



WINTER 2002

networks

SEIZING THE MOMENT: Redefining State Mental Health Agency Role in Time of Budget Uncertainty

By John D. Kotler, M.S.J.

The current economic downturn as well as concerns about erosion in state mental health agency funding during the past several decades have prompted many state mental health officials and other stakeholders to raise questions about the future role of state mental health agencies in guiding public mental health policy and ensuring that effective mental health services are available to those who need them.

“Public mental health agency funding is gradually and incrementally becoming a smaller part of the state budget pie,” observes Michael F. Hogan, Ph.D., Director of the Ohio Department of Mental Health. “At precisely the time that we may face budget cuts, we find ourselves with lower reserves of flexible resources. Further

budget reductions will result in cutting important services.”

Paradoxically, the erosion in funding administered by state mental health agencies occurred during a period of far-reaching public mental health reform that witnessed the closure and consolidation of more than 40 state psychiatric hospitals nationwide, the proliferation of community-based mental health services and the implementation of a range of strategies to reduce costs and promote efficiency including the use of managed behavioral health care. “It appears that successful mental health reform is correlated with and possibly contributed to the decline in mental health agency budgets,” Dr. Hogan asserts.

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Seeking New Funding Sources for Mental Health Services

By Robert J. Burns,
National Governors Association

In seeking to expand public mental health funding resources and maximize the impact of public mental health funds, state mental health agencies have looked to other human services, public housing and criminal justice programs, many of which finance mental health services and supports within the scope of their program objectives.

A number of federally funded human services programs provide a variety of non-medical mental health supports such as counseling to promote job readiness when mental illness can be classified as a barrier to employment. New Jersey’s Work

First Mental Health Initiative employs federal Temporary Assistance for Needy Families (TANF) financing to help county welfare agencies assess, refer, and coordinate treatment services for TANF recipients with mental health conditions. In Wisconsin’s Pathways to Independence project, the state departments of Health and Family Services and Workforce Development use Social Security and other human services funding to assist people with serious mental or physical disabilities to obtain employment through intensive benefits counseling, assertive community treatment, and long-term

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MESSAGE FROM NTAC

Greetings from NTAC and Happy New Year to all of you. In this issue we attempt to summarize the current and complicated funding concerns that state mental health agencies face across the country. Included in these complex and, at times, controversial variables are emergent trends and patterns that affect multiple states in different ways.

Among these trends and patterns are the increasing role state Medicaid offices play in financing community mental health services and the concomitant, if unintended, leveling off or decrease in general revenue funding. Also of significance is the unexpected impact that successful mental health reform and the resultant closure of state hospital beds has had on state mental health agency funding levels in some states. Of critical importance is the need to design, integrate, and support a comprehensive database of state budgets by funding source, adjusted for population, that allows for the tracking of mental health funding over time. Although the full impact of the 911 tragedy has yet to be seen, current and upcoming state budget shortfalls appear to be significant. In some states, mental health and substance abuse budgets may be affected.

The topic of state mental health agency financing was among the high-priority issues on the table at the National Association of State Mental Health Program Directors' (NASMHPD) 2001 Winter Commissioners Meeting in Washington, D. C., December 2-4. Upcoming issues of *networks* will focus on other priorities discussed at the meeting including state mental health agencies' role in developing state plans for responding to bioterrorism; establishing partnerships with the criminal justice system to meet the services needs of persons who are involved with both systems; and the increasing and critical need to develop and disseminate data-supported, evidence-based practices. The role of state mental health agencies will continue to evolve in our current environment. It is up to us to direct this process and not be directed by it.

A key part of NTAC's mission in 2002 will be to assist state mental health agencies to identify their most significant needs and to bring customized technical assistance to help you meet those needs. Another focus will be on showcasing promising and best practices that demonstrate success through data-based outcome measures. Following a review of your responses to the NTAC Needs Assessment sent in December, we shall complete our technical assistance activities plan for 2002-2003.

On a personal note, as I complete my second month as Director of NASMHPD's Office of Technical Assistance, I would like to thank all of you who have helped to make my orientation to this organization so pleasant and exciting. The NTAC staff and I look forward to working with and for you in the coming year.

