

Issue Brief



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Strengthening the Mental Health Safety Net: Issues and Innovations*

Summary

The public mental health services system serves as a safety net for people who are poor, uninsured, or for those whose private insurance benefits run out during their illness. The system ensures that mental health treatment is available for those in need, enabling individuals to return to their communities and lead more productive lives. However, several issues compete for state mental health resources and affect the ability of states to maintain or expand mental health coverage, enhance benefits, and bolster the mental health safety net. Among these issues are:

- **Rising pharmaceutical costs.** Uncontrolled growth in prescription drug costs could dominate state mental health spending and threaten state efforts to address other mental health priorities.
- **Federal mental health parity initiatives.** States without conforming parity laws may face federal preemption if congressional efforts are successful to reauthorize and expand the Mental Health Parity Act of 1996 to include substance abuse benefits, deductibles, coinsurance, copayments, and other forms of cost sharing.
- **Olmstead.** While the 1999 Supreme Court ruling in *Olmstead v. L.C.* may improve the mental health safety net by making more community-based treatment options available for individuals with disabilities, funding to support infrastructure development may take priority over competing state mental health interests.
- **Administrative simplification.** All mental health safety net providers and numerous state agencies will be required to invest heavily in standardizing their business processes and upgrading their information systems to comply with this provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

States also recognize that several seemingly unrelated public programs share the goal of enabling individuals to return to their communities and lead more productive lives. Although generally more restrictive than dedicated mental health programs, most human services, public housing,

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and criminal justice programs do, to varying degrees, provide or support mental health services within the scope of their specific program objectives.

- **Human services** funds treat mental illness when it is a barrier to employment. Frequently these funds provide wraparound and non-medical mental health support services, such as counseling to support job readiness.
- **Public housing** funds support homeless and disabled persons (where mental illness can be classified as a disability). Housing support for individuals with mental illness often includes housing vouchers, capital construction loans, and reimbursement for costs to operate housing units for low-income persons with disabilities. Providing wraparound or direct mental health treatment services is another housing support.
- **Criminal justice** funds coordinate community treatment services and place (or divert) individuals with mental conditions outside the justice system and into more appropriate treatment settings. Generally, criminal justice funds support jail diversion programs (also known as mental health courts), treatment during incarceration, and treatment to facilitate a return to the community.

Through better coordination among these programs, states are finding unique ways to support the mental health safety net and the services it provides.

The Financing and Delivery of Public Mental Health Services

Historically, people with mental illness were treated in state mental hospitals or in other institutional settings. However, in the 1960s, these institutions were considered ineffective because of overcrowding, staff shortages, and inadequate facilities. Patients were often discharged to receive care in their communities. At the time, many communities were not prepared to serve the comprehensive needs of these patients. Many found themselves unemployed and homeless, often ending up in the human services or criminal justice systems. Thus began a movement towards more community-based treatment.

Today, treatment advances and changes in public perception have dramatically transformed the mental health environment. Community mental health providers now offer a variety of psychosocial and pharmacological treatment options through a wide spectrum of treatment settings (e.g., outpatient, residential, partial hospitalization, and acute inpatient). Treatments are now available for mental conditions such as depression, anxiety and mood disorders, schizophrenia, Alzheimer's disease, and others. The availability of these treatments allows many individuals to return to their communities and lead more productive lives.

Though mental health treatment options have increased, financing and delivering these services have grown more complex. Until recently, private insurers have been resistant to provide coverage for mental health services. Even now, the involvement of private insurers is limited. Of the more than \$32 billion spent for people with private insurance in 1996, nearly \$12 billion (37.5 percent) came from individual out-of-pocket payments (copayments, coinsurance, deductibles, or other expenses) and \$2 billion (6.3 percent) was derived from other sources.¹ One major deterrent has been the high costs of intensive psychiatric treatment, long-term psychotherapy, and extended hospital stays. Moreover, the public mental health services system already provides a safety net for those who are poor, uninsured, or for those whose private insurance benefits run out during the course of their illness.²

Traditionally, the funding and delivery of public mental health services has been a state responsibility. Most state spending comes from general revenue, state Medicaid contributions, and other state sources. In the last decade, federal spending has only slightly surpassed that of state and local government. Medicare and Medicaid have been—and remain—the major sources of federal mental health spending.

Current Issues in a Changing Environment

A number of continuing and emerging issues impact states’ ability to sustain and improve financing and delivery of mental health services, including rising pharmaceutical costs, federal mental health parity initiatives, the *Olmstead* decision, and administrative simplification. In pursuing innovative ways to support mental health services, policymakers should be aware of how these external factors may affect their efforts.

