



Mental Health Fact Sheet

Dispelling Myths About Mental Illness

Mental illnesses are biologically based brain disorders that can be treated as effectively as other types of medical conditions.

- Mental illness is not due to personal weakness or inadequate willpower.
- Mental health is integral to and inseparable from overall health.
- Chemical regulators in the brain called neurotransmitters are responsible for sending messages between nerve cells. Research has demonstrated that impaired regulation of key neurotransmitters is responsible for both mental illness symptoms and physical symptoms such as pain.
- Like other chronic medical conditions, mental illnesses fall along a continuum in terms of severity, with some types of mental illness persistent and severe requiring long-term treatment.

Types of Mental Disorders

The Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association is the standard manual for diagnosing mental disorders. It recognizes 16 different categories of mental disorders. Some of the more well-known categories include:

- Anxiety disorders such as obsessive compulsive disorder and post-traumatic stress disorder
- Mood disorders such as bipolar disorder and major depression
- Schizophrenia and other psychotic disorders
- Cognitive disorders including dementia and delirium
- Eating Disorders
- Personality Disorders
- Sleep disorders
- Impulse-control disorders

How many people are affected?

Between 70 and 90 percent of people with mental illnesses can experience reduced symptoms and improved quality of life with appropriate medical and psycho-social treatment and support.

Adults

- One in five adults—more than 45 million Americans—suffers from some form of mental disorder in a given year.¹ Of this number, 5 percent suffer from some form of serious and persistent mental illness.²

Children

- Five to 9 percent of children suffer from mental illnesses severe enough to cause impairment.³
- Depression occurs in one of every 33 children and one of every eight adolescents.⁴

What is the social impact of untreated mental illness?

Despite tremendous advances in research and treatment for mental illnesses, many children and adults do not get the care they need.

- Less than one third of adults and fewer than half of all children with diagnosable mental disorders receive some form of treatment during the year.⁵
- Of those in juvenile detention, 65 percent of boys and 75 percent of girls have one or more psychiatric disorders.⁶
- Suicide is the third leading cause of death among people from ages 15–24.⁷
- Mental illnesses account for nearly one-quarter of all disability worldwide.⁸

What is the social impact of untreated mental illness? *continued*

- Nearly 13,000 families had to give up custody of their children in 2001 either to juvenile detention or to the foster care system to get mental health care.⁹
- On any given day, the Los Angeles county jail houses more people with mental illness than any treatment facility in the United States.¹⁰
- Emergency rooms are becoming more crowded as the number of uninsured increases and public spending on health care is reduced. More than 60 percent of emergency room physicians reported seeing an increase in psychiatric emergency cases over the past 6 to 12 months.¹¹

Obstacles to Access and Quality in Mental Health Care

- Stigma, misunderstanding and fear
- Silos in health care between physical health and mental health
- Gaps in care and services
- Lack of prevention, early screening and identification of mental illness
- Access to care limited in many areas, especially for community-based services
- Inadequate, restricted and fragmented funding

Fast Facts

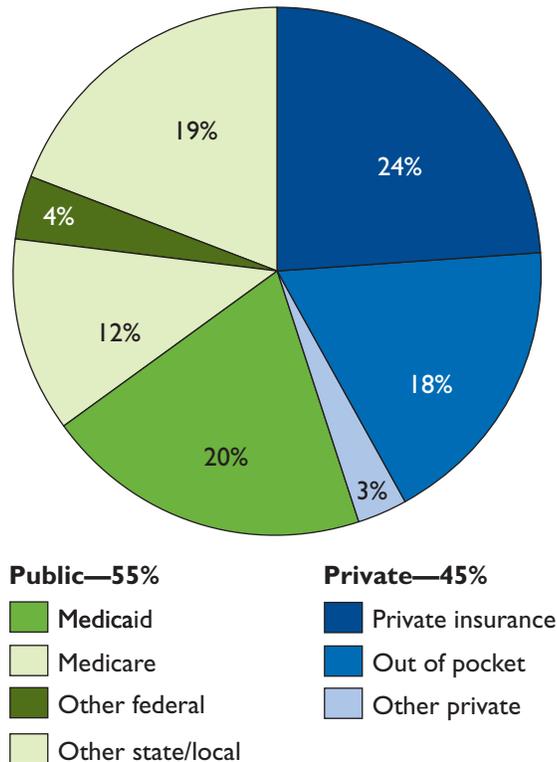
- State spending for mental health adjusted for inflation has decreased from \$16.5 billion in 1955 to \$11.5 billion in 1997.
- Medicaid now makes up more than 50 percent of public financing for mental health care.

Overview of the Mental Health Care System

Financing/Costs

- **Total Annual Cost:** \$152.4 billion each year for the total cost for mental illness in the U.S.
- **Direct Annual Cost:** \$73.4 billion on direct costs for the treatment of mental illness¹²
- **Indirect Annual Cost:** \$79 billion lost annually due to untreated and inappropriately treated mental illness, with \$63 billion due to lost productivity, \$12 billion due to premature mortality and another \$4 billion for crime and family care costs.¹³

Mental Health Spending, 1997



Source: Mark Coffey, et al., 2000 (revised)

Who funds mental health services?

- **Federal Government.** Many federal agencies play a role in funding a variety of mental health and other social services. The two largest federal funders are the Substance Abuse and Mental Health Services Administration (SAMHSA) that provides block grants to states and The Centers for Medicare and Medicaid Services (CMS) that provides financing for mental health services through the Medicaid program.
 - **State Government.** State mental health agencies, Medicaid programs and other social service agencies administer and provide services for people with mental illnesses. States provide funding through state appropriations.
 - **Local Government.** Counties and county-based providers play a key role in delivering services in most states.
 - **Private sector and individuals.** Private insurers, individuals and their families pay for services. Private for-profit and non-profit providers deliver services such as hospitalization, outpatient treatment, counseling and psychotherapy.
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Delivery System

The mental health care system has a range of health care professionals and providers who provide care and services to consumers.

