self-help programs at discharge (from outpatient)		65.0

SSA Financial Data

Characteristic	$ Millions
Total annual budget	195.7
Expenditures on SUD treatment and prevention (other than primary prevention) services	170.2
Expenditures on SUD primary prevention[a] services	12.7
Expenditures on infrastructure (e.g., workforce) and administration	11.7
State funding	155.8
SAMHSA SABG	16.9
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	23.0

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Not Applying
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR[b]
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes[c]
Has state seen past year increase in heroin treatment admissions?	No[d]
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	**No**
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

[c] Admissions for prescription drugs as primary drug of choice have **decreased** during FY15.

[d] Admissions for heroin as primary drug of choice have **increased** during FY15.

Delaware Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Substance Abuse and Mental Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	935,614	
Population with a substance use disorder (SUD; alcohol, illicit drugs or both)		9.2
Alcohol SUD		7.1
Illicit drug SUD		3.1
Marijuana SUD		1.8
Pain reliever SUD		0.8
Youth (12–17 years) with SUD		5.7
Young adults (18–25 years) with SUD		20.6
Adults with SUD (26 years or older)		7.7
Binge alcohol use past month		22.4
Illicit drug use past month		9.6

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	9,457
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	197,719
Providers funded by SSA to deliver SUD prevention	3

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.7
Illicit drug use (youth 12–17 years): past 30 days	10.8
Marijuana use (youth 12–17 years): past 30 days	9.2
Cigarette use (youth 12–17 years): past 30 days	6.9
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	80.2
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	74.2
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.6
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	53.6
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	50.4

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	9,744
Detoxification admissions (24-hour care)	1,645
Rehabilitation/residential admissions (24-hour care)	420
Ambulatory outpatient (regular plus intensive) admissions	4,797
Opioid replacement therapy admissions	779

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	72.0	
Rate of abstinence from illicit drugs at discharge (from outpatient)	46.5	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		58.3
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		99.0
Percentage of clients attending self-help programs at discharge (from outpatient)		0.0

SSA Financial Data

Characteristic	$ Millions
Total annual budget	23.1
Expenditures on SUD treatment and prevention (other than primary prevention) services	19.6
Expenditures on SUD primary prevention[a] services	2.9
Expenditures on infrastructure (e.g., workforce) and administration	0.2
State funding	14.9
SAMHSA SABG	6.0
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	2.2

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	DK/NR
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	DK/NR
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

District of Columbia Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Addiction Prevention & Recovery Administration

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	658,893	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		13.8
Alcohol SUD		12.0
Illicit drug SUD		3.9
Marijuana SUD		2.7
Pain reliever SUD		0.4
Youth (12–17 years) with SUD		6.3
Young adults (18–25 years) with SUD		21.9
Adults with SUD (26 years or older)		12.6
Binge alcohol use past month		33.7
Illicit drug use past month		15.2

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	567
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	3,925
Providers funded by SSA to deliver SUD prevention	3

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.9
Illicit drug use (youth 12–17 years): past 30 days	13.3
Marijuana use (youth 12–17 years): past 30 days	9.9
Cigarette use (youth 12–17 years): past 30 days	4.6
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.0
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	63.6
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	85.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	55.7
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	10,204
Detoxification admissions (24-hour care)	1,195
Rehabilitation/residential admissions (24-hour care)	1,873
Ambulatory outpatient (regular plus intensive) admissions	2,752
Opioid replacement therapy admissions	406

National Outcome Measures

Characteristic	%
Rate of abstinence from alcohol at discharge (from outpatient)	93.1
Rate of abstinence from illicit drugs at discharge (from outpatient)	80.5
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)	96.2
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	90.2
Percentage of clients attending self-help programs at discharge (from outpatient)	46.8

SSA Financial Data

Characteristic	$ Millions
Total annual budget	38.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	31.9
Expenditures on SUD primary prevention[a] services	4.5
Expenditures on infrastructure (e.g., workforce) and administration	1.2
State funding	26.5
SAMHSA SABG	2.7
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	9.3

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Not Applying
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	Yes
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	No
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR[b]
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	DK/NR

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Florida Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Substance Abuse Program Office

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	19,893,297	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.9
Alcohol SUD		6.1
Illicit drug SUD		2.5
Marijuana SUD		1.7
Pain reliever SUD		0.7
Youth (12–17 years) with SUD		5.7
Young adults (18–25 years) with SUD		16.2
Adults with SUD (26 years or older)		6.9
Binge alcohol use past month		20.8
Illicit drug use past month		8.6

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	6,511
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	6,858,965
Providers funded by SSA to deliver SUD prevention	58

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.8
Illicit drug use (youth 12–17 years): past 30 days	9.4
Marijuana use (youth 12–17 years): past 30 days	7.5
Cigarette use (youth 12–17 years): past 30 days	4.9
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.8
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	71.3
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.5
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	58.2
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	38.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	499,028
Detoxification admissions (24-hour care)	20,900
Rehabilitation/residential admissions (24-hour care)	14,944
Ambulatory outpatient (regular plus intensive) admissions	109,383
Opioid replacement therapy admissions	5,307

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	86.5	
Rate of abstinence from illicit drugs at discharge (from outpatient)	73.0	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		92.6
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		97.7

Characteristic	Rate	%
Percentage of clients attending self-help programs at discharge (from outpatient)		42.3

SSA Financial Data

Characteristic	$ Millions
Total annual budget	221.9
Expenditures on SUD treatment and prevention (other than primary prevention) services	164.8
Expenditures on SUD primary prevention[a] services	49.9
Expenditures on infrastructure (e.g., workforce) and administration	3.3
State funding	100.1
SAMHSA SABG	99.6
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	22.1

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Not Applying
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	Yes
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	DK/NR[b]
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Georgia Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Addictive Diseases

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	10,097,343	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.3
Alcohol SUD		5.5
Illicit drug SUD		3.1
Marijuana SUD		1.6
Pain reliever SUD		0.7
Youth (12–17 years) with SUD		5.1
Young adults (18–25 years) with SUD		14.9
Adults with SUD (26 years or older)		6.2
Binge alcohol use past month		19.8
Illicit drug use past month		9.5

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	103,838
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	1,061,186
Providers funded by SSA to deliver SUD prevention	36

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.3
Illicit drug use (youth 12–17 years): past 30 days	9.5
Marijuana use (youth 12–17 years): past 30 days	7.1
Cigarette use (youth 12–17 years): past 30 days	6.0
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.4
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	73.4
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	90.2
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	57.8
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	36.8

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	35,634
Detoxification admissions (24-hour care)	10,584
Rehabilitation/residential admissions (24-hour care)	2,851
Ambulatory outpatient (regular plus intensive) admissions	45,585
Opioid replacement therapy admissions	222

National Outcome Measures

Characteristic	%
Rate of abstinence from alcohol at discharge (from outpatient)	71.5
Rate of abstinence from illicit drugs at discharge (from outpatient)	63.4
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)	94.8
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	90.5
Percentage of clients attending self-help programs at discharge (from outpatient)	20.8

SSA Financial Data

Characteristic	$ Millions
Total annual budget	123.3
Expenditures on SUD treatment and prevention (other than primary prevention) services	105.9
Expenditures on SUD primary prevention[a] services	13.0
Expenditures on infrastructure (e.g., workforce) and administration	1.6
State funding	48.0
SAMHSA SABG	53.8
Value of Medicaid funding managed by the SSA (if any)	0.8
Funding from other sources (e.g., federal capacity expansion grants, local governments)	20.8

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Hawaii Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Alcohol and Drug Abuse Division

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	1,419,561	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.7
Alcohol SUD		7.6
Illicit drug SUD		2.6
Marijuana SUD		1.8
Pain reliever SUD		0.4
Youth (12–17 years) with SUD		6.8
Young adults (18–25 years) with SUD		20.2
Adults with SUD (26 years or older)		7.1
Binge alcohol use past month		23.0
Illicit drug use past month		10.3

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	12,214
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	97,136
Providers funded by SSA to deliver SUD prevention	15

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.2
Illicit drug use (youth 12–17 years): past 30 days	10.9
Marijuana use (youth 12–17 years): past 30 days	9.6
Cigarette use (youth 12–17 years): past 30 days	5.4
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	76.1
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	68.2
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	87.6
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	54.6
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	69.5

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	5,231
Detoxification admissions (24-hour care)	340
Rehabilitation/residential admissions (24-hour care)	619
Ambulatory outpatient (regular plus intensive) admissions	3,695
Opioid replacement therapy admissions	10

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	75.8	
Rate of abstinence from illicit drugs at discharge (from outpatient)	75.8	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		96.3
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		82.7
Percentage of clients attending self-help programs at discharge (from outpatient)		76.5

SSA Financial Data

Characteristic	$ Millions
Total annual budget	29.9
Expenditures on SUD treatment and prevention (other than primary prevention) services	23.0
Expenditures on SUD primary prevention[a] services	4.6
Expenditures on infrastructure (e.g., workforce) and administration	1.9
State funding	18.3
SAMHSA SABG	7.5
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	4.1

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Preparing Application
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	DK/NR[b]
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	No
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Idaho Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Substance Use Disorders Program

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	1,634,464	
Population with a substance use disorder (SUD; alcohol, illicit drugs or both)		8.3
Alcohol SUD		6.7
Illicit drug SUD		2.3
Marijuana SUD		1.6
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		5.9
Young adults (18–25 years) with SUD		16.2
Adults with SUD (26 years or older)		7.3
Binge alcohol use past month		19.6
Illicit drug use past month		6.8

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	12,082
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	5,627,680
Providers funded by SSA to deliver SUD prevention	66