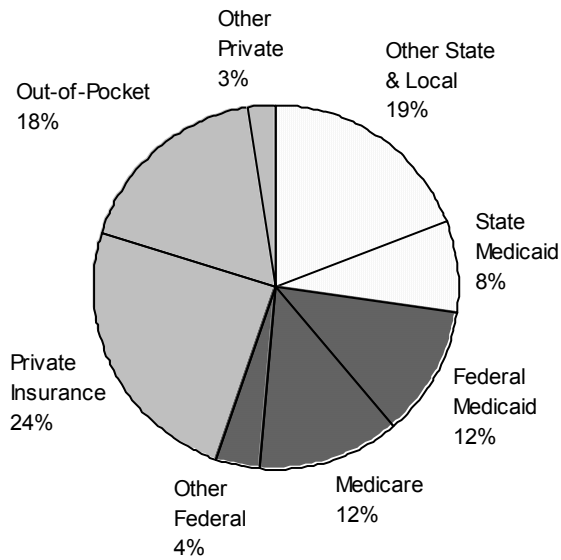
Rising Pharmaceutical Costs

Over the last decade, several new pharmacological advances have been developed to treat depression, attention-deficit/hyperactivity disorder, schizophrenia, and other mental conditions. Combined with behavioral therapy, new psychiatric drug therapies have allowed many patients to return to their communities and avoid the more expensive inpatient care. However, the new advances in psychotropic treatments have (along with changes in prescribing practices) contributed to a gradual rise in overall prescription drug costs nationwide. During 2000, pharmacy costs in nearly every state increased from 17 percent to 21 percent; some predict this trend will continue throughout the next decade.³ Uncontrolled growth in prescription drug costs could dominate state mental health spending and threaten state efforts to enhance benefits, maintain or expand coverage, and bolster the mental health safety net.

Federal Mental Health Parity Initiatives

Compared to standard medical coverage, insurance benefits for mental health and substance abuse services have remained limited. However, a movement has been underway since 1994 to bring parity to coverage for medical and behavioral health services. In 1996, Congress enacted a provision to HIPAA that imposes minimum federal standards for mental health coverage. The Mental Health Parity Act of 1996 prohibits group health plans that offer mental health benefits from imposing more restrictive annual or lifetime limits on spending for mental illness than for coverage of physical illness.⁴ Efforts are underway in Congress to reauthorize the act and expand its scope to include deductibles, coinsurance, copayments, and other forms of cost sharing, as well as substance abuse benefits.

Percentage of Total Mental Health Expenditures by Funding Source, 1997



Total Expenditures = \$73.4 billion

Note: Percentages may not total 100 because of rounding.

Source: National *Expenditures for Mental Health and Substance Abuse Treatment 1997* (Rockville, M.D.: U.S. Department of Health and Human Services, 2000).

Under the original act, states without conforming laws were subject to federal preemption. However, preemption does not provide flexibility to states to design programs to meet their unique needs. State public mental health programs will be challenged to maintain mental health coverage levels, bolster the mental health safety net, and address other state mental health priorities, while diverting significant resources to support newly mandated mental health benefits and consumer protections. Since 1997, 22 states have enacted parity laws, each with varying approaches to reducing coverage disparities.⁵

The Olmstead Decision

The 1999 *Olmstead* decision placed increased pressure on states to offer community-based treatment for those in the mental health services system. The decision was the result of a Georgia lawsuit where two women were placed in institutional settings after their treating professionals agreed they would be better served in community-based programs. The Supreme Court ruled that the Americans with Disabilities Act (ADA) required states to ensure community-based treatment alternatives are available (instead of institutional treatment) when such treatment is determined to be:

- medically appropriate;
- not opposed by the patient; and
- one that can be “reasonably accommodated” based on available resources.^{6,7}

Essentially, the Court held that it was discriminatory to isolate disabled persons in institutional settings when their disability could be more appropriately treated in a community-based setting. As a result, *Olmstead* is expected to improve the mental health safety net by making more community-based treatment available.

For states to ensure adequate treatment settings are available for people with mental illness, they will need to conduct statewide needs assessments, develop plans to address current needs, secure new funds to support infrastructure expansions and improvements, and dedicate a variety of other resources for implementation. Public mental health programs will be challenged to maintain coverage levels, bolster the safety net, and address other state priorities while dedicating substantial resources to support *Olmstead*-related activities.

Administrative Simplification

Administrative simplification, a major component of HIPAA, requires all health plans, health care clearinghouses, and other health care providers to standardize the electronic exchange of administrative and financial health care data. The provision applies directly to state Medicaid agencies, and indirectly to state mental health and substance abuse authorities, and any other public or private entities involved in the electronic transmittal of health-related data.