Professionals

- **Psychiatrists**—physicians who specialize in the diagnosis and treatment of mental illnesses and who are able to prescribe medications
- **Primary care physicians**—generalist physicians who treat a range of medical conditions including mental illnesses and who are able to prescribe medications
- **Psychologists**—licensed professionals trained in psychology, many with doctorates, who provide diagnosis and treatment of mental illnesses. Two states allow psychologists with special training to prescribe medications.
- **Nurses** provide medical treatment. Advanced nurse practitioners and clinical nurse specialists may diagnose, prescribe medication and monitor treatment for mental illnesses in joint agreements with physicians.
- **Social Workers**—licensed professionals who assist clients with locating appropriate services provided by government agencies, private sector organizations and others
- **Professional Counselors**—licensed professionals with education and training in counseling groups and individuals

Providers

- **State and county hospitals**—publicly funded and administered facilities. The number of clients has shrunk tremendously in the last 30 years in favor of community-based care.
 - **Private hospitals**—including both for-profit and nonprofit hospitals with emergency rooms and psychiatric departments
 - **Mental health/behavioral health clinics**—clinics and practices that specialize in the treatment of mental illness and/or substance abuse or both
 - **Mental health agencies**—state and local agencies that coordinate and administer services for clients with mental illnesses
 - **Community health centers**—free clinics and other health centers that provide services for low-income clients
 - **State, county and community social service agencies**—provide other services such as housing, education, employment, and transportation services
 - **Private medical clinics and doctors offices**
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Issues and Concerns for States and Consumers

Financing

- Funding comes from multiple sources at the federal, state and local levels as well as from private insurance and out-of-pocket spending.
 - Funding goes to multiple agencies at the state and local levels, resulting in fragmented services across programs.
 - Community-based services have been demonstrated to be less costly and more effective than hospitalization and emergency treatment, but it can be difficult to close state hospitals or reorganize the delivery system.
 - Community-based services often lack adequate funding or capacity to meet community needs.
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Financing, *continued*

- State budget shortfalls and rising Medicaid spending have forced states to institute strict cost containment measures such as cutting provider payments, limiting eligibility, scaling back optional services, restricting numbers and types of drugs, and increasing co-payments. Many of these measures negatively affect access to care for people with mental illnesses and may drive up costs elsewhere such as through emergency room use or hospitalization.
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Consumer Control of Care

- People with severe mental illnesses have limited control over the kinds of care and services that are available and who provides them.
 - Increased control with accountability can encourage consumers to participate more in their care.
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Social Supports

- Employment—Only about 1 in 3 individuals with a serious mental illness is employed, making it the group with the lowest employment rate among people with disabilities. Yet, most people with serious mental illnesses want to work. Due to high disability and low employment rates, three-fourths of people with serious mental illnesses earn less than \$20,000 a year.¹⁴
 - Housing—The severe shortage of affordable housing can result in people with severe mental illnesses ending up in institutions, jails, shelters and on the streets, hampering their recovery.
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Access Issues

- There is a lack of parity in coverage and financing for mental health. Under private insurance, greater restrictions exist on care for mental illnesses than other illnesses.
 - Some people expend their private insurance coverage and then have to rely on publicly funded services for mental health treatment.
 - Tension exists between fiscally driven decisions regarding drug coverage and the health of people with serious mental illnesses stabilized on a certain drug regimen.
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Endnotes

¹ U.S. Department of Health and Human Services (HHS), *Mental Health: A Report of the Surgeon General* (Rockville, Md.: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999).

² New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report* (Rockville, Md.: U.S. Department of Health and Human Services, Pub. No. SMA-03-3832, 2003), 2.

³ *Achieving the Promise*, *ibid.*

⁴ Patrice Harris, “Brain Disorders: A Clinical Perspective,” (presentation given at The Council of State Governments’ Mental Health Forum, Santa Fe, New Mexico, May 2004).

⁵ HHS, 64.

⁶ National Alliance for the Mentally Ill, “Psychiatric Disorders Common Among Detained Youth,” (10 December 2002), <<http://www.namisc.org/News/2002/Fall/DetainedYouthPsychiatricDisorders.htm>> (3 August 2004).

⁷ American Psychological Association, “Briefing Sheet on Suicide Prevention,” FY 2005, <<http://www.apa.org/ppo/funding/fy05suicideprev.html>> (2 August 2004).

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⁹ Senate Committee on Governmental Affairs, “Senator Collins: Pass Legislation To Better Coordinate Mental Health Services For Children,” (28 April 2004). < http://govt-aff.senate.gov/index.cfm?FuseAction=PressReleases.Detail&Affiliation=C&PressRelease_id=710&Month=4&Year=2004 (2 August 2004).

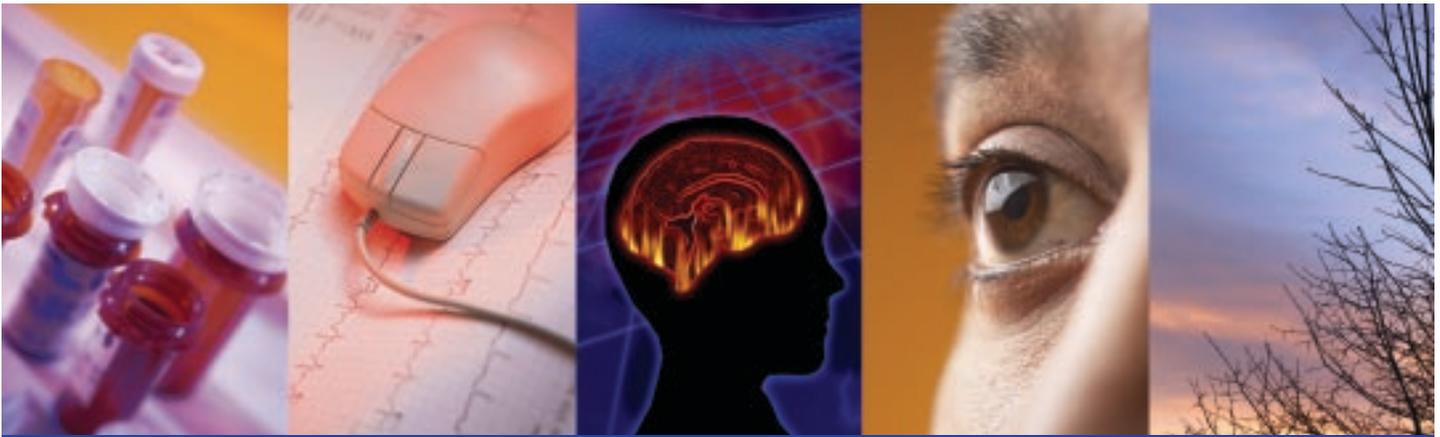
¹⁰ “Treatment Not Jail: A Plan to Rebuild Community Mental Health,” *Sacramento Bee*, 17 March 1999, sec. B, 6.