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.3
Illicit drug use (youth 12–17 years): past 30 days	7.6
Marijuana use (youth 12–17 years): past 30 days	5.6
Cigarette use (youth 12–17 years): past 30 days	6.8
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	76.9
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	76.3
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.6
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	59.2
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	0.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	8,100
Detoxification admissions (24-hour care)	112
Rehabilitation/residential admissions (24-hour care)	313
Ambulatory outpatient (regular plus intensive) admissions	4,536
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	%
Rate of abstinence from alcohol at discharge (from outpatient)	90.9
Rate of abstinence from illicit drugs at discharge (from outpatient)	86.8
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)	88.2
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	98.7
Percentage of clients attending self–help programs at discharge (from outpatient)	31.4

SSA Financial Data

Characteristic	$ Millions
Total annual budget	30.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	27.5
Expenditures on SUD primary prevention[a] services	3.1
Expenditures on infrastructure (e.g., workforce) and administration	0.2
State funding	18.5
SAMHSA SABG	6.9
Value of Medicaid funding managed by the SSA (if any)	2.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	3.5

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Yes
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	Yes
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Being Developed
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Illinois Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Alcoholism & Substance Abuse

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	12,880,580	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.7
Alcohol SUD		6.4
Illicit drug SUD		2.3
Marijuana SUD		1.5
Pain reliever SUD		0.4
Youth (12–17 years) with SUD		4.8
Young adults (18–25 years) with SUD		17.6
Adults with SUD (26 years or older)		6.4
Binge alcohol use past month		26.6
Illicit drug use past month		8.7

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	36,281
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	51,443
Providers funded by SSA to deliver SUD prevention	263

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.4
Illicit drug use (youth 12–17 years): past 30 days	8.1
Marijuana use (youth 12–17 years): past 30 days	6.3
Cigarette use (youth 12–17 years): past 30 days	5.9
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	79.6
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	75.3
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.1
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	57.8
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	65.8

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	71,499
Detoxification admissions (24-hour care)	11,706
Rehabilitation/residential admissions (24-hour care)	15,440
Ambulatory outpatient (regular plus intensive) admissions	43,761
Opioid replacement therapy admissions	2,099

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	84.4	
Rate of abstinence from illicit drugs at discharge (from outpatient)	75.2	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		95.8
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		97.8
Percentage of clients attending self-help programs at discharge (from outpatient)		39.2

SSA Financial Data

Characteristic	$ Millions
Total annual budget	214.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	185.2
Expenditures on SUD primary prevention[a] services	18.5
Expenditures on infrastructure (e.g., workforce) and administration	7.4
State funding	85.4
SAMHSA SABG	67.7
Value of Medicaid funding managed by the SSA (if any)	51.5
Funding from other sources (e.g., federal capacity expansion grants, local governments)	9.9

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Preparing Application
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	Yes
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	Yes
Does state have a shortage of substance abuse counselors?	No
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	No
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Indiana Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Addiction and Emergency Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	6,596,855	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.8
Alcohol SUD		7.0
Illicit drug SUD		3.0
Marijuana SUD		1.8
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		5.9
Young adults (18–25 years) with SUD		20.2
Adults with SUD (26 years or older)		7.2
Binge alcohol use past month		22.3
Illicit drug use past month		7.9

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	30,909
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	39,654
Providers funded by SSA to deliver SUD prevention	25

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.0
Illicit drug use (youth 12–17 years): past 30 days	7.9
Marijuana use (youth 12–17 years): past 30 days	6.0
Cigarette use (youth 12–17 years): past 30 days	7.7
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	77.1
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.7
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.1
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	58.6
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	47,397
Detoxification admissions (24-hour care)	1,066
Rehabilitation/residential admissions (24-hour care)	1,125
Ambulatory outpatient (regular plus intensive) admissions	23,170
Opioid replacement therapy admissions	356

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	77.1	
Rate of abstinence from illicit drugs at discharge (from outpatient)	67.9	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		91.4
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		95.3
Percentage of clients attending self-help programs at discharge (from outpatient)		24.9

SSA Financial Data

Characteristic	$ Millions
Total annual budget	47.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	38.0
Expenditures on SUD primary prevention services	8.0
Expenditures on infrastructure (e.g., workforce) and administration	0.5
State funding	10.3
SAMHSA SABG	31.0
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	6.3

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Preparing Application
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	Already Approved
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Iowa Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Public Health, Division of Behavioral Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	3,107,126	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.9
Alcohol SUD		6.2
Illicit drug SUD		2.2
Marijuana SUD		1.2
Pain reliever SUD		0.3
Youth (12–17 years) with SUD		4.7
Young adults (18–25 years) with SUD		17.9
Adults with SUD (26 years or older)		6.5
Binge alcohol use past month		26.3
Illicit drug use past month		7.3

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	167,998
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	32,475
Providers funded by SSA to deliver SUD prevention	21

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.4
Illicit drug use (youth 12–17 years): past 30 days	7.9
Marijuana use (youth 12–17 years): past 30 days	6.2
Cigarette use (youth 12–17 years): past 30 days	7.2
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	72.4
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	76.4
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	60.2
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	69.8

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	53,848
Detoxification admissions (24-hour care)	842
Rehabilitation/residential admissions (24-hour care)	2,962
Ambulatory outpatient (regular plus intensive) admissions	14,112
Opioid replacement therapy admissions	126

National Outcome Measures

Characteristic	**Rate**	**%**
Rate of abstinence from alcohol at discharge (from outpatient)	88.0	
Rate of abstinence from illicit drugs at discharge (from outpatient)	89.3	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		96.7
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		80.3
Percentage of clients attending self-help programs at discharge (from outpatient)		16.5

SSA Financial Data

Characteristic	**$ Millions**
Total annual budget	42.1
Expenditures on SUD treatment and prevention (other than primary prevention) services	33.0
Expenditures on SUD primary prevention[a] services	7.3
Expenditures on infrastructure (e.g., workforce) and administration	1.7
State funding	19.9
SAMHSA SABG	13.4
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	8.7

On Health Financing Reform

Characteristic	**Response**
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	No
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Kansas Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	2,904,021	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.4
Alcohol SUD		7.1
Illicit drug SUD		2.2
Marijuana SUD		1.4
Pain reliever SUD		0.4
Youth (12–17 years) with SUD		5.0
Young adults (18–25 years) with SUD		16.8
Adults with SUD (26 years or older)		7.3
Binge alcohol use past month		24.9
Illicit drug use past month		6.0

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	11,433
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	48,295
Providers funded by SSA to deliver SUD prevention	13

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.5
Illicit drug use (youth 12–17 years): past 30 days	6.7
Marijuana use (youth 12–17 years): past 30 days	5.1
Cigarette use (youth 12–17 years): past 30 days	6.3
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	73.7
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	79.9
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.5
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	56.8
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	4.1

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	18,872
Detoxification admissions (24-hour care)	2,018
Rehabilitation/residential admissions (24-hour care)	2,529
Ambulatory outpatient (regular plus intensive) admissions	5,487
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	98.8	
Rate of abstinence from illicit drugs at discharge (from outpatient)	98.8	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		100.0
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		87.5
Percentage of clients attending self-help programs at discharge (from outpatient)		23.3

SSA Financial Data

Characteristic	$ Millions
Total annual budget	44.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	38.0
Expenditures on SUD primary prevention[a] services	4.8
Expenditures on infrastructure (e.g., workforce) and administration	1.4
State funding	17.4
SAMHSA SABG	12.5
Value of Medicaid funding managed by the SSA (if any)	11.9
Funding from other sources (e.g., federal capacity expansion grants, local governments)	2.5

On Health Financing Reform *:*

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Already Approved
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	No
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	DK/NR[b]
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	No
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Kentucky Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department for Behavioral Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	4,413,457	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.9
Alcohol SUD		5.9
Illicit drug SUD		2.7
Marijuana SUD		1.4
Pain reliever SUD		1.4
Youth (12–17 years) with SUD		5.1
Young adults (18–25 years) with SUD		17.7
Adults with SUD (26 years or older)		6.6
Binge alcohol use past month		22.0
Illicit drug use past month		7.3

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	421,210
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	113,728,194
Providers funded by SSA to deliver SUD prevention	17

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	10.0
Illicit drug use (youth 12–17 years): past 30 days	7.0
Marijuana use (youth 12–17 years): past 30 days	5.1
Cigarette use (youth 12–17 years): past 30 days	9.5
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.5
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	75.4
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.3
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	0.0
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	17,920
Detoxification admissions (24-hour care)	6,421
Rehabilitation/residential admissions (24-hour care)	986
Ambulatory outpatient (regular plus intensive) admissions	9,549
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	82.2	
Rate of abstinence from illicit drugs at discharge (from outpatient)	66.3	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		97.3
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		96.3
Percentage of clients attending self-help programs at discharge (from outpatient)		24.6

SSA Financial Data

Characteristic	$ Millions
Total annual budget	38.3
Expenditures on SUD treatment and prevention (other than primary prevention) services	31.0
Expenditures on SUD primary prevention[a] services	6.1
Expenditures on infrastructure (e.g., workforce) and administration	1.2
State funding	16.1
SAMHSA SABG	20.2
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	1.9

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Louisiana Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Behavioral Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	4,649,676	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.2
Alcohol SUD		6.0
Illicit drug SUD		2.9
Marijuana SUD		1.5
Pain reliever SUD		1.0
Youth (12–17 years) with SUD		6.1
Young adults (18–25 years) with SUD		16.3
Adults with SUD (26 years or older)		7.0
Binge alcohol use past month		25.4
Illicit drug use past month		7.8

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	83,694
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	253,177
Providers funded by SSA to deliver SUD prevention	51

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	13.0
Illicit drug use (youth 12–17 years): past 30 days	8.4
Marijuana use (youth 12–17 years): past 30 days	5.1
Cigarette use (youth 12–17 years): past 30 days	8.1
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	77.9
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	74.3
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	87.5
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	53.8
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	15,208
Detoxification admissions (24-hour care)	3,273
Rehabilitation/residential admissions (24-hour care)	5,471
Ambulatory outpatient (regular plus intensive) admissions	5,247
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	90.6	
Rate of abstinence from illicit drugs at discharge (from outpatient)	67.5	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		95.9
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		94.0
Percentage of clients attending self-help programs at discharge (from outpatient)		52.0