The provision presents both opportunities and challenges to state policymakers. By requiring standardization of information systems, billing codes, enrollment data, and other health-related information, states can better coordinate funding streams and administrative functions across unrelated programs with mental health components, including those in education, criminal justice, and welfare. However, administrative simplification will require states to sacrifice many state and local informational codes used for patient enrollment, provider billing, public health reporting, and other purposes. This change could alter how public programs function. It will require significant investment to assess how state agencies will be affected.

With administrative simplification, all mental health safety net providers and numerous state agencies must invest heavily in standardizing their business processes and upgrading their information systems. Although numerous state agencies (including state mental health and

substance abuse authorities) will be affected, Medicaid is the only one that will receive federal funds to comply. Several states, including **Maryland, Michigan, Hawaii, Idaho, Indiana, New York, Ohio, and Washington**, have already established commissions or task forces to help coordinate and finance their HIPAA compliance activities. State implementation activities will undoubtedly continue until the October 16, 2002, compliance deadline.

Alternative Funding for Mental Health Priorities

The public mental health services system is a loosely organized array of mental health services funded with government resources and delivered by public, private, and nonprofit providers. Where public mental health services are provided and how they are funded depends on the public program being used and how it coordinates with other programs. Outside of Medicaid and dedicated state mental health programs, it is not uncommon for individuals in other public systems, including human services, public housing, and/or criminal justice, to have unmet mental health needs contributing to their hardship.

While mental health, human services, public housing, and criminal justice programs were all created for specific purposes, most share a common goal of enabling individuals to return to their communities and lead more productive lives. Most human services, public housing, and criminal justice programs include mental health services within the scope of services they provide to accomplish specific program objectives. Through better coordination among these programs, states are making the most of these funding sources to support their mental health priorities.

Human Services and Mental Health

As many as one-third of current welfare recipients have some form of mental illness. Long-term welfare recipients also are more likely than other recipients to be depressed three to five days a week.⁸ Mental illness can sometimes be an employment barrier if the illness is misinterpreted as a motivation or behavioral problem. However, through treatment and other social supports, welfare programs can address mental conditions as barriers to employment.

In **New Jersey**, the Division of Mental Health Services (DMHS) and the Division of Family Development (DFD) created the Welfare-to-Work/Work First New Jersey Mental Health Initiative to serve Temporary Assistance for Needy Families (TANF) recipients with mental disorders. The program provides mental health and job readiness services to TANF recipients. County welfare agencies identify and refer appropriate TANF recipients to the local mental health provider agencies. The provider agencies then provide further

Human Services Programs and Mental Health

The U.S. Department of Health and Human Services (HHS) provides several options for using human services programs to address mental illness as a barrier to work and economic self-sufficiency. The mental health and related services available include:

- **Social Services Block Grant (SSBG).** States may support mental health activities to help low-income individuals achieve economic self-support or self-sufficiency.
- **TANF Block Grants.** States may provide needy clients with non-medical mental health (and related wraparound) services to help overcome mental illness as a barrier to work.
- **WtW Block Grants.** States may target mental health services and other assistance to especially hard-to-serve welfare clients, including those with mental illness.

Appendix A contains additional information about these programs.

Source: Rebecca Brown, *Addressing Substance Abuse and Mental Health Problems Under Welfare Reform: State Issues and Strategies* (Washington, D.C.: National Governors Association Center for Best Practices, 2001).

assessments, referrals, and services. County welfare agencies work with case managers on an ongoing basis to review participants' progress and coordinate mental health treatment with employment support services. TANF and Welfare-to-Work (WtW) block grant funds support the program in six counties.

Oregon's WtW program includes assisting recipients with mental health problems. Most Portland area offices have onsite mental health counselors to provide staff support, participant counseling, and referral to additional services. Mental health services are available to—and, in some cases, mandated for—participants who are having difficulty achieving self-sufficiency. The program is supported under a TANF waiver and with WtW funds.

Wisconsin's Pathways to Independence is a research and demonstration project designed to remove barriers to employment for people with severe physical and mental disabilities. The Wisconsin Departments of Health and Family Services and Workforce Development contracted with 20 sites statewide. Each site is administered by a nonprofit organization, educational institution, county human services agency, or other provider group. The sites use a team approach to create networks of support for the vocational goals of participants. They provide intensive benefits counseling, assertive community treatment, and long-term vocational supports. Participants may also buy-in to the Medicaid program. All participants must have Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and meet other disability and vocational requirements. The project was developed through SSI and SSDI waivers and is supported with Social Security funds, state supplemental appropriations, and philanthropic contributions.