—Kevin Ann Huckshorn, R.N., M.S.N., I.C.A.D.C., NTAC Director

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Budget Issues *(continued from front cover)*

Citing research by Arie P. Shinnar and colleagues at the University of Pennsylvania, Dr. Hogan contends that widespread hospital closures have had the unintended effect of undercutting state mental health agency financing by eliminating the regular budget increases that came with indexing staff salaries and other hospital expenses to inflation.¹ Without their traditional brick and mortar foundation, he concludes, state mental health agency budgets have become less certain and public mental health services have come to seem less a state-level priority to many legislators and members of the public. "It appears that reduced overall mental health funding results in part from very low levels of hospital services, and thus ironically community care may suffer from reduced levels of hospital services," Dr. Hogan notes. *(continued on page 3)*

National Alcohol Screening Day

Public mental health agencies and providers are invited to participate in National Alcohol Screening Day (NASD), April 11, 2002, by conducting information dissemination and screening activities on April 11 or on another day during April, Alcohol Awareness Month. National Alcohol Screening Day, funded by the National Institute on Alcohol Abuse and Alcoholism, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention, offers an opportunity to provide information about alcohol use and its health effects as well as to screen individuals for at-risk drinking, alcohol abuse and alcoholism. Registered sites receive a variety of materials to help them carry out the event. Spanish-language materials are available.

**To register, contact
NASD at (781) 239-0071
or download a registration form at:
www.mentalhealthscreening.org/nasd/nasmhpd**

Budget Issues *(continued from page 2)*

In addition to these structural changes, many state mental health officials believe that the reluctance of public mental health systems to seek new responsibilities and constituencies has undermined their base of public support and jeopardized their ability to lead the development of public mental health policy and practice, and even to serve their traditional client base including adults with serious mental illness and children and youth with serious emotional disturbances. “The real issue is relevance,” James L. Stone, M.S.W., Commissioner of the New York State Office of Mental Health, told participants at the National Association of State Mental Health Program Directors (NASMHPD) Winter 2001 Commissioners Meeting, December 2-4, in Washington, D.C. “Erosion in funding is the consequence of not being viewed as relevant.”

State mental health agencies need to take on new challenges, asserts Stephen W. Mayberg, Ph.D., Director of the California Department of Mental Health. Dr. Mayberg urges state mental health agencies to move beyond their traditional scope of operation to provide services to persons with a wider range of mental health problems and to collaborate with a “new set of partners” including criminal justice, public health, housing, school and crisis response agencies as well as the private sector to demonstrate their ability to meet the needs of current clients and address emerging national priorities—from responding to the mental health impact of terrorism to promoting economic growth by helping to improve the mental health and resiliency of the nation’s workforce.

Funding Trends

Between 1981 and 1997, funding administered by state mental health agencies declined by more than 6 percent when adjusted for inflation, according to a report by the National Association of State Mental Health Program Directors Research Institute, Inc. (NRI).² The report notes that unadjusted state mental health agency funding grew at a substantially slower pace than that for other key state priorities including welfare, public health, hospitals and corrections. NRI is compiling data on state mental health agency funding sources and expenditures for the period since 1997 and plans to issue a report on these data in mid-2002.

Although the erosion in state mental health agency-administered funding came primarily in hospital expenditures while budgets for community-based services actually increased, the fact that total state mental health agency funding did not keep pace with inflation raises questions about the adequacy of funding for public mental health agency services.

One of the most important trends in state mental health financing is the increasing role Medicaid plays in funding state and local public mental health services. Medicaid funds accounted for half of all state- and locally administered mental health program expenditures in 1997, up from about one third of expenditures in 1985, according

to Jeffrey A. Buck, Ph.D., Associate Director for Organization and Financing at the Center for Mental Health Services (CMHS).³ That proportion is likely to increase to two-thirds during the next 10 to 20 years, Dr. Buck predicts.

Many states have increased their reliance on Medicaid because the federal program enables them to leverage limited state financial resources to obtain federal funds to help pay for public mental health services. Medicaid matches state mental health funding for eligible individuals and services on at least a dollar-for-dollar basis; for states with relatively low per capita income, the federal match can go as high as three dollars for each dollar contributed by the state. Thus states that convert services formerly financed through mental health general revenues to Medicaid can generate from one to three dollars in additional federal funding for every dollar the state contributes.