SSA Financial Data

Characteristic	$ Millions
Total annual budget	81.7
Expenditures on SUD treatment and prevention (other than primary prevention) services	74.2
Expenditures on SUD primary prevention[a] services	5.0
Expenditures on infrastructure (e.g., workforce) and administration	1.2
State funding	41.3
SAMHSA SABG	24.8
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	15.5

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Being Developed
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Maine Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Substance Abuse

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	1,330,089	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.6
Alcohol SUD		6.4
Illicit drug SUD		2.6
Marijuana SUD		1.8
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		5.2
Young adults (18–25 years) with SUD		20.0
Adults with SUD (26 years or older)		7.3
Binge alcohol use past month		21.6
Illicit drug use past month		11.3

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	761
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	1,329,192
Providers funded by SSA to deliver SUD prevention	40

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.4
Illicit drug use (youth 12–17 years): past 30 days	11.1
Marijuana use (youth 12–17 years): past 30 days	9.3
Cigarette use (youth 12–17 years): past 30 days	7.2
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	74.8
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	67.5
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.8
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	58.2
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	46.3

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	15,654
Detoxification admissions (24-hour care)	1,219
Rehabilitation/residential admissions (24-hour care)	1,227
Ambulatory outpatient (regular plus intensive) admissions	8,118
Opioid replacement therapy admissions	3,639

National Outcome Measures

Characteristic	Number/%
Rate of abstinence from alcohol at discharge (from outpatient)	81.5%
Rate of abstinence from illicit drugs at discharge (from outpatient)	75.6%
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)	92.2%
Percentage of outpatient clients in stable living situation at discharge (from outpatient)	97.3%
Percentage of clients attending self-help programs at discharge (from outpatient)	38.5%

SSA Financial Data

Characteristic	$ Millions
Total annual budget	34.9
Expenditures on SUD treatment and prevention (other than primary prevention) services	29.2
Expenditures on SUD primary prevention[a] services	4.0
Expenditures on infrastructure (e.g., workforce) and administration	1.6
State funding	11.9
SAMHSA SABG	6.7
Value of Medicaid funding managed by the SSA (if any)	13.4
Funding from other sources (e.g., federal capacity expansion grants, local governments)	3.0

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, and heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Being Developed
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Maryland Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Alcohol & Drug Abuse Administration

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	5,976,407	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.0
Alcohol SUD		6.5
Illicit drug SUD		2.6
Marijuana SUD		1.4
Pain reliever SUD		0.7
Youth (12–17 years) with SUD		5.2
Young adults (18–25 years) with SUD		18.3
Adults with SUD (26 years or older)		6.7
Binge alcohol use past month		23.1
Illicit drug use past month		8.9

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	7,971
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	312,591
Providers funded by SSA to deliver SUD prevention	24

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	13.4
Illicit drug use (youth 12–17 years): past 30 days	9.6
Marijuana use (youth 12–17 years): past 30 days	7.5
Cigarette use (youth 12–17 years): past 30 days	5.0
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	80.5
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	72.1
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	93.3
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	55.9
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	70,365
Detoxification admissions (24-hour care)	5,182
Rehabilitation/residential admissions (24-hour care)	11,359
Ambulatory outpatient (regular plus intensive) admissions	29,097
Opioid replacement therapy admissions	4,130

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	86.8	
Rate of abstinence from illicit drugs at discharge (from outpatient)	71.9	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		95.7
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		99.0
Percentage of clients attending self-help programs at discharge (from outpatient)		19.1

SSA Financial Data

Characteristic	$ Millions
Total annual budget	159.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	142.5
Expenditures on SUD primary prevention[a] services	6.3
Expenditures on infrastructure (e.g., workforce) and administration	7.0
State funding	117.7
SAMHSA SABG	31.7
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	10.1

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Applied, not yet approved
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR[b]
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Massachusetts Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Bureau of Substance Abuse Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	6,745,408	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.9
Alcohol SUD		7.1
Illicit drug SUD		2.8
Marijuana SUD		2.0
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		5.6
Young adults (18–25 years) with SUD		20.0
Adults with SUD (26 years or older)		7.3
Binge alcohol use past month		25.9
Illicit drug use past month		11.6

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	0
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	56,664,162
Providers funded by SSA to deliver SUD prevention	49

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	14.5
Illicit drug use (youth 12–17 years): past 30 days	10.6
Marijuana use (youth 12–17 years): past 30 days	8.9
Cigarette use (youth 12–17 years): past 30 days	5.6
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	74.9
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	68.5
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.6
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	62.0
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	38.9

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	68,328
Detoxification admissions (24-hour care)	54,962
Rehabilitation/residential admissions (24-hour care)	14,130
Ambulatory outpatient (regular plus intensive) admissions	28,465
Opioid replacement therapy admissions	8,303

National Outcome Measures

Characteristic	Number	%
Rate of abstinence from alcohol at discharge (from outpatient)	77.8	
Rate of abstinence from illicit drugs at discharge (from outpatient)	83.4	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		98.6
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		92.3
Percentage of clients attending self-help programs at discharge (from outpatient)		85.5

SSA Financial Data

Characteristic	$ Millions
Total annual budget	129.0
Expenditures on SUD treatment and prevention (other than primary prevention) services	117.7
Expenditures on SUD primary prevention[a] services	7.9
Expenditures on infrastructure (e.g., workforce) and administration	3.4
State funding	90.1
SAMHSA SABG	32.3
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	6.6

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Already Approved
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	Already Approved
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	No
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	DK/NR[b]
Has state seen past year increase in heroin treatment admissions?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	DK/NR
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	DK/NR
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	DK/NR

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Michigan Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Recovery Oriented Systems of Care

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	9,909,877	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.8
Alcohol SUD		6.8
Illicit drug SUD		3.0
Marijuana SUD		1.9
Pain reliever SUD		0.7
Youth (12–17 years) with SUD		5.8
Young adults (18–25 years) with SUD		17.4
Adults with SUD (26 years or older)		7.6
Binge alcohol use past month		24.3
Illicit drug use past month		11.5

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	147,376
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	350,302
Providers funded by SSA to deliver SUD prevention	140

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.9
Illicit drug use (youth 12–17 years): past 30 days	11.4
Marijuana use (youth 12–17 years): past 30 days	9.1
Cigarette use (youth 12–17 years): past 30 days	7.1
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	75.7
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	71.4
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	90.9
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	57.2
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	78.6

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	73,983
Detoxification admissions (24-hour care)	11,503
Rehabilitation/residential admissions (24-hour care)	12,160
Ambulatory outpatient (regular plus intensive) admissions	42,904
Opioid replacement therapy admissions	3,521

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	81.6	
Rate of abstinence from illicit drugs at discharge (from outpatient)	76.0	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		90.1
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		94.2
Percentage of clients attending self-help programs at discharge (from outpatient)		27.2

SSA Financial Data

Characteristic	$ in Millions
Total annual budget	131.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	117.1
Expenditures on SUD primary prevention[a] services	13.1
Expenditures on infrastructure (e.g., workforce) and administration	1.4
State funding	29.8
SAMHSA SABG	51.0
Value of Medicaid funding managed by the SSA (if any)	43.9
Funding from other sources (e.g., federal capacity expansion grants, local governments)	6.8

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Already Approved
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	Already Approved
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	Yes

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	DK/NR[b]
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Minnesota Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Alcohol and Drug Abuse Division

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	5,457,173	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.4
Alcohol SUD		6.6
Illicit drug SUD		2.4
Marijuana SUD		1.6
Pain reliever SUD		0.4
Youth (12–17 years) with SUD		4.9
Young adults (18–25 years) with SUD		18.2
Adults with SUD (26 years or older)		7.2
Binge alcohol use past month		27.1
Illicit drug use past month		7.6

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	45,016
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	155,412
Providers funded by SSA to deliver SUD prevention	26

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.9
Illicit drug use (youth 12–17 years): past 30 days	7.8
Marijuana use (youth 12–17 years): past 30 days	6.7
Cigarette use (youth 12–17 years): past 30 days	7.0
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	77.7
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.0
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.3
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	60.8
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	68.3

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	30,578
Detoxification admissions (24-hour care)	0
Rehabilitation/residential admissions (24-hour care)	15,764
Ambulatory outpatient (regular plus intensive) admissions	16,060
Opioid replacement therapy admissions	1,411

National Outcome Measures

Characteristic	Number	%
Rate of abstinence from alcohol at discharge (from outpatient)	86.4	
Rate of abstinence from illicit drugs at discharge (from outpatient)	77.3	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		90.9
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		95.2
Percentage of clients attending self-help programs at discharge (from outpatient)		77.3

SSA Financial Data

Characteristic	$ Millions
Total annual budget	155.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	148.8
Expenditures on SUD primary prevention[a] services	5.6
Expenditures on infrastructure (e.g., workforce) and administration	0.9
State funding	100.8
SAMHSA SABG	19.9
Value of Medicaid funding managed by the SSA (if any)	32.6
Funding from other sources (e.g., federal capacity expansion grants, local governments)	2.0

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Mississippi Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Bureau of Alcohol & Drug Abuse

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau))	2,994,079	
Population with a substance use disorder (SUD; alcohol, illicit drugs or both)		7.8
Alcohol SUD		5.8
Illicit drug SUD		2.8
Marijuana SUD		1.4
Pain reliever SUD		0.7
Youth (12–17 years) with SUD		5.7
Young adults (18–25 years) with SUD		14.7
Adults with SUD (26 years or older)		6.8
Binge alcohol use past month		19.9
Illicit drug use past month		7.3

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	141,459
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	675,745
Providers funded by SSA to deliver SUD prevention	29