On the federal level, the Health Resources and Services Administration (HRSA) bolstered the community mental health safety net through its Bureau of Primary Health Care (BPHC). Last year, through the Opportunities for Health Centers to Expand/Improve Access and Services initiative, BPHC awarded \$85 million to community and migrant health centers and other grantees to encourage the integration of mental health services within existing primary care programs. Additional grants will be awarded during fiscal 2002 to community providers on a competitive basis based on each applicant's needs assessment and their service delivery and evaluation plans. Grantees may receive up to \$100,000 each and may use the funds to:

- introduce mental health providers into health center primary care clinic teams;
- use mental health professionals, substance abuse counselors, nurses, social workers and other health professionals to screen, diagnose, and develop individual patient care plans, conduct treatment therapies, and ensure follow-up with hard-to-serve populations;
- develop information registries to track clinical progress and outcomes for mental health and substance abuse patients; and
- establish formal linkages with community mental health and substance abuse providers.

BPHC funds are part of a \$146.5-million spending plan to strengthen the health care safety net and promote excellence in clinical practice. Because community and migrant health centers are largely funded by the federal government, states will be limited in modifying the program to meet their unique needs. However, accessing new federal funds to support these safety net programs may present an opportunity to direct any state savings (particularly Medicaid dollars) to other mental health priorities. The challenge for state policymakers is to ensure that eligible individuals use the mental health services available through community and migrant health centers before accessing other state-funded programs.

Public Housing and Mental Health

One-third of all homeless persons have a serious mental illness or condition.⁹ Enabling these individuals to become self-sufficient is a challenge for mental health and housing authorities alike. The U.S. Department of Housing and Urban Development (HUD) offers federal housing grants to support homeless and/or disabled individuals (where mental illness can be classified as a disability). State mental health agencies and other stakeholders may use these federal grants to provide housing and wraparound services. Although HUD programs do not monitor the quality of mental health support services, grant applicants must demonstrate a strong commitment to coordinating supportive activities across multiple agencies.

Local housing authorities in **Connecticut** received more than \$40 million from HUD during the 1990s, mostly through the McKinney grants program, to support and enhance the delivery of mental health services. The state developed a substantial marketing plan to educate local housing authorities about the different types of support the state mental health agency could offer. The marketing plan encouraged local housing authorities to apply for the McKinney grants. In exchange, state mental health service providers offered to be a supportive referral source for local housing authorities. The housing funds received by local authorities supported housing that would have otherwise been supported with state mental health funds or not at all.

Oregon will use the proceeds from the sale of its former Dammasch State Hospital property south of Portland to establish a trust fund. Under statutes enacted in 1999, 70 percent of the trust fund's interest will be invested in the development of community housing alternatives for persons with mental illness. In addition, a portion of the property will be developed into housing for persons with mental illness on scattered sites throughout the larger development. Nonprofit corporations throughout Oregon have successfully used the HUD Section 811 Capital Advance program to construct 24 small apartment complexes that provide nearly 400 units of permanent, affordable housing for tenants with mental illness. Many of these apartment complexes have mental health clients serving as resident managers, providing peer support and taking care of general landlord responsibilities.

Housing Support for Mental Health

HUD provides opportunities to use federal housing programs to address mental illness for those who are homeless and/or disabled (where mental illness can be classified as a disability). Housing assistance and other supportive services may be provided for persons with mental illness through the following HUD programs:

- **Section 8 Fair Housing.** States may provide rental assistance (vouchers) to help low-income disabled persons find decent, safe, and sanitary housing in the private market.
- **Section 811 Supportive Housing for the Disabled.** States may build, rehabilitate, operate, or lease units of housing (coupled with supportive services) for low-income persons with disabilities.
- **Continuum of Care (“McKinney”) Grants.** States may develop innovative community systems to combat homelessness based on locally developed priorities (which may include targeting those who suffer from mental illness and are homeless).

Appendix B contains additional information about these programs.

Source: U.S. General Accounting Office. *Mental Health: Community-Based Care Increases for People With Serious Mental Illness*. Report to the Committee on Finance, U.S. Senate. (GAO-01-224, December 2000).

Criminal Justice and Mental Health

Nearly 16 percent of state prison inmates have reported either a mental condition or an overnight stay in a mental hospital (compared to 7 percent of those in federal prisons).¹⁰ According to the National Alliance for the Mentally Ill, this figure does not account for unreported mental conditions of inmates, or the estimated 20 percent to 40 percent of those with mental illness who come into contact with the criminal justice system without being incarcerated. Many of the latter's interactions are minor offenses related to untreated mental illness. For some individuals, untreated mental conditions can evolve into more serious criminal behavior. This essentially leaves courts, jails, and prisons as treatment centers of last resort. Through the innovative use of federal criminal justice funds, states are finding ways to relieve the treatment burden on the legal system, placing offenders with mental conditions in more appropriate, cost-effective treatment settings. Federal criminal justice funds may be applied to jail diversion (such as mental health courts), treatment during incarceration, and treatment during reentry into the community.