¹¹ National Alliance for the Mentally Ill, “Emergency Departments See Dramatic Increase in People with Mental Illness Seeking Care,” (27 April 2004). < <http://www.namisc.org/News/2004/Spring/EMR-Increases.htm>> (2 August 2004).

¹² TL Mark, RM Coffey, E King, et al., “Spending on Mental Health and Substance Abuse Treatment, 1987-1997.” *Health Affairs* 19, no. 4 (2000): 108-120.

¹³ *Achieving the Promise*; DP Rice and LS Miller, “The Economic Burden of Schizophrenia: Conceptual and Methodological Issues and Cost Estimates,” in *Schizophrenia*, eds. M.Moscarelli, A. Rupp, and N. Sartorius (Chichester, United Kingdom: Wiley, 1996).

¹⁴ *Ibid.*, 46.



Helping people with mental illness recover through a state action plan

by Jack Meyer, New Directions for Policy

Background

More than 54 million Americans have a mental health disorder in any given year, according to the *Surgeon General's Report on Mental Health*. About 5 percent of those with mental illness have schizophrenia, major depression, or bipolar disorder. Mental health disorders are “brain disorders”—not a “normal” part of life and not a sign of personal weakness. In fact, mental illness is a leading cause of disability worldwide.

Mental disorders cross all boundaries of race, gender, and ethnicity, although the prevalence of some disorders can be higher for some population groups. In addition to the potentially devastating toll on patient health, mental illnesses come with high financial costs. The National Mental Health Association reports that untreated mental health problems rack up nearly \$200 billion a year in costs, including some \$92 billion in untreated mental health problems, \$95 billion in lost productivity, and \$8 billion in crime and welfare costs.

Addressing the needs of individuals with mental disorders can involve a myriad of providers, services and settings. Services range from medical and clinical to psychosocial rehabilitation and assertive treatment services to help people recover physically, as well as assistance with housing and employment needs.

Unfortunately, jails, prisons, and juvenile facilities have all too often become the treatment facilities for adults, children and adolescents with mental illness.

Caring for the mentally ill is a critical issue for state government. Although mental health services are available in both the public and private sector, public sector spending

accounts for approximately 53 percent of all spending on mental health and substance abuse treatment services. The public system is administered by state mental health agencies and financed through state appropriations, Medicaid, and federal Substance Abuse and Mental Health Services Administration programs. Medicaid, a federal-state program for the nation's poor, accounts for more than 50 percent of state and local mental health spending and is expected to reach 60 percent by 2007.

Understanding mental illness, patient needs, and how services are currently provided are important steps in determining what actions states can take to improve access to quality treatment. Because of the nature of mental illness, individuals often

require a multi-faceted approach to care. In other words, meeting the needs of people with mental illness means addressing their “total care” needs, and that can include job training, providing transportation to their health care provider, or protecting patient access to physician-prescribed medicine.

Given today's budgetary difficulties in the states, ensuring that patient needs are met through such an array of services can appear challenging. Yet, the costs of inaction—i.e., not addressing the medical and social needs of this special patient population—can result in greater financial costs, but most notably, can ultimately put consumers at risk.

Despite a wide array of effective treatments, too many people with mental illness have unmet needs or are underserved. In fact, fewer than one-third of adults and half of all children with a diagnosable mental disorder receive any level of treatment in any one year.

From May 16–19, 2004, The Council of State Governments convened a Health Policy Forum on Mental Health in Santa Fe, New Mexico. A bipartisan group of 17 legislators came together from across the country to develop an action plan for states to address the many challenges individuals with mental illness face in accessing and navigating the complex mental health care system. The group developed the following goal statement:

Goal Statement: Help people with mental illness recover through:

- Early detection.
- Outreach to vulnerable and underserved populations.

- Access to vital health and social services.
- Promotion of work, learning and independent living.
- Fostering consumer and family-centered care.
- Reducing stigma and heightening community awareness.

What follows are the findings and determinations of the legislative participants when asked to develop strategies and policy options that are realistic, appropriate, and best meet the needs of people with mental illness. Whether acted on together or individually, these are important options that can be part of any state action plan to improve the well-being and quality of care for people with mental illness in their states.

Taking Inventory

States are advised to take an inventory of both the unmet needs of people with mental illness and the resources currently available to help these consumers. The inventory will enable states to better determine resource gaps and areas that could benefit from coordination of care.

Strategies & Actions: Outreach, Access and Quality

States can implement any number of strategies to address the treatment needs of people with mental illness. However, targeting state efforts toward issues related to quality, access, and outreach helps focus on this special population's greatest needs.