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.7
Illicit drug use (youth 12–17 years): past 30 days	7.9
Marijuana use (youth 12–17 years): past 30 days	5.1
Cigarette use (youth 12–17 years): past 30 days	8.1
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	80.1
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	76.7
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	85.4
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	51.6
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	7,874
Detoxification admissions (24-hour care)	0
Rehabilitation/residential admissions (24-hour care)	2,963
Ambulatory outpatient (regular plus intensive) admissions	3,779
Opioid replacement therapy admissions	3,585

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	56.9	
Rate of abstinence from illicit drugs at discharge (from outpatient)	5.4	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		97.7
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		17.2
Percentage of clients attending self-help programs at discharge (from outpatient)		76.4

SSA Financial Data

Characteristic	$ Millions
Total annual budget	20.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	15.4
Expenditures on SUD primary prevention[a] services	3.7
Expenditures on infrastructure (e.g., workforce) and administration	0.7
State funding	5.1
SAMHSA SABG	14.2
Value of Medicaid funding managed by the SSA (if any)	1.3
Funding from other sources (e.g., federal capacity expansion grants, local governments)	vfg0.0

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	No
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	DK/NR
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Missouri Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	6,063,589	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.4
Alcohol SUD		6.7
Illicit drug SUD		2.7
Marijuana SUD		1.7
Pain reliever SUD		0.6
Youth (12–17 years) with SUD		5.8
Young adults (18–25 years) with SUD		18.1
Adults with SUD (26 years or older)		7.1
Binge alcohol use past month		24.4
Illicit drug use past month		8.9

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	270,233
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	4,619,924
Providers funded by SSA to deliver SUD prevention	22

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.4
Illicit drug use (youth 12–17 years): past 30 days	9.5
Marijuana use (youth 12–17 years): past 30 days	7.1
Cigarette use (youth 12–17 years): past 30 days	8.6
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	76.3
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	76.1
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.0
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	57.8
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	53,870
Detoxification admissions (24-hour care)	5,999
Rehabilitation/residential admissions (24-hour care)	8,703
Ambulatory outpatient (regular plus intensive) admissions	34,269
Opioid replacement therapy admissions	616

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	96.0	
Rate of abstinence from illicit drugs at discharge (from outpatient)	94.7	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		96.8
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		99.0
Percentage of clients attending self-help programs at discharge (from outpatient)		32.0

SSA Financial Data

Characteristic	$ Millions
Total annual budget	113.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	102.8
Expenditures on SUD primary prevention[a] services	7.3
Expenditures on infrastructure (e.g., workforce) and administration	3.1
State funding	43.5
SAMHSA SABG	23.6
Value of Medicaid funding managed by the SSA (if any)	38.4
Funding from other sources (e.g., federal capacity expansion grants, local governments)	7.8

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	DK/NR[b]
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	DK/NR

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Montana Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Chemical Dependency Bureau

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	1,023,579	
Population with a substance use disorder (SUD; alcohol and illicit drugs both)		10.2
Alcohol SUD		8.3
Illicit drug SUD		2.6
Marijuana SUD		2.1
Pain reliever SUD		0.6
Youth (12–17 years) with SUD		6.8
Young adults (18–25 years) with SUD		22.6
Adults with SUD (26 years or older)		8.5
Binge alcohol use past month		25.3
Illicit drug use past month		11.1

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	5,310
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	421,990
Providers funded by SSA to deliver SUD prevention	1

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	13.2
Illicit drug use (youth 12–17 years): past 30 days	10.4
Marijuana use (youth 12–17 years): past 30 days	8.7
Cigarette use (youth 12–17 years): past 30 days	7.9
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	73.6
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	70.7
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.2
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	62.6
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	7,072
Detoxification admissions (24-hour care)	973
Rehabilitation/residential admissions (24-hour care)	376
Ambulatory outpatient (regular plus intensive) admissions	5,185
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	86.4	
Rate of abstinence from illicit drugs at discharge (from outpatient)	77.	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		90.9
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		95.2
Percentage of clients attending self-help programs at discharge (from outpatient)		55.0

SSA Financial Data

Characteristic	$ Millions
Total annual budget	18.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	15.3
Expenditures on SUD primary prevention[a] services	2.3
Expenditures on infrastructure (e.g., workforce) and administration	1.0
State funding	7.1
SAMHSA SABG	6.7
Value of Medicaid funding managed by the SSA (if any)	2.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	2.7

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	DK/NR[b]
Has state seen past year increase in heroin treatment admissions?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	No
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Nebraska Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	1,881,503	
Population with a substance use disorder (SUD; alcohol and illicit drugs or both)		9.4
Alcohol SUD		7.8
Illicit drug SUD		2.7
Marijuana SUD		1.4
Pain reliever SUD		0.5
Youth (12–17 years) with SUD		6.5
Young adults (18–25 years) with SUD		20.0
Adults with SUD (26 years or older)		7.9
Binge alcohol use past month		23.7
Illicit drug use past month		6.8

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	115,268
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	624,484
Providers funded by SSA to deliver SUD prevention	33

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.3
Illicit drug use (youth 12–17 years): past 30 days	8.0
Marijuana use (youth 12–17 years): past 30 days	6.2
Cigarette use (youth 12–17 years): past 30 days	6.8
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.9
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	77.1
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	93.5
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	62.3
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	60.7

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	17,642
Detoxification admissions (24-hour care)	0
Rehabilitation/residential admissions (24-hour care)	2,363
Ambulatory outpatient (regular plus intensive) admissions	10,616
Opioid replacement therapy admissions	1,338

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	72.8	
Rate of abstinence from illicit drugs at discharge (from outpatient)	78.5	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		93.2
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		94.8
Percentage of clients attending self-help programs at discharge (from outpatient)		39.4

SSA Financial Data

Characteristic	$ Millions
Total annual budget	30.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	27.9
Expenditures on SUD primary prevention[a] services	2.1
Expenditures on infrastructure (e.g., workforce) and administration	0.3
State funding	23.3
SAMHSA SABG	6.9
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	0.2

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Not Applying
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	Already Approved
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	No
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	No
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	DK/NR[b]
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Nevada Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division Public and Behavioral Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	2,839,099	
Population with a substance use disorder (SUD; alcohol and illicit drugs or both)		9.2
Alcohol SUD		7.7
Illicit drug SUD		2.6
Marijuana SUD		1.9
Pain reliever SUD		0.8
Youth (12–17 years) with SUD		5.8
Young adults (18–25 years) with SUD		18.6
Adults with SUD (26 years or older)		8.1
Binge alcohol use past month		25.0
Illicit drug use past month		10.8

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	5,445
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	635,726
Providers funded by SSA to deliver SUD prevention	28

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.8
Illicit drug use (youth 12–17 years): past 30 days	10.2
Marijuana use (youth 12–17 years): past 30 days	8.3
Cigarette use (youth 12–17 years): past 30 days	6.0
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.0
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	71.5
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	58.7
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	99.6

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	11,164
Detoxification admissions (24-hour care)	1,923
Rehabilitation/residential admissions (24-hour care)	1,632
Ambulatory outpatient (regular plus intensive) admissions	5,505
Opioid replacement therapy admissions	78

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	89.4	
Rate of abstinence from illicit drugs at discharge (from outpatient)	81.5	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		91.0
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		98.2
Percentage of clients attending self-help programs at discharge (from outpatient)		51.3

SSA Financial Data

Characteristic	$ Millions
Total annual budget	20.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	12.4
Expenditures on SUD primary prevention[a] services	5.2
Expenditures on infrastructure (e.g., workforce) and administration	2.0
State funding	7.5
SAMHSA SABG	11.9
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	0.9

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Not Applying
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR [b]
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Being Developed
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

New Hampshire Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Alcohol and Drug Abuse Policy

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	1,326,813	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.3
Alcohol SUD		7.6
Illicit drug SUD		2.9
Marijuana SUD		1.9
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		6.8
Young adults (18–25 years) with SUD		23.7
Adults with SUD (26 years or older)		7.4
Binge alcohol use past month		24.9
Illicit drug use past month		11.3

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	30,613
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	352,053
Providers funded by SSA to deliver SUD prevention	16

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	14.8
Illicit drug use (youth 12–17 years): past 30 days	11.8
Marijuana use (youth 12–17 years): past 30 days	9.6
Cigarette use (youth 12–17 years): past 30 days	7.1
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	74.5
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	69.2
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.4
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	60.6
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	0.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	18,078
Detoxification admissions (24-hour care)	17
Rehabilitation/residential admissions (24-hour care)	1,736
Ambulatory outpatient (regular plus intensive) admissions	5,584
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	85.7	
Rate of abstinence from illicit drugs at discharge (from outpatient)	83.8	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		95.1
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		94.4
Percentage of clients attending self-help programs at discharge (from outpatient)		35.6

SSA Financial Data

Characteristic	$ Millions
Total annual budget	14.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	11.2
Expenditures on SUD primary prevention[c] services	2.6
Expenditures on infrastructure (e.g., workforce) and administration	0.7
State funding	4.8
SAMHSA SABG	5.8
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	3.8

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	DK/NR[b]
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Not Applying
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	Already Approved
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

.[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

New Jersey Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Mental Health and Addiction Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	8,938,175	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.6
Alcohol SUD		6.6
Illicit drug SUD		2.2
Marijuana SUD		1.3
Pain reliever SUD		0.5
Youth (12–17 years) with SUD		5.2
Young adults (18–25 years) with SUD		19.2
Adults with SUD (26 years or older)		6.1
Binge alcohol use past month		21.6
Illicit drug use past month		7.4

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	63,393
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	164,075
Providers funded by SSA to deliver SUD prevention	35