Jail Diversion

The use of mental health courts is a problem-solving approach to administering justice that seeks to address the root causes of a person's involvement with the criminal justice system. When an offender is determined to have a mental condition, judges can force the offender into treatment in lieu of prosecution or as a condition of reduced charges. This can include dropping criminal charges, deferring prosecution, or imposing conditions of bail or probation. Modeled after drug courts, mental health courts rely on effective interactions among prosecutors, public defenders, attorneys, community mental health providers, and the courts. Mental health courts promote accountability by ensuring that offenders receive treatment that will make them less likely to return to the criminal justice system in the future as a result of their illness.

Incarceration

A variety of mental health treatment and support services are available to incarcerated offenders who may have a mental illness or condition. Treatment in prison focuses on rehabilitation and may reduce suicide rates and recidivism. Treatment usually includes access to appropriate mental

Criminal Justice and Mental Health

The Department of Justice (DOJ) provides the opportunity to leverage federal justice funds to support those with mental illness that come into contact with the criminal justice system. Supportive mental health services may be provided through the following DOJ programs:

- **Byrne Discretionary Grants Program.** States may undertake demonstration projects and other innovative activities to target unmet mental health needs in the criminal justice system.
- **Community Oriented Policing Services (COPS) Program.** States may receive federal technical assistance to help local law enforcement interact more effectively with offenders with mental illness.
- **Community Prevention Grants Program (Title V).** States may support community-based prevention activities, including the coordination of juvenile services for youth with mental illness.
- **Juvenile Accountability Incentive Block Grant (JAIBG).** States may develop accountability-based interventions (jail diversion programs) for offenders with mental illness in the juvenile justice system.
- **Youth Offender Reentry Initiative Grant Program.** States may undertake demonstration projects and other innovative activities to help young offenders with mental conditions reintegrate into the community.

Appendix C contains additional information about these programs.

Source: U.S. Department of Justice, Office of Justice Programs [online] (Washington, D.C.: U.S. Department of Justice, 06/21/2001). Available from <<http://www.ojp.usdoj.gov>>.

health professionals and treatment settings, and support counseling to help the individual prepare to return to the community.

Community Reentry

Treatment following release from jail is also called reentry or community corrections. This treatment provides support services to facilitate an individual's return to the community and helps avoid future interaction with the criminal justice system. Similar to jail diversion, reentry services often occur during probation or parole when an individual is required to use support services as a release condition. Support services may include regular interaction with community mental health providers and employment and housing supports.

Maryland's Community Criminal Justice Treatment Program (MCCJTP) is a model community service program. Through the state mental health authority, Maryland awarded grants for localities to develop interagency advisory boards composed of community criminal justice stakeholders. These stakeholders included law enforcement officials, state attorneys, public defenders, prison wardens, mental health and substance abuse providers, education officials, and others. The local boards use the funds to develop collaborative transitional case management services between treatment and criminal justice professionals. The program targets offenders with mental conditions while they are confined as well as probationers and parolees with mental conditions, particularly those who are homeless.

Since the program's inception, the state has seen improved identification of mental health needs, improved treatment during incarceration, increased communication among in-jail and community-based service providers, and reduced recidivism in local jails. The program is primarily funded by the state mental health agency with support by the DOJ Byrne State and Local Law Enforcement Assistance Program, HUD Shelter Plus Care housing funds, and HHS grants from the Projects for Assistance in Transition from Homelessness (PATH) program.¹¹

In **Wisconsin**, Wraparound Milwaukee uses a modified managed care model to coordinate treatment and other support services for youth as an alternative to incarceration. Essentially, child welfare and juvenile justice systems created a public managed care organization (MCO) that offers more than 60 services through individualized benefit plans. Care coordinators develop a care plan based on each family's needs and current resources. Services are delivered by outside providers who have contracted with the MCO on a fee-for-service basis. Rather than automatically placing youth into residential treatment settings, services are tailored to meet each family's unique needs.

Since the program's inception, the cost of providing treatment and other support services has dramatically decreased—from more than \$5,000 to \$3,300 per child per month. Residential treatment has decreased 60 percent and inpatient psychiatric admissions are down 80 percent. Recidivism is also down and savings are reinvested into serving more youth. The program was originally created through a grant from the Center for Mental Health Services (CMHS) and now includes funds from Medicaid and Supplemental Security Income (SSI). The mental health division of the Milwaukee County Human Services Department administers Wrap Around Milwaukee.¹²

Coordinating Resources Among Diverse Programs

With the variety of organizational and policy variations in government, it is sometimes difficult for policymakers and program administrators to ascertain which programs pay for certain services. Decentralized federal support for mental health services has created a need for states to manage many unrelated federal and state funding streams, coverage options, and eligibility

requirements. Outside of informal working relationships, it can be difficult for independent public entities to coordinate coverage and provide beneficiaries with a seamless continuum of care. However, states are developing innovative mental health service systems where funding is integrated and programs are cost-effective.