As Medicaid becomes a larger factor in public mental health financing, state mental health agencies often lose significant control over the provision of public mental health services.

However, as Medicaid becomes a larger factor in public mental health financing, state mental health agencies often lose significant control over the provision of public mental health services. A number of state mental health officials believe that this trend undercuts state mental health agencies’ role in guiding public mental health policy and ensuring the implementation of best practices. “The state Medicaid agency is increasingly becoming the state mental health agency in a number of states,” says Roy Sargeant, Chief of the Idaho Bureau of Mental Health and Substance Abuse. “Neither the funds nor the discussions about policy issues are being led by the state mental health agency in many of these states.”

Frank J. Sullivan, Ph.D., Senior Advisor for Mental Health and Substance Abuse with the Center for Medicare and Medicaid Services’ (CMS) Center for Medicaid and State Operations, says

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¹ Schinnar, A.P.; Rothbard, A.B.; Yin, D.; and Lutterman, T. (1992) “Public Choice and Organizational Determinants of State Mental Health Expenditure Patterns,” *Administration and Policy in Mental Health* 19(4): 235-250.

² Lutterman, T., Hirad, A., and Poindexter, B. (1999). *Funding Sources and Expenditures of State Mental Health Agencies*. Alexandria, VA: National Association of State Mental Health Program Directors Research Institute, Inc.

³ Buck, J.A. (2001). “Spending for State Mental Health Care,” *Psychiatric Services* 52(10): 1294.

CALENDAR OF EVENTS

February 10-12. NASMHPD Research Institute, Inc. **12th Annual Conference on State Mental Health Agency Research, Program Evaluation and Policy.** Baltimore, MD. Contact Vera Hollen at (703) 739-9333, ext. 116; www.nasmhpd.org/NRI

February 28-March 1. Joint Center for Poverty Research, Northwestern University and the University of Chicago. **Research Conference: *The Hard-To-Employ and Welfare Reform.*** Washington, DC. Call Patricia Lasley at (847) 491-4145 or Matthew Mohlenkamp at (773) 702-0472; www.jcpr.org

March 3-6. The Research and Training Center for Children's Mental Health. **15th Annual Research Conference: *A System of Care for Children's Mental Health: Expanding the Research Base.*** Tampa, FL. Call Catherine Newman at (813) 974-8429; <http://rtckids.fmhi.usf.edu>

March 5-9. National Association of School Psychologists. **34th Annual Convention.** Chicago, IL. Call (301) 657-0270; www.nasponline.org

March 7-9. Washington Business Group on Health. **Controlling Cost and Improving Quality in Tough Times: *Health Care Solutions for Employers.*** Washington, DC. Call (202) 624-1763; www.wbgh.org

March 23-26. National Council for Community Behavioral Healthcare and Association of Behavioral Healthcare Management. **Annual Training Conference, *In the Public Interest: Training Matters.*** Chicago, IL. Call (301) 984-6200; www.nccbh.org

April 1-3. National Institute of Mental Health. **15th NIMH Services Research Conference. *Evidence in Mental Health Services Research: What Types, How Much and Then What?*** Washington, DC. Call (301) 443-4513; www.nimh.nih.gov

April 4-6. North Carolina Division of Mental Health, South Carolina Department of Mental Health, North Carolina Division of Services for the Deaf and Hard of Hearing and Greensboro Area Health Education Center. **BreakOut VII: A National Conference of Psychosocial Rehabilitation and Deafness, *Community Intervention: Preserving Our Roots.*** Raleigh, NC. Call (919) 571-4980; www.gahec.org

For additional calendar items, visit NTAC's website at:
www.nasmhpd.org/ntac/events.html

Budget Issues *(continued from page 3)*

that an important part of the solution to the Medicaid dilemma is for state mental health and Medicaid agencies to collaborate more closely. However, a number of state mental health officials question whether such collaboration will occur unless the federal government takes the lead in promoting it.

A second problem is that Medicaid's medical orientation limits the range of services that eligible consumers receive. For example, Medicaid generally does not cover employment and housing supports, peer counseling and drop-in centers, or a number of other supports that are considered important elements in the provision of comprehensive services and supports for persons with psychiatric disabilities.