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	13.6
Illicit drug use (youth 12–17 years): past 30 days	7.1
Marijuana use (youth 12–17 years): past 30 days	5.4
Cigarette use (youth 12–17 years): past 30 days	5.1
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.4
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.9
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	93.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	59.6
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	49,785
Detoxification admissions (24-hour care)	5,206
Rehabilitation/residential admissions (24-hour care)	10,793
Ambulatory outpatient (regular plus intensive) admissions	18,642
Opioid replacement therapy admissions	3,127

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	94.5	
Rate of abstinence from illicit drugs at discharge (from outpatient)	89.1	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		96.8
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		97.8
Percentage of clients attending self-help programs at discharge (from outpatient)		53.2

SSA Financial Data

Characteristic	$ Millions
Total annual budget	143.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	130.3
Expenditures on SUD primary prevention[a] services	13.2
Expenditures on infrastructure (e.g., workforce) and administration	6.4
State funding	98.9
SAMHSA SABG	39.2
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	5.4

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	Most but not all
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Planning
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	Yes
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	Yes-MAT[b]
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	Medicaid spending on SUD increased

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] MAT: Medication-assisted treatment

New Mexico Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Behavioral Health Services Division

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	2,085,572	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.6
Alcohol SUD		7.4
Illicit drug SUD		3.3
Marijuana SUD		2.1
Pain reliever SUD		1.0
Youth (12–17 years) with SUD		7.2
Young adults (18–25 years) with SUD		18.3
Adults with SUD (26 years or older)		8.4
Binge alcohol use past month		24.4
Illicit drug use past month		10.6

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	1,045
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	1,583,920
Providers funded by SSA to deliver SUD prevention	23

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.9
Illicit drug use (youth 12–17 years): past 30 days	12.4
Marijuana use (youth 12–17 years): past 30 days	9.2
Cigarette use (youth 12–17 years): past 30 days	7.4
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.6
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	68.1
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.6
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	60.1
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	71.3

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	2,239
Detoxification admissions (24-hour care)	250
Rehabilitation/residential admissions (24-hour care)	233
Ambulatory outpatient (regular plus intensive) admissions	1,767
Opioid replacement therapy admissions	5

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	78.2	
Rate of abstinence from illicit drugs at discharge (from outpatient)	81.5	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		33.4
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		87.9
Percentage of clients attending self-help programs at discharge (from outpatient)		79.1

SSA Financial Data

Characteristic	$ Millions
Total annual budget	39.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	34.1
Expenditures on SUD primary prevention[a] services	4.8
Expenditures on infrastructure (e.g., workforce) and administration	0.2
State funding	21.0
SAMHSA SABG	8.7
Value of Medicaid funding managed by the SSA (if any)	3.6
Funding from other sources (e.g., federal capacity expansion grants, local governments)	6.0

On Health Financing Reform :

Characteristic	Response
Has the State expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	Applied, not yet approved
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	Yes

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	Yes
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	DK/NR
Has state seen past year increase in prescription drug treatment admissions?	DK/NR
Has state seen past year increase in heroin treatment admissions?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	DK/NR
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	DK/NR

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

New York Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Alcoholism & Substance Abuse Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	19,746,227	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.2
Alcohol SUD		6.6
Illicit drug SUD		2.7
Marijuana SUD		1.9
Pain reliever SUD		0.5
Youth (12–17 years) with SUD		5.8
Young adults (18–25 years) with SUD		17.8
Adults with SUD (26 years or older)		6.8
Binge alcohol use past month		24.8
Illicit drug use past month		9.9

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	95,098
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	4,273,392
Providers funded by SSA to deliver SUD prevention	120

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	14.4
Illicit drug use (youth 12–17 years): past 30 days	9.6
Marijuana use (youth 12–17 years): past 30 days	8.1
Cigarette use (youth 12–17 years): past 30 days	5.1
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	78.7
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	70.3
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.4
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	57.5
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	47.4

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	131,173
Detoxification admissions (24-hour care)	16,971
Rehabilitation/residential admissions (24-hour care)	26,043
Ambulatory outpatient (regular plus intensive) admissions	54,948
Opioid replacement therapy admissions	7,438

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	84.1	
Rate of abstinence from illicit drugs at discharge (from outpatient)	71.8	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		94.5
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		95.3
Percentage of clients attending self-help programs at discharge (from outpatient)		23.2

SSA Financial Data

Characteristic	$ Millions
Total annual budget	525.2
Expenditures on SUD treatment and prevention (other than primary prevention) services	411.3
Expenditures on SUD primary prevention[a] services	52.1
Expenditures on infrastructure (e.g., workforce) and administration	52.1
State funding	414.2
SAMHSA SABG	101.2
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	9.8

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	DK/NR
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	DK/NR

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

North Carolina Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Mental Health, Developmental Disabilities & Substance Abuse Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	9,943,964	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.4
Alcohol SUD		5.8
Illicit drug SUD		3.4
Marijuana SUD		1.7
Pain reliever SUD		0.7
Youth (12–17 years) with SUD		5.9
Young adults (18–25 years) with SUD		18.5
Adults with SUD (26 years or older)		7.1
Binge alcohol use past month		20.0
Illicit drug use past month		7.5

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	103,346
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	51,644
Providers funded by SSA to deliver SUD prevention	20

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.6
Illicit drug use (youth 12–17 years): past 30 days	8.7
Marijuana use (youth 12–17 years): past 30 days	6.7
Cigarette use (youth 12–17 years): past 30 days	6.2
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	81.5
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	71.7
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	89.4
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	59.7
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	104.1

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	75,387
Detoxification admissions (24-hour care)	5,383
Rehabilitation/residential admissions (24-hour care)	5,094
Ambulatory outpatient (regular plus intensive) admissions	49,067
Opioid replacement therapy admissions	308

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	83.8	
Rate of abstinence from illicit drugs at discharge (from outpatient)	52.5	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		99.3
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		98.5
Percentage of clients attending self-help programs at discharge (from outpatient)		26.7

SSA Financial Data

Characteristic	$ Millions
Total annual budget	156.5
Expenditures on SUD treatment and prevention (other than primary prevention) services	142.7
Expenditures on SUD primary prevention[a] services	9.0
Expenditures on infrastructure (e.g., workforce) and administration	2.2
State funding	124.6
SAMHSA SABG	29.5
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	2.4

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	DK/NR[b]
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	Yes

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	Yes
Does state have a shortage of substance abuse counselors?	No
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	No
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Being Developed
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

North Dakota Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Mental Health & Substance Abuse

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	739,482	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.9
Alcohol SUD		8.4
Illicit drug SUD		2.7
Marijuana SUD		1.4
Pain reliever SUD		0.4
Youth (12–17 years) with SUD		5.8
Young adults (18–25 years) with SUD		20.7
Adults with SUD (26 years or older)		7.9
Binge alcohol use past month		30.4
Illicit drug use past month		6.5

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	236,111
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	8,164,526
Providers funded by SSA to deliver SUD prevention	18

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.7
Illicit drug use (youth 12–17 years): past 30 days	6.1
Marijuana use (youth 12–17 years): past 30 days	5.2
Cigarette use (youth 12–17 years): past 30 days	8.1
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	75.8
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	81.6
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.0
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	54.7
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	2.5

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	5,061
Detoxification admissions (24-hour care)	36
Rehabilitation/residential admissions (24-hour care)	692
Ambulatory outpatient (regular plus intensive) admissions	3,129
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	91.5	
Rate of abstinence from illicit drugs at discharge (from outpatient)	92.1	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		95.5
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		97.3
Percentage of clients attending self-help programs at discharge (from outpatient)		22.9

SSA Financial Data

Characteristic	$ Millions
Total annual budget	24.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	23.3
Expenditures on SUD primary prevention[a] services	1.1
Expenditures on infrastructure (e.g., workforce) and administration	0.4
State funding	9.4
SAMHSA SABG	4.8
Value of Medicaid funding managed by the SSA (if any)	8.8
Funding from other sources (e.g., federal capacity expansion grants, local governments)	1.9

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	DK/NR
Has state seen past year increase in heroin treatment admissions?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	DK/NR
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	DK/NR
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	DK/NR

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Ohio Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Mental Health and Addiction Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	11,594,163	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.4
Alcohol SUD		6.4
Illicit drug SUD		2.9
Marijuana SUD		1.8
Pain reliever SUD		0.8
Youth (12–17 years) with SUD		5.2
Young adults (18–25 years) with SUD		18.4
Adults with SUD (26 years or older)		7.1
Binge alcohol use past month		24.8
Illicit drug use past month		9.7

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	280,383
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	2,410,780
Providers funded by SSA to deliver SUD prevention	138

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.0
Illicit drug use (youth 12–17 years): past 30 days	9.2
Marijuana use (youth 12–17 years): past 30 days	7.4
Cigarette use (youth 12–17 years): past 30 days	7.3
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	74.3
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	73.7
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.3
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	55.3
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	22,571
Detoxification admissions (24-hour care)	3,082
Rehabilitation/residential admissions (24-hour care)	4,178
Ambulatory outpatient (regular plus intensive) admissions	40,780
Opioid replacement therapy admissions	5,545

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	90.9	
Rate of abstinence from illicit drugs at discharge (from outpatient)	83.1	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		92.1
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		97.7
Percentage of clients attending self-help programs at discharge (from outpatient)		28.1

SSA Financial Data

Characteristic	$ Millions
Total annual budget	273.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	235.1
Expenditures on SUD primary prevention[a] services	26.1
Expenditures on infrastructure (e.g., workforce) and administration	12.6
State funding	26.3
SAMHSA SABG	86.5
Value of Medicaid funding managed by the SSA (if any)	153.3
Funding from other sources (e.g., federal capacity expansion grants, local governments)	7.7

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	No
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	Yes
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Oklahoma Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Mental Health and Substance Abuse Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	3,878,051	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.4
Alcohol SUD		7.2
Illicit drug SUD		2.2
Marijuana SUD		1.6
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		4.9
Young adults (18–25 years) with SUD		17.5
Adults with SUD (26 years or older)		7.3
Binge alcohol use past month		23.3
Illicit drug use past month		7.7