In 1996 the **Michigan** legislature amended the Mental Health Code Act, empowering its 49 county-sponsored community mental health services programs (CMHSPs) to voluntarily administer mental health benefits for several unrelated state programs. Since that time, the state has used several mechanisms, including a Medicaid managed care waiver, use of Medicaid optional services, and compliance with the *Olmstead* decision, to create an innovative, integrated and cost-effective mental health services system. Some unique features of the program follow.

State Mental Health Agency Responsibilities

If there were a single point where the many unrelated public mental health programs and funding streams converge, it would be the state mental health agency. The state mental health agency is responsible for ensuring the integrity of the public mental health safety net through a number of roles, including:

- **Provider.** Provides services directly through state-owned or state-operated psychiatric hospitals or other facilities.
- **Purchaser.** Contracts with nonprofit or private sector providers to deliver mental health services on a fee-for-service or capitated basis.
- **Regulator.** Monitors mental health providers and enforces quality standards.
- **Manager.** Coordinates supportive services for persons with mental illness, such as housing support, employment assistance, and preparing individuals to return to their communities.

Source: U.S. General Accounting Office. *Mental Health: Community-Based Care Increases for People with Serious Mental Illness*. Report to the Committee on Finance, U.S. Senate. (GAO-01-224, December 2000).

- **Local Coordination.** All public mental health services are administered locally by CMHSPs through sole-source contracts with various state agencies. The CMHSPs are the single point of entry into the public mental health services system. Each CMHSP is responsible for consolidating the various state policies, programs, and payment sources for its clients and for ensuring that appropriate funds follow each patient.
- **Sole-Source Funding.** CMHSPs are supported with prepaid funds from the various agencies for which they administer the mental health benefits. These agencies include the state mental health and substance abuse authorities, the state Medicaid agency, and others. The prepaid funds are awarded to the CMHSPs through sole-source contracts and are determined by the number of beneficiaries in need of treatment for serious mental illness, developmental disabilities, and substance abuse.
- **Medicaid Waiver/Olmstead.** Michigan successfully argued that their sole-source contract model with the CMHSPs promoted community integration for disabled persons (as required by the Supreme Court's *Olmstead* decision). As a result, CMS granted the state an indefinite exemption from federal procurement rules requiring competition, followed by approval of the state's Medicaid waiver request. Through the program, the state Medicaid agency may now enter into capitated, sole-source contracts with each of the 49 county-sponsored CMHSPs.
- **Reinvestment.** Any administrative savings realized by CMHSPs are returned to the state Medicaid agency. The savings leverage additional federal matching dollars to cover several optional mental health services under Medicaid. While providing more effective case management, some CMHSPs have already returned to the state Medicaid agency more than double the amount that would have originally been spent.

Although the idea of sharing resources across multiple agencies is not new, the **Texas** Integrated Funding Initiative (TIFI) was the first project in the state that focused exclusively on building local infrastructure to coordinate resources.

TIFI is consortium of state, local, and community stakeholders that funds community demonstration projects to develop the infrastructure for purchasing/arranging services and to determine the community funding strategy (including rate setting). Each pilot site is required to coordinate its efforts through a local administrative services organization (ASO), which are generally county mental health departments or nonprofit organizations already established in the community. Texas law also requires that these delivery services be family- and community-based, be accountable for outcomes, and maximize all funding sources available.

- **Stakeholder involvement.** The TIFI consortium originated with the Texas Health and Human Services Commission. It includes representation from the Texas Department of Mental Health and Mental Retardation, Department of Protective and Regulatory Services, Education Agency, Youth Commission, Juvenile Probation Commission, Commission on Alcohol and Drug Abuse, Council on Developmental Disabilities, and others. Half of the members of the consortium are family members and/or youth representatives, each appointed by a participating agency.
- **Pooled funding.** Most funding for TIFI comes from the state mental health agency and contributions from other participating consortium members. Additional funding is provided by a CMHS care grant from the Substance Abuse and Mental Health Services Administration.

Since its inception, TIFI has continued funding two pilot programs (originated through a grant from the Robert Wood Johnson Foundation) and created six new project sites to develop integrated service delivery systems for children with multiple needs.