A third issue is that many of the public mental health systems' traditional clients, including indigent persons with serious mental illness who have not been designated disabled under the Social Security Administration's Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) programs and persons with acute rather than long-term psychiatric problems, often are ineligible for Medicaid.

A fourth problem is that state mental health general funds are increasingly used to provide the state match for federal Medicaid funding, further limiting state mental health agency flexibility in directing the use of general funds and reducing service levels for persons with mental illness who are not Medicaid eligible.

Finally, there is the issue of Medicaid's prohibition of reimbursements for services to persons ages 22 to 64 provided by institutions for mental disease (IMDs) including psychiatric hospitals and community-based residential facilities with 16 or more beds. There is considerable debate within the public mental health community about this policy, known as the IMD Exclusion. Opponents of the IMD Exclusion view the policy as an example of discrimination against persons with mental illness, since there is no similar exclusion for coverage of hospital services for persons with development disabilities or other disorders. However, other advocates believe that the IMD Exclusion discourages the use of hospitalization and promotes development of community-based services for persons with mental illness.

Opponents of the IMD Exclusion point out that the policy excludes persons with mental illness from benefitting from Medicaid's home and community-based waivers, which allow for great flexibility in the provision of community-based services for persons with a variety of disabilities who might otherwise be hospitalized. To take advantage of this waiver, the proposed community-based services must be revenue neutral—meaning that no additional Medicaid funds will be required in moving from hospital to community-based services. However, in a sort of Catch-22, since Medicaid does not pay for IMD services, there is no way to shift the IMD population from hospital to community-based services without incurring increased costs.

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Operating in a New Environment

There appears to be a growing consensus among state mental health officials that public mental health agencies need to take the initiative in establishing their niche in the new political and economic environment. To succeed in this effort, state mental health agencies need to engage other agencies and systems in collaborative efforts to meet shared goals, says Janet Corson, J.D., Director of the Indiana Division of Mental Health and Addiction. At the same time, Ms. Corson says that state mental health agencies need to be careful about taking on new responsibilities unless there is adequate funding.

Having accurate and comprehensive data is another element in demonstrating the relevance of state mental health agency services. "Without good data, you can't make good decisions and you can't demonstrate that your services are effective," asserts Martha B. Knisley, Director of the District of Columbia Department of Mental Health.

Ms. Knisley views many of the current trends affecting public mental health systems as part of an ongoing evolution in state mental health agencies' role. What state mental health agencies need to bring to the table in this new environment, Ms. Knisley says, is leadership, innovation and flexibility.

David Nelson, Vice President for Health Care Reform at the National Mental Health Association (NMHA), contends that the nation has yet to make the full commitment and investment needed to ensure that high-quality public mental health services are available to all those who need them. "We have to make the case that although investing in public mental health services is expensive, not making that investment is even more expensive in the long run," Mr. Nelson observes.

In Dr. Hogan's view, there are "two ways that state mental health agencies obtain funding—by being a problem or being a priority. Generally speaking we have not been able to establish mental health as a priority in the current political and economic environment. We have a record of getting funds when there is a problem. The real question is how do we become a priority?"

To survive and flourish in this "fundamentally different environment," Dr. Hogan asserts, state mental health agencies need to identify key national goals such as economic growth, improved schools and enhanced national security and find ways for public mental health systems to play a role in addressing these issues. He urges state mental health systems to address issues such as mental health in schools and the workplace, areas where state mental health systems have not had extensive involvement. "We have to develop links with other agencies," he says. "We have to be strategic, we have to capture the high ground." ♦

SUGGESTED READING

Judge David L. Bazelon Center for Mental Health Law. (2001). *Recovery in the Community: Funding Mental Health Rehabilitation Approaches Under Medicaid*. Washington, DC: Author.

Burns, R. (2001). "Strengthening the Mental Health Safety Net: Issues and Innovations," *Issue Brief*. Washington, DC: National Governors Association, Health Policy Studies Division, NGA Center for Best Practices.