Outreach

As noted earlier, many people with mental illness do not seek treatment. Eliminating the stigma associated with mental illness and educating the community about available treatments and resources can help individuals who have not previously sought treatment. States can be important partners in outreach and early detection of mental illness by working with the following:

- Schools and early childhood care providers
- Public and private health care providers (e.g., community health centers, hospitals and physicians)
- Emergency responders
- Courts and jails
- Home-based care providers
- Homeless shelters
- Senior centers
- Patient and other groups

Possible Action Steps for States

Education and Awareness Campaigns

- *Mental Health Awareness Campaign.* A dual purpose mental health awareness campaign should be developed to deliver important messages that 1) encourage individuals to seek treatment for mental illness and 2) help combat the stigma of mental illness that discourages people from seeking treatment. States are encouraged to work with outreach partners, such as schools, community centers, and police stations to develop and launch such a program. Programs could include public service announcements, advertisements, newspaper articles, and any other appropriate means to inform the public about the availability of support and services for individuals with mental illness.
- *Consumer Hotlines.* A toll-free number should provide information to the public about available resources including, but not limited to, mental health services, employment support, housing assistance, and mentoring programs. The consumer hotline should be integrated with other education and awareness efforts to ensure broad dissemination of its availability.

Job Training and Employer Programs

- *Job Training Programs.* Approximately 2.5 million adults with severe mental illness are unemployed. Of these individuals, nearly 70 percent want to work. States play an important role for these individuals by providing job training programs. In addition to the financial benefits of employment, holding a job, either full- or part-time, often leads to improvements in self-esteem, alleviates psychiatric symptoms, and reduces dependency.
- *Employer Incentives.* Another option is for states to create incentives for employers to hire individuals in recovery.

Incentives could include special employer recognition programs, tax breaks, or priority in state contracts.

State Employees and State Contract Pilot Programs

- *State Employee Mental Health Awareness Campaign.* As employers, states have a unique opportunity to set a positive example for in-state private employers. A state employee mental health awareness campaign pilot program specifically should educate state workers about the nature of mental illness and encourage individuals in need to seek treatment. States should also review their employee benefit packages to ensure that mental health coverage for their workers is fully adequate.
- *State “Mental Health Friendly” Contract Preference.* States should give priority in state contract awards to vendors deemed “mental health” friendly. “Mental health friendly” is defined as a company that provides mental health insurance coverage and/or related services to their employees.

Access

Consumers only benefit from available treatments if they can access them. Barriers to treatment can range from physical obstacles, such as lack of transportation or access restrictions on medicines, to cultural or language barriers. Access to a full range of services—medical and social—is critical to helping people with mental illness recover. People with mental illness benefit from open and seamless access to the following:

- Health services including effective medicines
- Supportive social services
- Employment support services
- Housing services
- Transportation
- Peer-support, mentoring, and other voluntary services

Possible Action Steps for States

Access Guarantees to Mental Health Services

- *Required Mental Health Coverage.* States have some flexibility in what services are covered through Medicaid and SCHIP. As a “brain disorder,” mental illness is a medical condition that requires appropriate treatment. States could review their Medicaid and SCHIP program benefits and administration to ensure that the state’s most vulnerable patient population has access to mental health services when needed.
- *Open and Seamless Access to Care Campaign.* Access to an array of health services, particularly medicines, is critical for people with mental illness. States could ensure access to

care through the promotion of sound clinical practices. States could protect access to mental health services by prohibiting restrictions or limitations on a health care provider and patient’s decision as to appropriate treatment.

- *Equal Coverage for Mental Health Care.* States could also enact mental health parity laws. As a “brain disorder,” mental illness is a medical condition that requires appropriate treatment. States could eliminate discrimination by health insurers by establishing a standard of parity for the coverage of treatments for mental illness.

Employment Assistance Programs

- *Job Transition Assistance.* People with mental illness often need assistance transitioning into the workforce. By protecting access to health benefits, states could enable consumers to feel secure starting or returning to jobs that may not offer a full range of health benefits.
- *Job Protection.* States should also provide support and job protection for employees with mental illness. States should ensure that consumers who seek treatment are not treated unfairly or subject to discrimination because of their illness.

Housing Support Program

Lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in the community for people with mental illness. States should offer financial assistance through grants or low to no-interest loans to help people with mental illness find permanent housing.

Quality

To best ensure quality of care, it is important to define “quality” and the desired health outcomes. From there, actual health outcomes can be measured against the desired results. The bipartisan group identified a number of ways to promote quality of care:

- Identify evidence-based and promising practices.
- Develop provider performance measures.
- Hold health care providers accountable for quality of care.
- Ensure efficient and appropriate use of resources.
- Assure consumer safety.
- Reduce inappropriate care and medical errors.

Possible Action Steps for States

Mental Health Services Programs

- *Treatment Type.* People with mental illness often require individually-tailored treatments. Not everyone responds the

same to a given treatment. Accordingly, states should ensure access to the treatments deemed appropriate by the health care provider and the patient, including access to medicines, through legislation exempting treatments for mental illness from restrictions or limitations. Disease management and case management programs provide a proactive approach to managing and coordinating the care of individuals with mental illness that focuses on improving patient care while lowering overall treatment costs. States should promote quality of care through support of such programs.

- *Treatment Setting.* A growing body of evidence has demonstrated that most people with mental illness can be treated more effectively and at less cost in community settings rather than traditional psychiatric hospitals. States should ensure that patient care is delivered in the most appropriate setting, by providing support for mental health treatments delivered in the setting deemed most appropriate by a patient and/or health care provider, whether in-hospital or community-based.

Patient Protections

- *Mental Health Ombudsman Program.* For people with mental illness and their families, the mental health system can seem complex and overwhelming. States should establish an ombudsman program to advocate for the interests of individuals with mental illness. This could be carried out through a separate Office of the Ombudsman or through the creation of a patient advocate within the Department of Mental Health Services or Department of Health to advocate on behalf of individuals with mental illness.
- *Mental Health Quality Improvement Initiative.* To ensure quality of health care, states could implement a quality-improvement and evaluation process for mental health care delivery systems.

State Employees & State Contracts

- *Mental Health Quality Improvement State Vendor Initiative.* As a payer of health care services, states should build quality goals into provider contracts and require health care providers to meet specific quality standards.

- *Health Care Provider On-Time Payment System.* Health care providers are more likely to enter and stay in an area of practice if there is timely and adequate reimbursement of their services. States should encourage the delivery of quality care by meeting the reimbursement needs of mental health care providers through the implementation of an appropriate and on-time payment system.