Conclusions

As the mental health care environment continues to change, states are striving to help those in the public mental health system receive the most appropriate services in the most suitable settings. The ultimate goal is to help care recipients return to their communities and lead more productive lives. States must be empowered to design mental health systems that effectively coordinate unrelated funding streams, coverage options, and eligibility requirements; and that provide public mental health clients with a seamless continuum of care. The challenge is to develop this continuum while fully utilizing mental health funding opportunities from alternative sources.

¹ U.S. General Accounting Office, *Mental Health: Community-Based Care Increases for People with Serious Mental Illness*, GAO-01-224 (Washington, D.C.: December 2000).

² U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Health Services, National Institutes of Health, National Institute of Mental Health, 1999).

³ Darlene C. Collins, *State Initiatives to Promote Cost-Effective Use of Pharmacy Benefits* (Washington, D.C.: National Governors Association Center for Best Practices, 2000).

⁴ U.S. General Accounting Office, *Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States*, GAO/HEHS-00-85 (Washington, D.C.: March 31, 2000); U.S. General Accounting Office, *Private Health Insurance: HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws*, GAO/HEHS-98-217R (Washington, D.C.: July 22, 1998); and U.S. General Accounting Office, *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards*, GAO/HEHS-99-100 (Washington, D.C.: May 12, 1999).

⁵ Tracy Delaney, *Mental Health Parity* (Washington, D.C.: National Conference of State Legislatures, 2001).

⁶ *Olmstead v. L.C.*, 527 U.S. 581 (1999).

⁷ U.S. General Accounting Office, *Mental Health: Community-Based Care Increases for People with Serious Mental Illness*, GAO-01-224 (Washington, D.C.: December 2000).

⁸ Rebecca Brown, *Addressing Substance Abuse and Mental Health Problems Under Welfare Reform: State Issues and Strategies* (Washington, D.C.: National Governors Association Center for Best Practices, 2001).

⁹ U.S. Department of Health and Human Services, *Mental Health and Homelessness: A Guide for Mental Health Planning and Advisory Councils* (Washington, D.C.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2000).

¹⁰ U.S. Department of Justice, *Mental Health and Treatment of Inmates and Probationers* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, July 1999); and U.S. Department of Justice, *Mental Health Treatment in State Prisons, 2000* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, July 2001).

¹¹ Catherine Conly, *Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program*, Program Focus (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, April 1999).

¹² Bruce Kamradt, *Wraparound Milwaukee: Aiding Youth With Mental Health Needs*, Juvenile Justice, Vol. VII, No.1 (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Programs, April 2000).

APPENDIX A: HUMAN SERVICES SUPPORT FOR THE MENTAL HEALTH SAFETY NET

PROGRAM	PURPOSE	SAMPLE ACTIVITIES	ELIGIBLE APPLICANTS	ADMINISTERING AGENCY
Head Start	Provide comprehensive developmental services for low-income, preschool children (ages three to five) and other services for their families	Behavioral health assessment and referral services for children under age five	Local public or private not-for-profit, or for-profit agencies	U.S. Department of Health and Human Services (HHS) / Administration on Children and Families (ACF) / Head Start Bureau
Social Services Block Grant (SSBG)	Help low-income individuals achieve economic self-support or self-sufficiency	Mental health support services; transportation services; family planning; information, referral, and counseling services; and appropriate combinations of services to meet the needs of children, the aged, the mentally retarded, the blind, the emotionally disturbed, the physically handicapped, and those with substance abuse problems	States and territories	HHS / ACF / Division of State Assistance
Temporary Assistance for Needy Families (TANF) Block Grants	Support families in their transition from welfare to work	Mental health screening, assessment, and referral services; coordinated case management; support for wraparound services; treatment combined with work activity	States and territories	HHS / ACF / Office of Family Assistance
Welfare-to-Work (WtW) Block Grants	Provide post-employment support services for hard-to-serve welfare recipients	Nonmedical mental health treatment; life skills training and vocational counseling; case management and mentoring programs; other innovative activities	State (formula) and local (competitive) units of government	U.S. Department of Labor (DOL) / Employment and Training Administration