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Michigan's Regional Approach Promotes Comprehensive, Flexible Mental Health Services

Beginning October 2002, the Michigan Department of Community Health will institute a new regional mental health care system that is designed to provide state-of-the-art services and supports along with maximum flexibility in the use of funding from a range of federal and state resources.

The new system will build on the foundation established in 1998 when the Department of Community Health initiated a managed Medicaid carve-out involving the state's 49 county-sponsored community mental health services programs. This was accomplished through implementation of two Medicaid waivers that enabled Michigan to create a statewide prepaid health plan encompassing most state mental health and developmental disability services as well as outpatient substance abuse programs. The prepaid health plan is separate from the state's Medicaid physical health plan.

We will provide the regional community mental health services programs with funding and flexibility, but we will be rigorous in tracking the quality of services, consumer response and public perceptions.

In the new phase beginning later this year, each of the county-based community mental health services programs will join forces with one or more of the other programs to form approximately 20 regional alliances, each encompassing at least 20,000 covered lives. The new regional community mental health services programs will be able to draw on a wide range of funding sources including Medicaid, state mental health agency general funds, the state mental health block grant and substance abuse services. Case managers will use these resources to provide a flexible mix of services that meet the needs of individual consumers. In essence, the regional alliances will receive a capitated sum that will provide great flexibility in the types of services and supports that can be provided, including mental health services, housing assistance, rental subsidies and vocational preparation.

Terry Geiger, Acting Deputy Director of Mental Health and Substance Abuse Services within the Department of Community Health, said that the regional approach is expected to lead to significant cost savings and efficiencies by enabling local community mental health centers that make up each regional alliance to coordinate data and records management as well as other administrative functions and by promoting greater uniformity in contracting, reporting and billing practices within

each region. "Some of the greatest benefits will appear in the less urban areas, where coordinated efforts and services will make it possible for each county program to bring its particular strengths to the affiliation," Mr. Geiger observes. For example one county might contribute expertise in substance abuse treatment while another might offer outstanding day-treatment services. Still to be developed is a strategy for ensuring that consumers have access to all services offered in a region, some of which may encompass several counties. A potential solution, Mr. Geiger said, is to establish annexes or satellite offices for key programs in several sites throughout a region.

A major factor in making this initiative possible is Medicaid's agreement to offer Michigan an indefinite exemption from federal procurement regulations mandating competitive bidding in selecting the new regional mental health entities. Mr. Geiger said that the state made the case that providing sole-source contracts to the newly formed regional groups would promote community integration in keeping with the U.S. Supreme Court's *Olmstead* ruling. However, each of the regional entities will have to submit a proposal to the state mental health system demonstrating its ability to carry out comprehensive, high-quality, consumer-oriented mental health services. The state mental health system will closely monitor the performance of the regional entities to ensure that they are successfully carrying out their new responsibilities. If a program is unable to do so, the state will open that region to competitive bidding from other providers.

"We will provide the regional community mental health services programs with funding and flexibility, but we will be rigorous in tracking the quality of services, consumer response and public perceptions," Mr. Geiger explained. He added that state block grant funds will be used to help promote statewide improvements in specific areas, such as person-centered planning.

Mr. Geiger emphasized that an important strength of the regional mental health services strategy is that it promotes collaboration and cooperation among the state mental health, Medicaid, substance abuse and local mental health agencies to provide a flexible and wide ranging set of services that include comprehensive mental health services as well as supports in areas that include housing, rental subsidies and vocational preparation.

For additional information, contact Terry Geiger, Acting Deputy Director, Michigan Mental Health and Substance Abuse Services, at (517) 335-0196 or geiger@state.mi.us

New Funding Sources *(continued from front cover)*

vocational supports. Oregon uses funds from both the TANF and Welfare-to-Work programs to place mental health counselors in several local welfare offices to provide recipients with counseling and referral for additional mental health services. In Oregon mental health services are available to—and in some cases mandated for—participants who are having difficulty achieving self-sufficiency.

Public housing funds may be used to support persons with mental illness who are homeless when their mental illness is classified as a disability. Housing support for individuals with mental illness often include housing vouchers, capital construction loans, and reimbursement for costs of operating housing units for low-income persons with disabilities. In some cases—such as with McKinney continuity-of-care grants—housing funds may be used to provide mental health services and supports.