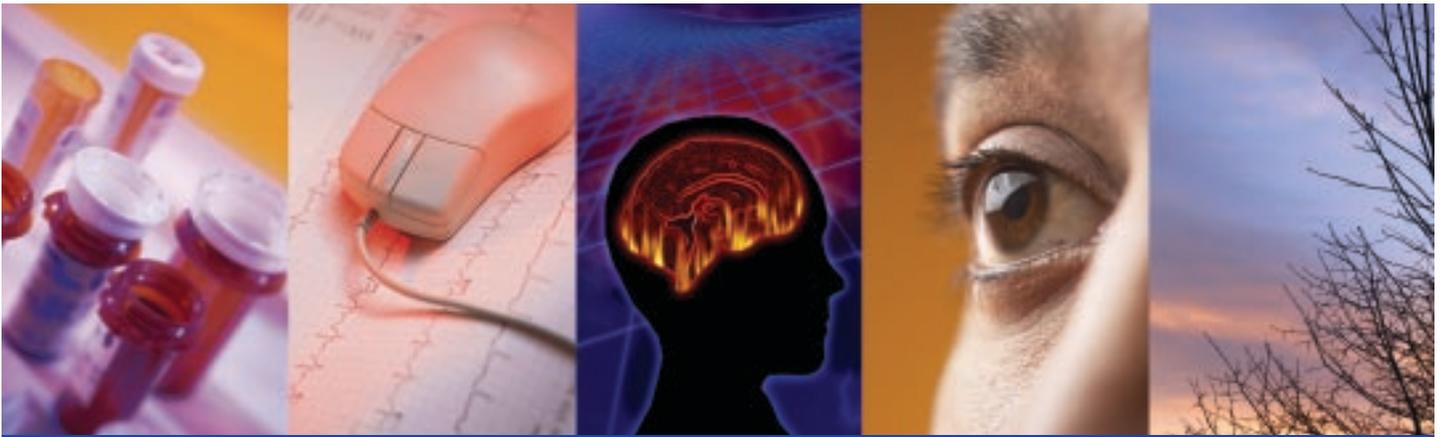
Criteria for Evaluating Success

States should work with mental health professionals and patient advocacy groups to develop clinically sound criteria, the goals of which are to achieve successful patient outcomes. Whenever possible, outcome measures are desirable (reducing symptoms of disease, improved functional status, return to work, less absenteeism from school for youth). But process indicators such as timely access to appropriate services are also helpful. States can set specific goals and targets and track the progress in meeting them, making mid-course corrections as needed over time to improve results.

About the Author

Jack A. Meyer, Ph.D., is the founder and president of New Directions for Policy (NDP), a Washington-based organization that assists business, purchasers and providers of health care, and federal, state, and local governments through market analysis, strategic planning, and policy analysis and evaluation. Dr. Meyer has conducted policy analysis and directed research on health care issues for several major foundations as well as federal and state government and the business sector on a number of issues, particularly on access to care and the uninsured. Dr. Meyer is the author and editor of numerous books, monographs, and articles. His recent publications include “Building on the Job-Based Health Care System: What Would It Take?” *Health Affairs*; *Covering America: Real Remedies for the Uninsured*, prepared under a grant from the Robert Wood Johnson Foundation; *Assessing State Strategies for Health Coverage Expansion: Summary of Case Studies of Oregon, Rhode Island, New Jersey, and Georgia*, prepared for the Commonwealth Fund; “Improving Men’s Health: Developing a Long-Term Strategy.” *American Journal of Public Health*; and *Reaching Out: Successful Efforts to Provide Children and Families with Health Care*, prepared for the W.K. Kellogg Foundation.

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Selected State Approaches to Improve Mental Health Care

States have been key players in establishing new and innovative approaches for providing mental health care and supportive services. Listed below are categories of state action with selected examples from individual states of approaches aimed at improving mental health care. CSG does not endorse any particular state method or program,

nor has it conducted independent evaluation of any of the programs listed. Instead, these approaches and examples are provided to inform state leaders of trends in mental health policy and to provide for consideration a range of approaches implemented by states.

Transforming Mental Health Care Systems

These are examples of state action aimed at transforming systems of financing and delivery of mental health care.

State Mental Health Plans

Under this approach, a state brings all relevant stakeholders and state agencies together to develop a comprehensive state mental health plan that outlines available funding, how it will be used and specific goals for the state to implement. Because care and services are funded and provided by so many different state agencies and community-based organizations, bringing all parties together can help ensure that systems of care and social supports are designed efficiently and effectively and aid recovery and life in the community for people with mental illness.

State example: Nevada passed SB 301 in 2003, establishing the Nevada Mental Health Plan Implementation Commission. The Commission is charged with developing a statewide action plan that addresses the recommendations from the President's New Freedom Commission.

Systems for Prevention and Early Identification

Prevention is a relatively new term in mental health, but there is growing recognition among researchers and leaders that preventive efforts and early identification of mental illness may be able to lessen the severity of symptoms, prevent brain damage over time, and reduce impairment and premature death from mental illness. States are involved in preventive efforts, such as education and awareness campaigns, as well as screening and assessment efforts to connect people to treatment.

State example: New Mexico School Mental Health Initiative was created in 1995. Aimed at improving student mental health, the Initiative provides services including early intervention training programs and pilot programs to perform mental health screening for teens.

Interagency and Multibranch Collaboration

State and community networks of care and services for mental health often have grown with little coordination or strategic planning. This lack of coordination and integration can make the mental health care system a confusing, bureaucratic tangle of programs. States have increasingly recognized the need for comprehensive, coordinated approaches for mental illness across multiple government agencies and branches of government.

State example: New Jersey's "Children's System of Care Initiative" integrates services throughout the child welfare, mental health, Medicaid, and juvenile justice agencies to create a single statewide integrated system of behavioral health services for children with serious emotional and behavioral disturbances and their families.