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	6,446,322
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	9,482,592
Providers funded by SSA to deliver SUD prevention	16

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	10.0
Illicit drug use (youth 12–17 years): past 30 days	7.5
Marijuana use (youth 12–17 years): past 30 days	5.2
Cigarette use (youth 12–17 years): past 30 days	6.6
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	74.6
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	76.0
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	90.1
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	54.4
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	108,282
Detoxification admissions (24-hour care)	2,292
Rehabilitation/residential admissions (24-hour care)	3,614
Ambulatory outpatient (regular plus intensive) admissions	14,822
Opioid replacement therapy admissions	13

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	87.1	
Rate of abstinence from illicit drugs at discharge (from outpatient)	79.2	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		96.2
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		98.4
Percentage of clients attending self-help programs at discharge (from outpatient)		30.0

SSA Financial Data

Characteristic	$ Millions
Total annual budget	67.1
Expenditures on SUD treatment and prevention (other than primary prevention) services	53.4
Expenditures on SUD primary prevention[a] services	9.4
Expenditures on infrastructure (e.g., workforce) and administration	4.3
State funding	37.5
SAMHSA SABG	17.6
Value of Medicaid funding managed by the SSA (if any)	3.4
Funding from other sources (e.g., federal capacity expansion grants, local governments)	8.7

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	DK/NR[b]
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	DK/NR
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	DK/NR
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Oregon Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Addictions and Mental Health Division

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	3,970,239	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.3
Alcohol SUD		7.1
Illicit drug SUD		3.2
Marijuana SUD		1.9
Pain reliever SUD		1.0
Youth (12–17 years) with SUD		6.5
Young adults (18–25 years) with SUD		19.3
Adults with SUD (26 years or older)		8.0
Binge alcohol use past month		21.7
Illicit drug use past month		13.9

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	55,295
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	78,514
Providers funded by SSA to deliver SUD prevention	44

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.7
Illicit drug use (youth 12–17 years): past 30 days	12.3
Marijuana use (youth 12–17 years): past 30 days	9.6
Cigarette use (youth 12–17 years): past 30 days	6.2
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	76.2
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	69.5
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	94.6
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	62.4
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	66.7

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years, and other service levels)	113,313
Detoxification admissions (24-hour care)	3,546
Rehabilitation/residential admissions (24-hour care)	5,110
Ambulatory outpatient (regular plus intensive) admissions	56,531
Opioid replacement therapy admissions	8,432

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	82.3	
Rate of abstinence from illicit drugs at discharge (from outpatient)	76.7	

Characteristic	Rate	%
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		96.3
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		96.5
Percentage of clients attending self-help programs at discharge (from outpatient)		30.5

SSA Financial Data

Characteristic	$ Millions
Total annual budget	85.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	63.7
Expenditures on SUD primary prevention[a] services	7.0
Expenditures on infrastructure (e.g., workforce) and administration	14.4
State funding	23.2
SAMHSA SABG	21.2
Value of Medicaid funding managed by the SSA (if any)	32.4
Funding from other sources (e.g., federal capacity expansion grants, local governments)	8.5

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	No
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	Yes
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Pennsylvania Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Drug & Alcohol Programs

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	12,787,209	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.3
Alcohol SUD		6.5
Illicit drug SUD		2.8
Marijuana SUD		1.5
Pain reliever SUD		0.7
Youth (12–17 years) with SUD		5.7
Young adults (18–25 years) with SUD		19.7
Adults with SUD (26 years or older)		6.7
Binge alcohol use past month		25.0
Illicit drug use past month		8.4

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	220,926
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	8,008,348
Providers funded by SSA to deliver SUD prevention	51

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	13.1
Illicit drug use (youth 12–17 years): past 30 days	8.5
Marijuana use (youth 12–17 years): past 30 days	6.8
Cigarette use (youth 12–17 years): past 30 days	7.6
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	77.5
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	74.3
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.1
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	56.4
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	N.R.

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	72,920
Detoxification admissions (24-hour care)	7,459
Rehabilitation/residential admissions (24-hour care)	12,265
Ambulatory outpatient (regular plus intensive) admissions	30,850
Opioid replacement therapy admissions	1,063

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	75.3	
Rate of abstinence from illicit drugs at discharge (from outpatient)	63.5	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		95.5
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		99.8

Characteristic	Rate	%
Percentage of clients attending self-help programs at discharge (from outpatient)		39.4

SSA Financial Data

Characteristic	$ Millions
Total annual budget	106.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	70.9
Expenditures on SUD primary prevention[a] services	21.6
Expenditures on infrastructure (e.g., workforce) and administration	18.0
State funding	46.8
SAMHSA SABG	51.8
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	8.2

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Rhode Island Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Healthcare Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	1,055,173	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		10.8
Alcohol SUD		8.5
Illicit drug SUD		3.7
Marijuana SUD		2.6
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		6.5
Young adults (18–25 years) with SUD		22.6
Adults with SUD (26 years or older)		9.0
Binge alcohol use past month		27.5
Illicit drug use past month		15.8

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	13,355
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	691
Providers funded by SSA to deliver SUD prevention	5

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	14.3
Illicit drug use (youth 12–17 years): past 30 days	15.1
Marijuana use (youth 12–17 years): past 30 days	13.0
Cigarette use (youth 12–17 years): past 30 days	6.2
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	76.0
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	61.8
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	89.8
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	57.4
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	83.5

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	9,980
Detoxification admissions (24-hour care)	1,456
Rehabilitation/residential admissions (24-hour care)	1,734
Ambulatory outpatient (regular plus intensive) admissions	2,628
Opioid replacement therapy admissions	1,607

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	89.9	
Rate of abstinence from illicit drugs at discharge (from outpatient)	87.7	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		95.8
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		97.0
Percentage of clients attending self-help programs at discharge (from outpatient)		17.3

SSA Financial Data

Characteristic	$ Millions
Total annual budget	25.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	19.6
Expenditures on SUD primary prevention[a] services	3.9
Expenditures on infrastructure (e.g., workforce) and administration	2.2
State funding	4.3
SAMHSA SABG	7.4
Value of Medicaid funding managed by the SSA (if any)	8.2
Funding from other sources (e.g., federal capacity expansion grants, local governments)	5.7

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Yes
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	Yes
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	Yes

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	Yes
Does state have a shortage of substance abuse counselors?	No
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	Yes

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	DK/NR[b]
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

South Carolina Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Department of Alcohol and Other Drug Abuse Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	4,832,482	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.0
Alcohol SUD		6.0
Illicit drug SUD		2.9
Marijuana SUD		1.7
Pain reliever SUD		0.7
Youth (12–17 years) with SUD		5.7
Young adults (18–25 years) with SUD		16.5
Adults with SUD (26 years or older)		6.8
Binge alcohol use past month		23.0
Illicit drug use past month		8.8

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	102,870
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	6,432,981
Providers funded by SSA to deliver SUD prevention	33

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.7
Illicit drug use (youth 12–17 years): past 30 days	10.4
Marijuana use (youth 12–17 years): past 30 days	7.1
Cigarette use (youth 12–17 years): past 30 days	7.3
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	76.7
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	71.5
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	87.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	55.3
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	33.1

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	44,769
Detoxification admissions (24-hour care)	2,444
Rehabilitation/residential admissions (24-hour care)	678
Ambulatory outpatient (regular plus intensive) admissions	36,654
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	90.8	
Rate of abstinence from illicit drugs at discharge (from outpatient)	87.9	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		98.1
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		98.6
Percentage of clients attending self-help programs at discharge (from outpatient)		14.0

SSA Financial Data

Characteristic	$ Millions
Total annual budget	38.1
Expenditures on SUD treatment and prevention (other than primary prevention) services	28.4
Expenditures on SUD primary prevention[a] services	7.8
Expenditures on infrastructure (e.g., workforce) and administration	0.9
State funding	6.5
SAMHSA SABG	19.4
Value of Medicaid funding managed by the SSA (if any)	3.3
Funding from other sources (e.g., federal capacity expansion grants, local governments)	8.8

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	No
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR[b]
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

South Dakota Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Community Behavioral Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	853,175	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.0
Alcohol SUD		8.0
Illicit drug SUD		2.1
Marijuana SUD		1.5
Pain reliever SUD		0.3
Youth (12–17 years) with SUD		5.0
Young adults (18–25 years) with SUD		19.7
Adults with SUD (26 years or older)		7.6
Binge alcohol use past month		26.6
Illicit drug use past month		6.2

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	98,865
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	118,691
Providers funded by SSA to deliver SUD prevention	10

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	10.5
Illicit drug use (youth 12–17 years): past 30 days	6.2
Marijuana use (youth 12–17 years): past 30 days	5.1
Cigarette use (youth 12–17 years): past 30 days	8.0
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	72.2
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	77.0
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.2
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	60.8
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	11.6

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	25,596
Detoxification admissions (24-hour care)	4,702
Rehabilitation/residential admissions (24-hour care)	3,558
Ambulatory outpatient (regular plus intensive) admissions	5,744
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	82.4	
Rate of abstinence from illicit drugs at discharge (from outpatient)	80.2	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		84.1
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		98.3
Percentage of clients attending self-help programs at discharge (from outpatient)		21.3

SSA Financial Data

Characteristic	$ Millions
Total annual budget	25.7
Expenditures on SUD treatment and prevention (other than primary prevention) services	20.5
Expenditures on SUD primary prevention[a] services	4.3
Expenditures on infrastructure (e.g., workforce) and administration	1.0
State funding	12.7
SAMHSA SABG	4.5
Value of Medicaid funding managed by the SSA (if any)	4.3
Funding from other sources (e.g., federal capacity expansion grants, local governments)	4.2

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Not Applying
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR[b]