Local housing authorities in Connecticut received \$40 million from a variety of U.S. Department of Housing and Urban Development (HUD) programs to assume responsibility for housing services previously funded by the state mental health agency, which now refers consumers to local housing authorities. In Oregon, nonprofit corporations have used HUD funds to construct apartment complexes for tenants with mental illness on a section of property formerly owned by a state mental hospital.

Criminal justice funds may be used to coordinate community treatment services and place or divert individuals with mental conditions into more appropriate non-corrections treatment settings. Criminal justice funds support jail diversion programs such as mental health courts, treatment during incarceration, and treatment to facilitate a return to the community.

Maryland used funds from the U.S. Department of Justice, HUD, and the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop local interagency case management services involving law enforcement and court officials, mental health and substance abuse providers, educators, and others to help individuals involved with the criminal justice system to remain in or return to the community. Wisconsin's Wraparound Milwaukee uses funds from a number of sources to create a managed care model in which youth receive coordinated mental health services and supports as an alternative to incarceration.

For an in-depth discussion of these and other public mental health funding sources, see "Strengthening the Mental Health Safety Net: Issues and Innovations," an Issue Brief of the National Governors Association Center for Best Practices (www.nga.org/center). For further information, contact Robert J. Burns, Policy Analyst, Health Policy Studies Division, National Governors Association Center for Best Practices, Washington, DC., at (202) 624-7729 or email: rburns@nga.org ♦

www.funding.trends

Center for Medicaid and Medicare Services (CMS): Provides up-to-date information on federal policies concerning the Medicaid, Medicare and S-CHIP programs. (Formerly, the Health Care Financing Administration). www.hcfa.gov

Center for Mental Health Services (CMHS): Addresses a wide range of mental health issues including public mental health financing. Provides information about CMHS programs and activities. www.mentalhealth.gov

Council of State Governments Criminal Justice/Mental Health Consensus Project: Provides information about this innovative project involving the National Association of State Mental Health Program Directors, the Council of State Governments and several law enforcement, court and corrections organizations to improve the criminal justice system's response to persons with mental illness. www.csgeast.org/programs/criminal_justice/crimjust.html

Judge David L. Bazelon Center for Mental Health Law: Provides information on public mental health issues, legislation and advocacy. www.bazelon.org

The Henry J. Kaiser Family Foundation: Addresses state and national health trends with particular emphasis on Medicaid and insurance issues. www.kff.org

National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc.: Provides information on state mental health agency funding trends and other issues in the delivery of public mental health services supported by state mental health agencies. Includes information about the 2001 State Profile System and other mental health research and data issues. www.nasmhpd.org/nri

National Council of State Legislatures: Offers information on a wide range of state budget and policy issues including the impact of the current recession on state budgets and funding priorities. www.ncsl.org

National Governors Association: Provides state perspectives on a range of issues including health and health-care financing. NGA's Center for Best Practices explores effective strategies for addressing a wide range of health care and other challenges. www.nga.org

New Reports: **Latino Mental Health and Transition**

NTAC has just published reports on meeting the mental health needs of Latinos and transition-age youth. *Creating Culturally Competent Mental Health Systems for Latinos: Perspectives from an Expert Panel*, the latest installment in NTAC's *Cultural Diversity Series*, explores the provision of culturally competent public mental health services to Latinos from the perspectives of some of the nation's leading experts in the field.

The important goal of providing effective public mental health services to youth with serious emotional disturbances who are moving toward adulthood is the subject of *State Efforts To Expand Transition Supports for Adolescents Receiving Public Mental Health Services*. Written by a recognized expert on this topic, the report discusses state initiatives to implement effective transition services and identifies factors that help or hinder efforts to improve services.

To order one or both publications, please send a check for \$10 per report payable to NTAC, 66 Canal Center Plaza, Suite 302, Alexandria, VA 22314; or visit www.nasmhpd.org/ntac



The National Technical Assistance Center for State Mental Health Planning provides focused, state-of-the-art technical assistance and consultation to State Mental Health Agencies, State Mental Health Planning and Advisory Councils, consumers and families to help ensure that the best practices and most up-to-date knowledge in mental health and related fields are translated into action at the state and local levels.

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