Integration of Mental Health with General Health Care

Mental health has long been financed separately from general primary care. However, most mental health care is delivered by primary care doctors in general health care settings. Separate systems of care may perpetuate the myth that mental health is different from overall physical health. Separate

Improving Access to Mental Health Care

States finance a large portion of mental health care and are responsible for overseeing the availability of mental health care. Some people, particularly those with serious mental illness, may not have access to services or be aware of what services are available. Cuts in federal, state or private sector funding can also seriously disrupt access to care for mental illness. States have used a variety of innovative approaches to ensure that clients have access to needed services.

systems also fragment monitoring and follow-up of patients, possibly contributing to errors, misdiagnosis and unnecessary complications.

Under Medicaid, some states negotiated mental health services contracts separately with managed care organizations and behavioral health providers because patterns of use among people with mental illness are different from with the overall population. Some states, however, performed mental health “carve outs” under Medicaid managed care in a way that created a bridge to primary care, created efficiencies in the system as a whole, and delivered cost-savings.

State example: Massachusetts “Value Options” Mental Health Carve Out has been hailed for its coordination of behavioral and physical health care.

Expansions of Health Care Coverage for People with Mental Illness

Recognizing that lack of health care coverage prevents many individuals from seeking needed care, Medicaid has played an increasing role in financing care for people with mental illness. States have expanded coverage to uninsured individuals. Methods to expand coverage include extending eligibility to very low-income adults without children, using premium assistance programs to help low-income workers access employer sponsored insurance, creating high risk pools for individuals who are priced out of the market due to chronic health care conditions, using new Medicaid buy-in options for people with disabilities and mandating that private insurance offer benefits for mental illness similar to general health care. State budget cuts and a drop in the number of employers offering health insurance benefits have threatened some of these coverage expansions.

State example: Authorized by the State Health Workforce Recruitment and Retention Act of 2002, New York’s Medicaid Buy-in program for people with disabilities began in July 2003. This program is aimed at helping people with psychiatric disorders and other disabling conditions to maintain health care coverage through Medicaid as they move into employment. The program also allows working individuals with psychiatric disorders who cannot afford or who are not offered coverage to buy-in to Medicaid to receive treatment that is crucial to recovery and continued employment.

Consumer Protections for Access to Care

People with mental illnesses, as those with other kinds of chronic conditions, require frequent use of health care services to maintain recovery. Services needed include doctor visits, medication management and inpatient and outpatient hospital treatment. Efforts to contain health care costs that restrict access to providers, treatments or medications, or that limit the number of days of treatment can hinder individuals with mental illnesses from receiving the care that is vital to maintaining recovery. Individuals with mental illness often require individually tailored treatments, because treatment and medications can vary greatly in their effectiveness in treating specific symptoms or disorders and in their side effects. In some cases, it can take years to find the right balance of medications for an individual with a serious and persistent mental illness. Advocates argue that treatment decisions should be made by the provider and patient based on patient acceptability, prior individual drug response, individual side-effect profile, and long-term treatment planning. States have taken steps to protect consumers with mental illness with both private and public coverage from burdensome restrictions on access to care, ranging from mental health parity laws to exemptions for mental health drugs from preferred drug lists.

State example: Michigan passed legislation in 2004 that prohibited the Medicaid program from instituting prior authorization on any central nervous system prescription drugs classified as an anticonvulsant, antidepressant, antipsychotic, or non-controlled substance antianxiety drug. Washington state, North Carolina and Florida have similar provisions.

Blended, Flexible Funding

Funding for mental health care and social services comes from federal, state and local sources as well as private funding. Blending funding across silos is essential to ensure efficient allocation of resources, close gaps and ensure access to appropriate care and supportive services.

State example: In 1999, the California legislature enacted AB 34 to provide integrated, comprehensive services to aid homeless mentally ill individuals. Operated by community mental health organizations, AB34 initiatives in California use flexible funding from the state to provide housing subsidies, rental assistance and supportive services necessary to assist individuals with finding housing and employment.

“No Wrong Door” Initiatives

States have recognized the need to provide outreach and assistance to families and individuals to ensure they can access treatment and services for mental illness. With these kind of approaches,

Assuring Quality Mental Health Care

Health care leaders have long known that there is a significant gap between what we know and what we do in health care. Gaps in quality of care result in inappropriate or unnecessary care being delivered, wasted resources, unnecessary complications, errors in treatment, and poor health outcomes. State mental health leaders are working to address gaps in quality through many approaches, such as using information technology, monitoring plan and provider performance on a variety of measures, providing consumers greater control over care and implementing evidence-based practices.

Implementing Evidence-Based Practices

states creatively ensure that no matter where an individual seeks services—whether through an emergency room visit, a night at a homeless shelter, a telephone inquiry to a state office or other contact—that there are links to assessment, treatment and supportive services needed to achieve recovery and a life in the community. States use state offices and programs, community-based programs and providers, and peer educators to ensure that an individual with one kind of need knows about and receives assistance with accessing other necessary services.

State example: Washington state’s Department of Social and Health Services has created a “No Wrong Door” program to coordinate services across various programs. Three specific groups were recognized as key targets for program coordination: people with multiple disabilities including mental illness; troubled youth and their families; and long-term welfare recipients, many of whom were dealing with chemical dependency or mental illness. For more information about Washington’s initiative, see www1.dshs.wa.gov/basicneeds/.

Information Technology

The President’s New Freedom Commission on Mental Health identified information technology as a key component to improving the quality of mental health care and outcomes. Telemedicine can ensure that mental health care is available in remote areas. Electronic medical records and electronic prescribing can ensure treatment follows accepted standards of quality; aid in diagnosis, treatment and long-term monitoring of patients; eliminate gaps in the information available to the range of providers delivering care; and prevent costly medical errors. States are implementing information technology in health care settings with appropriate concern and controls for protecting the privacy of people with mental illness.