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Being Developed
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Tennessee Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Substance Abuse Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	6,549,352	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.4
Alcohol SUD		5.6
Illicit drug SUD		2.5
Marijuana SUD		1.6
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		5.2
Young adults (18–25 years) with SUD		16.1
Adults with SUD (26 years or older)		6.2
Binge alcohol use past month		16.9
Illicit drug use past month		7.2

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	16,614
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	183,521,236
Providers funded by SSA to deliver SUD prevention	85

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	9.9
Illicit drug use (youth 12–17 years): past 30 days	8.2
Marijuana use (youth 12–17 years): past 30 days	6.0
Cigarette use (youth 12–17 years): past 30 days	7.6
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	77.5
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	74.9
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	89.5
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	53.7
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	18,605
Detoxification admissions (24-hour care)	3,419
Rehabilitation/residential admissions (24-hour care)	8,121
Ambulatory outpatient (regular plus intensive) admissions	8,505
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	91.4	
Rate of abstinence from illicit drugs at discharge (from outpatient)	83.5	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		97.8
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		98.1
Percentage of clients attending self-help programs at discharge (from outpatient)		66.6

SSA Financial Data

Characteristic	$ Millions
Total annual budget	62.4
Expenditures on SUD treatment and prevention (other than primary prevention) services	47.7
Expenditures on SUD primary prevention[a] services	9.2
Expenditures on infrastructure (e.g., workforce) and administration	4.0
State funding	29.7
SAMHSA SABG	28.3
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	4.4

On Health Financing Reform :

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Texas Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Mental Health and Substance Abuse Division

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	26,956,958	
Population with a substance use disorder (SUD; alcohol illicit drugs, or both)		8.0
Alcohol SUD		6.7
Illicit drug SUD		2.2
Marijuana SUD		1.5
Pain reliever SUD		0.6
Youth (12–17 years) with SUD		5.8
Young adults (18–25 years) with SUD		16.5
Adults with SUD (26 years or older)		6.7
Binge alcohol use past month		22.4
Illicit drug use past month		7.2

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	130,124
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	15,338,880
Providers funded by SSA to deliver SUD prevention	91

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.5
Illicit drug use (youth 12–17 years): past 30 days	7.8
Marijuana use (youth 12–17 years): past 30 days	5.8
Cigarette use (youth 12–17 years): past 30 days	5.2
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	79.7
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	72.6
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	90.0
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	58.2
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	88.4

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	43,775
Detoxification admissions (24-hour care)	7,497
Rehabilitation/residential admissions (24-hour care)	15,554
Ambulatory outpatient (regular plus intensive) admissions	27,624
Opioid replacement therapy admissions	2,079

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	96.0	
Rate of abstinence from illicit drugs at discharge (from outpatient)	92.8	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		97.6
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		99.2
Percentage of clients attending self-help programs at discharge (from outpatient)		30.3

SSA Financial Data

Characteristic	$ Millions
Total annual budget	161.9
Expenditures on SUD treatment and prevention (other than primary prevention) services	107.8
Expenditures on SUD primary prevention[a] services	40.2
Expenditures on infrastructure (e.g., workforce) and administration	6.4
State funding	36.2
SAMHSA SABG	125.2
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	0.6

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Not Applying
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	Already Approved
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Utah Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Substance Abuse and Mental Health

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	2,942,902	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		7.1
Alcohol SUD		5.4
Illicit drug SUD		2.9
Marijuana SUD		1.4
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		4.6
Young adults (18–25 years) with SUD		15.1
Adults with SUD (26 years or older)		5.7
Binge alcohol use past month		16.3
Illicit drug use past month		7.0

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	2,372,370
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	12,315,662
Providers funded by SSA to deliver SUD prevention	16

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	7.8
Illicit drug use (youth 12–17 years): past 30 days	7.3
Marijuana use (youth 12–17 years): past 30 days	5.4
Cigarette use (youth 12–17 years): past 30 days	5.4
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	87.2
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	81.1
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	93.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	65.8
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	24.2

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	16,219
Detoxification admissions (24-hour care)	4,298
Rehabilitation/residential admissions (24-hour care)	1,489
Ambulatory outpatient (regular plus intensive) admissions	11,082
Opioid replacement therapy admissions	403

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	87.1	
Rate of abstinence from illicit drugs at discharge (from outpatient)	77.9	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		91.7
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		97.2
Percentage of clients attending self-help programs at discharge (from outpatient)		29.2

SSA Financial Data

Characteristic	$ Millions
Total annual budget	45.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	35.8
Expenditures on SUD primary prevention[a] services	5.5
Expenditures on infrastructure (e.g., workforce) and administration	4.0
State funding	10.8
SAMHSA SABGt	11.9
Value of Medicaid funding managed by the SSA (if any)	10.4
Funding from other sources (e.g., federal capacity expansion grants, local governments)	12.4

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Vermont Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Alcohol and Drug Abuse Programs

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	626,562	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.2
Alcohol SUD		6.8
Illicit drug SUD		2.9
Marijuana SUD		2.3
Pain reliever SUD		0.7
Youth (12–17 years) with SUD		6.6
Young adults (18–25 years) with SUD		21.0
Adults with SUD (26 years or older)		7.5
Binge alcohol use past month		21.2
Illicit drug use past month		12.7

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	1,276
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	423,348
Providers funded by SSA to deliver SUD prevention	5

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	14.8
Illicit drug use (youth 12–17 years): past 30 days	13.7
Marijuana use (youth 12–17 years): past 30 days	11.3
Cigarette use (youth 12–17 years): past 30 days	8.1
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	72.6
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	66.2
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	58.6
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	16,719
Detoxification admissions (24-hour care)	1,791
Rehabilitation/residential admissions (24-hour care)	2,684
Ambulatory outpatient (regular plus intensive) admissions	6,124
Opioid replacement therapy admissions	1,696

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	74.5	
Rate of abstinence from illicit drugs at discharge (from outpatient)	61.8	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		92.5
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		96.6
Percentage of clients attending self-help programs at discharge (from outpatient)		25.9

SSA Financial Data

Characteristic	$ Millions
Total annual budget	38.9
Expenditures on SUD treatment and prevention (other than primary prevention) services	34.4
Expenditures on SUD primary prevention[a] services	3.7
Expenditures on infrastructure (e.g., workforce) and administration	0.8
State funding	7.1
SAMHSA SABG	6.1
Value of Medicaid funding managed by the SSA (if any)	24.3
Funding from other sources (e.g., federal capacity expansion grants, local governments)	1.5

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	Yes
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Yes
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Virginia Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Office of Substance Abuse Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	8,326,289	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.5
Alcohol SUD		7.4
Illicit drug SUD		2.6
Marijuana SUD		1.5
Pain reliever SUD		0.6
Youth (12–17 years) with SUD		5.6
Young adults (18–25 years) with SUD		19.5
Adults with SUD (26 years or older)		7.0
Binge alcohol use past month		22.2
Illicit drug use past month		8.0

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	46,997
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	679,839
Providers funded by SSA to deliver SUD prevention	40

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.0
Illicit drug use (youth 12–17 years): past 30 days	7.7
Marijuana use (youth 12–17 years): past 30 days	6.1
Cigarette use (youth 12–17 years): past 30 days	6.1
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	82.2
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	75.0
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	92.8
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	57.9
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	34.0

SSA Substance Use Disorder Treatment Service

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	33,035
Detoxification admissions (24-hour care)	290
Rehabilitation/residential admissions (24-hour care)	4,553
Ambulatory outpatient (regular plus intensive) admissions	27,691
Opioid replacement therapy admissions	1,959

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	71.2	
Rate of abstinence from illicit drugs at discharge (from outpatient)	63.0	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		89.9
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		97.2
Percentage of clients attending self-help programs at discharge (from outpatient)		43.0

SSA Financial Data

Characteristic	$ Millions
Total annual budget	90.7
Expenditures on SUD treatment and prevention (other than primary prevention) services	77.4
Expenditures on SUD primary prevention[a] services	10.2
Expenditures on infrastructure (e.g., workforce) and administration	1.8
State funding	48.3
SAMHSA SABG	40.4
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	2.0

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	No
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	Yes
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	DK/NR[b]
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Washington Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Behavioral Health & Recovery

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	7,061,530	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.4
Alcohol SUD		7.6
Illicit drug SUD		3.0
Marijuana SUD		2.0
Pain reliever SUD		0.9
Youth (12–17 years) with SUD		5.9
Young adults (18–25 years) with SUD		19.5
Adults with SUD (26 years or older)		8.2
Binge alcohol use past month		20.8
Illicit drug use past month		13.7

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	40,157
Preventive contacts per capita made by SSA population-based SUD prevention initiatives	55,313
Providers funded by SSA to deliver SUD prevention	135

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.6
Illicit drug use (youth 12–17 years): past 30 days	11.5
Marijuana use (youth 12–17 years): past 30 days	9.8
Cigarette use (youth 12–17 years): past 30 days	6.6
Perception of risk from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years; percent reporting moderate or great risk)	73.3
Perception of risk from smoking marijuana once or twice a week (youth 12–17 years; percent reporting moderate or great risk)	69.4
Perception of risk from smoking one/more packs of cigarettes per day (youth 12–17 years; percent reporting moderate or great risk)	89.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	61.9
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	100.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals provided treatment services (unduplicated count)	69,432
Detoxification admissions (24-hour care)	0
Rehabilitation/residential admissions (24-hour care)	9,868
Ambulatory outpatient (regular plus intensive) admissions	28,813
Opioid replacement therapy admissions	2,966

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	81.9	
Rate of abstinence from illicit drugs at discharge (from outpatient)	64.2	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		94.1
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		77.9
Percentage of clients attending self-help programs at discharge (from outpatient)		30.0

SSA Financial Data

Characteristic	$ Millions
Total annual budget	176.0
Funding for SUD treatment and prevention (other than primary prevention) services	158.7
Funding for SUD primary prevention[a] services	9.3
State funding	53.1
SAMHSA SABG	31.5
Value of Medicaid funding managed by the SSA (if any)	83.2