APPENDIX B: PUBLIC HOUSING SUPPORT FOR THE MENTAL HEALTH SAFETY NET

PROGRAM	PURPOSE	SAMPLE ACTIVITIES	ELIGIBLE APPLICANTS	ADMINISTERING AGENCY
Section 811 Supportive Housing for Persons with Disabilities	Increase rental housing units (coupled with supportive services) for low-income persons with disabilities, including homeless persons with mental illness (where mental illness can be classified as a disability)	Interest-free capital advances, project rental assistance *Must be coupled with a supportive services plan	Nonprofit organizations	U.S. Department of Housing and Urban Development (HUD) / Office of Public and Indian Housing (PIH)
Welfare to Work (WtW) Housing Voucher Program	Enable TANF-receiving families with a critical need for housing to obtain and/or retain viable employment	Housing assistance combined with job training, child care, and other services	Public housing authorities	HUD / PIH
Section 8 Rental Assistance Programs	Enable those who are homeless and disabled (where mental illness can be classified as a disability) to rent affordable private housing			
Mainstream Housing Opportunities for Persons with Disabilities (Mainstream Program)	Enable persons with disabilities (elderly and nonelderly) to rent affordable private housing	Disability-based tenant rental assistance (vouchers), capital advances, and the coverage of certain administrative costs	Public housing authorities and nonprofit disability organizations	HUD / PIH
Rental Assistance for Nonelderly Persons with Disabilities (Related to Certain Types of Developments)	Enable nonelderly persons with disabilities to rent affordable private housing (due to a preference for admission of elderly families in certain types of project developments)	Disability-based tenant rental assistance (vouchers), capital advances, and the coverage of certain administrative costs	Public housing authorities	HUD / PIH
Rental Assistance for Nonelderly Persons with Disabilities (In Support of Designated Housing Plans)	Enable nonelderly persons with disabilities to rent affordable private housing (in plans with a demonstrated need for non-elderly housing alternatives)	Disability-based tenant rental assistance (vouchers), capital advances, and the coverage of certain administrative costs	Public housing authorities	HUD / PIH
Continuum of Care (“McKinney”) Grants	Encourage the development of innovative community systems to combat homelessness based on locally developed priorities (which may include targeting those who are homeless and suffer from mental illness).			
Supportive Housing Program (SHP)	To develop housing and supportive services enabling homeless individuals to live as independently as possible	Acquire, construct, rehabilitate, or lease facilities for homeless persons with mental illness; pay for new or increased supportive services; meet some of the day-to-day operational and administrative expenses of facilities; mental health supportive services only (no funding for housing)	State and local units of government; private nonprofit organizations; public nonprofit community mental health centers	HUD / PIH
Shelter Plus Care (S+C) Program	To provide rental assistance for hard-to-serve homeless people with disabilities, along with supportive services that are funded by other sources	Tenant-, sponsor-, and owner-based rental assistance for persons with mental illness; single-room occupancy assistance for those with mental conditions	State and local units of government; public housing authorities	HUD / PIH
Single Room Occupancy Program (SRO)	To bring more standard single-room occupancy units into the local housing supply and make them available to homeless individuals	Transitional and permanent housing; and safe havens for persons with mental illness	Public housing authorities; private nonprofit organizations	HUD / PIH

APPENDIX C: CRIMINAL JUSTICE SUPPORT FOR THE MENTAL HEALTH SAFETY NET

PROGRAM	PURPOSE	SAMPLE ACTIVITIES	ELIGIBLE APPLICANTS	ADMINISTERING AGENCY
Byrne Discretionary Grants Program	Address unmet service needs in the criminal justice system	Enhance cross-systems collaboration between courts and mental health agencies; develop court-based mental health services	State and local criminal justice agencies, judges, court administrators, and prosecutors; private nonprofit organizations; educational institutions; and others	Department of Justice (DOJ) / Office of Justice Programs (OJP) / Bureau of Justice Assistance (BJA)
Community Oriented Policing Services (COPS) Program	Provide local law enforcement with the training and technical assistance to implement and sustain community policing	Improve police training to better interact with those who suffer from mental illness	State and local units of government	DOJ / Office of Community Oriented Policing Services (COPS)
Community Prevention Block Grants Program (Title V)	Sustain community-based delinquency prevention efforts that will prevent youth from entering the juvenile justice system	Develop innovative delinquency prevention programs for persons with mental illness in the juvenile justice system	State and local units of government [†]	DOJ / OJP / Office of Juvenile Justice and Delinquency Prevention (OJJDP)
Juvenile Accountability Incentive Block Grant (JAIBG)	Promote accountability-based interventions in the juvenile justice system.	Develop innovative jail diversion programs for persons with mental illness in the juvenile justice system	State and local units of government	DOJ / OJP / OJJDP
Local Law Enforcement Block Grants (LLEBG) Program	Support ongoing extracurricular activities or programs for targeted youth groups	Support extracurricular programs, such as the Boys and Girls Clubs of America	Local law enforcement agencies	DOJ / OJP / BJA
Youth Offender Initiative Reentry Grant Program	Enhance community safety by helping young offenders to reintegrate into the community	Provide mental health counseling; supervision; transitional community services; life skills training; other social and personal support	State, local, and tribal units of government; nonprofit organizations; and others	DOJ / OJP / Corrections Program Office (CPO)

[†] Funds are allocated to qualifying states. Local units of government (city, county, township, or other political subdivision) may then competitively apply for funds through their respective state agencies).