State example: The Arizona Department of Health Services provided funding in 1996 to develop the Northern Arizona Regional Behavioral Health Authority to enhance the availability of behavioral health services across Northern Arizona. Since then, the Arizona TeleBehavioral Health Network has developed a centralized system for coordinating behavioral health services delivered via telemedicine in the state.

Performance Measurement

Some states have established programs to measure how well the care that is delivered conforms to accepted standards of quality. States have selected areas of care that they want to monitor, collect data from plans or providers on these performance measures and then analyze and compare performance. Based on this information, states can then develop targeted plans for improvement for specific providers or can implement system-wide initiatives aimed at improving outcomes for a specific measure. Performance measurement is relatively new to mental health, but more states are using performance measures to determine the effectiveness of their programs.

State example: The National Association of State Mental Health Program Directors (NASMHPD) formed a task force in 1997 to develop consensus measures for mental health care for use by hospitals and other health care institutions in the accreditation process. Examples of performance measures for mental health developed by the task force include consumer assessment of access, quality and outcomes; reduction in symptoms; follow-up contact within seven days of hospital discharge; employment rates; and contact with the criminal justice system. For more information on performance measures and quality improvement efforts in mental health, see the NASMHPD National Research Institute at www.nri-inc.org/.

Consumer Directed Care

Some states are working to increase opportunities for consumers to control their care and who provides it, based on the belief that an engaged consumer is the best guardian of quality, cost-effective care.

State example: Florida’s Self-Directed Care pilots were authorized in June 2000 through enactment of SB 682/HB 421 by the Florida legislature. Under the program, individuals with serious mental illnesses who rely on publicly financed mental health services may select vendors of their choice to perform services and provide care. Participants in the program determine the services they need. A community advisory board guides the program, and outcomes are being evaluated compared with the traditional system of care.

Assertive Community Treatment/Intensive Case Management

This approach to mental health care uses a multidisciplinary team of professionals to provide community-based, comprehensive, integrated services for clients. All services are coordinated and delivered through the team rather than through multiple providers at multiple sites.

Implementing Evidence-Based Practices, *continued*

Efforts to improve quality have also focused on disseminating information and highlighting evidence-based practices, which are interventions that have undergone rigorous scientific evaluation for effectiveness. While there is still some debate over what constitutes an evidence-based practice and who makes this determination, many researchers agree that there is enough scientific evidence for certain mental health interventions to warrant their widespread adoption.

State example: Rhode Island’s Assertive Community Treatment (ACT) program uses 11 mobile treatment teams to provide medical care, job training, substance abuse counseling and 24-hour crisis intervention across the state.

Medication Management/Algorithms

States are ensuring that standards of quality and appropriate use are followed and monitored in prescribing mental health drugs. State programs use provider guidelines, algorithms/flow charts or case management to ensure that health care professionals are prescribing mental health medications using the best available scientific evidence regarding appropriateness and effectiveness.

State example: Texas Medication Algorithm Project (T-MAP) is an evidence-based system for managing medications for people with severe psychiatric disorders to improve quality of care and outcomes. Clinicians follow a step-by-step flow chart to determine which medications may be most appropriate for an individual patient. TMAP also provides clinical and technical support to providers in an effort to make care more consistent, and education to patients and their family members so they can be actively involved in the decision-making process.

Integrated Treatment for Co-Occurring Disorders

In the past, substance abuse and mental health services were part of distinct systems. People with co-occurring disorders—those diagnosed with substance use disorders and one or more mental disorders—were often treated for these conditions separately and often simultaneously at great cost, with gaps in care and lacking coordination. As a growing body of research indicated that comprehensive, integrated treatment could improve outcomes and be cost-effective, states have moved to create programs and integrate services to deal with people with co-occurring disorders.

State example: Arizona’s Department of Health Services’ Division of Behavioral Health established a statewide Integrated Treatment Consensus Panel that in 1999 produced a set of principles for improving treatment for people with co-occurring mental health and substance use disorders. These principles have guided the panel as it has developed additional guidelines, procedures and training for providers in the state on integrated treatment models.

Patient Self-Management

As with any chronic health condition, patient self-management and assessment is critical to maintaining health and reducing preventable complications from mental illness. Recognizing the importance of education and motivation for people with mental illness to manage their symptoms and recovery, states have instituted strategies to empower consumers to manage their health and treatment.

State example: The New York State Office of Mental Health has adopted wellness self-management as a key part of its strategy to implement evidence-based practices in mental health care in the state.

Supported Employment

Research has demonstrated that more than 60 percent of adults with mental illness can work if supportive employment is offered. Supportive employment programs use pre-employment assistance, training and coaching by employment specialists knowledgeable about mental health issues. Supportive employment opportunities are integrated with an individual’s mental health treatment plan.

State example: Oregon’s Department of Human Services has developed the Oregon Employment Initiative to assist people with disabilities with finding employment. Trained employment specialists meet with consumers, help them develop goals and assist them with accessing employment and necessary support services.

Family Psychoeducation

This approach involves working with families to help them handle issues associated with having a family member with mental illness and develop a family environment that supports recovery. Practitioners work with family members individually and in group settings to educate them about mental illness, help them build coping skills, develop strategies and communication techniques for handling difficult situations, strengthen supportive, respectful interaction and enhance connections to support groups.

State example: New Jersey’s Intensive Family Support Services program has provided an array of services to families since 1989 and is the only state to use this approach statewide. Education, consultation and support programs are offered to any family that has a member with a serious mental illness regardless of the family’s ability to pay.

CSG’s Mental Health Tool Kit was made possible through an unrestricted educational grant from Wyeth.