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Already Approved
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	Yes
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	Yes
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	No
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	No
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

West Virginia Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division on Alcoholism and Drug Abuse

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	1,850,326	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		8.2
Alcohol SUD		6.1
Illicit drug SUD		2.7
Marijuana SUD		1.7
Pain reliever SUD		1.2
Youth (12–17 years) with SUD		5.7
Young adults (18–25 years) with SUD		16.6
Adults with SUD (26 years or older)		7.2
Binge alcohol use past month		19.4
Illicit drug use past month		6.3

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	9,731
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	1,259,487
Providers funded by SSA to deliver SUD prevention	12

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	11.1
Illicit drug use (youth 12–17 years): past 30 days	6.9
Marijuana use (youth 12–17 years): past 30 days	5.2
Cigarette use (youth 12–17 years): past 30 days	8.9
Perception of “great or moderate risk” from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	74.8
Perception of “moderate or great risk” from smoking marijuana once or twice a week (youth 12–17 years)	75.1
Perception of “moderate or great risk” from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.4
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	53.7
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	29.4

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	28,066
Detoxification admissions (24-hour care)	318
Rehabilitation/residential admissions (24-hour care)	219
Ambulatory outpatient (regular plus intensive) admissions	29,599
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	**Rate**	**%**
Rate of abstinence from alcohol at discharge (from outpatient)	54.4	
Rate of abstinence from illicit drugs at discharge (from outpatient)	84.7	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		97.7
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		92.8
Percentage of clients attending self-help programs at discharge (from outpatient)		24.1

SSA Financial Data

Characteristic	**$ Millions**
Total annual budget	18.8
Expenditures on SUD treatment and prevention (other than primary prevention) services	15.6
Expenditures on SUD primary prevention[a] services	2.2
Expenditures on infrastructure (e.g., workforce) and administration	1.1
State funding	10.7
SAMHSA SABG	6.3
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	1.9

On Health Financing Reform

Characteristic	**Response**
Has the state expanded Medicaid eligibility?	Adopted
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	Yes
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Not Applying
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR[b]
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	No
Does state have a shortage of substance abuse counselors?	Yes
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	DK/NR
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	DK/NR
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	No
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: "Don't Know/No Response"

Wisconsin Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division of Mental Health and Substance Abuse Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	5,757,564	
Population with a substance use disorder (SUD; alcohol, illicit drugs, or both)		9.4
Alcohol SUD		7.7
Illicit drug SUD		2.3
Marijuana SUD		1.6
Pain reliever SUD		0.5
Youth (12–17 years) with SUD		6.2
Young adults (18–25 years) with SUD		20.3
Adults with SUD (26 years or older)		8.0
Binge alcohol use past month		30.0
Illicit drug use past month		8.4

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	448,161
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	2,430,723
Providers funded by SSA to deliver SUD prevention	88

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	15.1
Illicit drug use (youth 12–17 years): past 30 days	9.4
Marijuana use (youth 12–17 years): past 30 days	7.2
Cigarette use (youth 12–17 years): past 30 days	7.4
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	76.5
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	79.4
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	91.6
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	0.0
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	38.7

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	42,522
Detoxification admissions (24-hour care)	4,291
Rehabilitation/residential admissions (24-hour care)	2,211
Ambulatory outpatient (regular plus intensive) admissions	23,571
Opioid replacement therapy admissions	221

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	83.6	
Rate of abstinence from illicit drugs at discharge (from outpatient)	88.4	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		92.8
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		95.6
Percentage of clients attending self-help programs at discharge (from outpatient)		32.9

SSA Financial Data

Characteristic	$ Millions
Total annual budget	32.0
Expenditures on SUD treatment and prevention (other than primary prevention) services	23.0
Expenditures on SUD primary prevention[a] services	8.9
Expenditures on infrastructure (e.g., workforce) and administration	0.1
State funding	3.7
SAMHSA SABG	25.4
Value of Medicaid funding managed by the SSA (if any)	0.1
Funding from other sources (e.g., federal capacity expansion grants, local governments)	2.8

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	DK/NR[b]
Are all SUD providers in the state certified Medicaid providers?	DK/NR
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	DK/NR
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	DK/NR
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	DK/NR
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	DK/NR

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	DK/NR
Does state have a shortage of substance abuse counselors?	DK/NR
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	DK/NR

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	Yes
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	Yes
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Being Developed
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	Yes
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	Yes
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	Yes

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

[b] DK/NR: “Don’t Know/No Response”

Wyoming Substance Abuse Profile 2015

Substance Abuse Prevalence and Public Service Delivery System Characteristics

State Agency: Division Mental Health and Substance Abuse Services

Substance Use Disorder (SUD) Prevalence

Characteristic	Number	%
State population (U.S. Census Bureau)	584,153	
Population with a substance use disorder (SUD; alcohol, illicit drugs or both)		9.7
Alcohol SUD		8.1
Illicit drug SUD		2.3
Marijuana SUD		1.5
Pain reliever SUD		0.6
Youth (12–17 years) with SUD		6.7
Young adults (18–25 years) with SUD		18.9
Adults with SUD (26 years or older)		8.4
Binge alcohol use past month		24.4
Illicit drug use past month		6.6

Single State Agency (SSA) Substance Use Disorder Prevention Services

Characteristic	Number
Individuals served by SSA-supported individual-based SUD prevention programs/strategies	3,845
Individuals served by SSA-supported population-based SUD prevention initiatives (individuals may get multiple preventive services per year, for example through media campaigns)	8,007,588
Providers funded by SSA to deliver SUD prevention	2

National Outcome Measures

Characteristic	%
Alcohol use (youth 12–17 years): past 30 days	12.3
Illicit drug use (youth 12–17 years): past 30 days	7.8
Marijuana use (youth 12–17 years): past 30 days	6.0
Cigarette use (youth 12–17 years): past 30 days	9.4
Perception of "great or moderate risk" from having five or more drinks of an alcoholic beverage once or twice a week (youth 12–17 years)	80.5
Perception of "moderate or great risk" from smoking marijuana once or twice a week (youth 12–17 years)	78.7
Perception of "moderate or great risk" from smoking one/more packs of cigarettes per day (youth 12–17 years)	93.7
Parents reporting that they have talked to their child about the dangers or problems associated with using tobacco, alcohol, or other drugs	60.9
Share of SSA Substance Abuse Block Grant (SABG) prevention spending used on evidence-based practices	56.0

SSA Substance Use Disorder Treatment Services

Characteristic	Number
Individuals served (unduplicated count; includes individuals admitted in previous years)	8,852
Detoxification admissions (24-hour care)	315
Rehabilitation/residential admissions (24-hour care)	434
Ambulatory outpatient (regular plus intensive) admissions	2,129
Opioid replacement therapy admissions	0

National Outcome Measures

Characteristic	Rate	%
Rate of abstinence from alcohol at discharge (from outpatient)	71.5	
Rate of abstinence from illicit drugs at discharge (from outpatient)	81.6	
Percentage of clients without arrests (prior 30 days) at discharge (from outpatient)		88.0
Percentage of outpatient clients in stable living situation at discharge (from outpatient)		98.4
Percentage of clients attending self-help programs at discharge (from outpatient)		26.8

SSA Financial Data

Characteristic	$ Millions
Total annual budget	40.6
Expenditures on SUD treatment and prevention (other than primary prevention) services	29.5
Expenditures on SUD primary prevention[a] services	9.7
Expenditures on infrastructure (e.g., workforce) and administration	1.4
State funding	35.7
SAMHSA SABG	3.2
Value of Medicaid funding managed by the SSA (if any)	0.0
Funding from other sources (e.g., federal capacity expansion grants, local governments)	1.8

On Health Financing Reform

Characteristic	Response
Has the state expanded Medicaid eligibility?	Not at this time
Does SSA work with Medicaid agency on what SUD benefits to include in alt. benefit plans?	No
Are all SUD providers in the state certified Medicaid providers?	No
Has state filed (or is it planning to file) Medicaid State Plan Amendment that will include health home services for SUD?	Considering
Does state have any Accountable Care Organizations operating (or being developed) that include SUD services?	No
Does state work on a Dual Eligible Demonstration that will address individuals with SUDs?	No
Have there been changes in state funding for SUD services due to insurance reform and Medicaid expansion?	No

Characteristic	Response
Does state have a sufficient workforce to meet current SUD service demands?	Yes
Does state have a shortage of substance abuse counselors?	No
Does state have enough SUD providers that accept Medicaid to meet demand for SUD services?	No

Heroin and Prescription Drug Abuse Trends

Characteristic	Response
Is prescription drug abuse a high priority to the SSA?	Yes
Is heroin abuse a high priority to the SSA?	Yes
Has recent legislation passed addressing prescription drug, heroin abuse, or both?	No
Has state seen past year increase in prescription drug treatment admissions?	Yes
Has state seen past year increase in heroin treatment admissions?	Yes
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for prescribers?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for pharmacists?	No
Has SSA taken steps to implement educational activities related to prescribing and prescription drugs for patients/families?	No
Has any agency or professional association in state issued opioid prescribing guidelines for providers?	Yes
Has state enacted laws requiring pain clinics to register with the state?	Yes
Do any initiatives in state address stigma/discrimination associated with receiving treatment for opioid use disorders?	No
Has state changed (or is it planning to change) laws/regulations that govern naloxone administration?	No
Does state have legislation requiring opioid prescribers to report to Prescription Drug Monitoring Programs?	No

[a] Primary prevention includes activities directed at individuals who do not require treatment for substance abuse. Such activities may include education, mentoring, and other activities designed to reduce the risk of substance abuse by individuals. Note that under the SABG regulation, early intervention activities should not be included as part of primary prevention.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)