Sample Mental Health Legislation Table

Consumer Protection Measures—Pharmacy Benefits

State	Bill/Statute	Description
Indiana	IC 12-15-35.5-3	Exempts mental health medications from access restrictions.
Louisiana	SB 689, 2004	Requires the Department of Health and Human Services to report on evaluations of the cost of administering the preferred drug list and the use of medical services provided by the state and any correlation to the preferred drug list.
Maryland	HB 363, 2003	Provides a Pharmacy Access Hotline for recipients who have problems obtaining needed medications or have other pharmacy-related problems.
Minnesota	HF 351, 2002	If prior authorization of a drug is required by the commissioner, the commissioner must provide a 30-day notice period before implementing the prior authorization. If a prior authorization request is denied by the department, the recipient may appeal the denial. If an appeal is filed, the drug must be provided without prior authorization until a decision is made on the appeal.
Oregon	S.819, 2001	Exempts mental medications from access restrictions.
South Carolina	SC ST SEC 44-22-10	Ensures proper medical services for persons with mental illness.
Vermont	H. 485, 123 2001	Authorizes pharmacy benefit coverage when a patient's health care provider prescribes a prescription not on the preferred drug list.
Wisconsin	SB 44, 2003	Allows exceptions for patients who are stabilized on nonpreferred medications into the states' preferred drug lists.

Mental Health Parity Laws

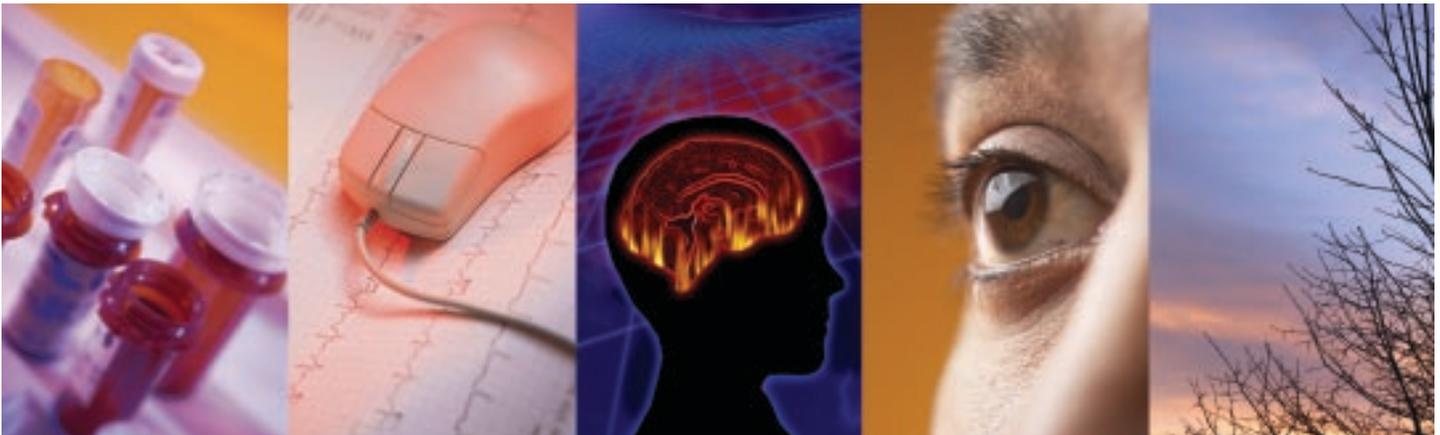
State	Bill/Statute	Description
Vermont	Act 25	Enacted in 1997. Removed the remaining limits placed on MH/SA coverage, including separate outpatient visit or inpatient day limits and higher deductibles and coinsurance rates. The Vermont law also extended parity to substance abuse benefits.
New Mexico	Stat. ann. 59A-23E-18	Requires that group plans must not have treatment limitations or financial requirements on the provision of mental health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions. The scope of the law includes those mental health benefits described in the group health plan, or group health insurance offered in connection with the plan. The law does not apply to benefits for the treatment of substance abuse, chemical dependency, or gambling addictions. The law includes a cost exemption that allows employers that qualify to opt out.
Virginia	VA Code 38.2-3412.1	State health care plans, health insurers, health service plans and HMO's must provide coverage for biologically based mental illness which may not be different or separate from coverage for any other illness.
Kansas	K.S.A. 40-2258	Provides that all group health insurance policies, medical service plans, contracts, hospital service corporation contracts, hospital and medical service corporation contract, and HMO's which provide coverage for mental health benefits to include coverage for the diagnosis and treatment of mental illness under the same conditions as any other type of health care.

Mental Health/Criminal Justice Initiatives

State	Bill/Statute	Description
Arizona	Rev. Stat. 31-132 & 31-224	Requires that a prisoner's medical record file, including the prisoner's mental health file, be transmitted before or during the inmate's transfer between a county jail and state department of corrections facility.
Colorado	Rev. Stat. 16-11.9-101 et seq	Requires the development of a standardized procedure to screen for mental illness in the adult criminal justice and juvenile justice systems. The standardized procedure would be used by law enforcement, courts, and correction agencies across the state. This also requires consideration of confidentiality issues and further assessment for those with possible mental illness.
Michigan	Comp. Laws Sec. 801.55	Authorizes sheriffs and circuit, district, municipal, and recorder's court judges to use methods including the reduction of waiting time for prisoners awaiting psychiatric evaluations and the use of community mental health resources as alternative to incarceration for appropriate individuals.
Maine	34-B M.R.S.A 1219	Instructs state officials to develop a plan to train state law enforcement personnel about serious mental illness and methods for evaluating, treating, and managing persons with serious mental illness.
Pennsylvania	Senate Resolution No. 125, 2003	Directs a state panel to review information about the fiscal impact of three mental health programs in Pennsylvania to determine if similar programs could be established across the state. This resolution also directs the Legislative Budget and Finance Committee to review the fiscal impact of two mental health diversion programs and another program that assists offenders with mental illness after they are released from state prisons.
Texas	Ch. 614	Establishes the Texas Council on Offenders with Mental Impairments, and directs the council to establish several pilot programs and oversee all offenders with mental impairments. This legislation also develops more collaboration among mental health agencies that are involved with the criminal justice system and ensures continuity of care for offenders with mental illness.
Washington	Rev. Cod 72.09.370	Requires the identification of inmates in state prisons who have a mental disorder and assigns a team of representatives from pertinent organizations such as community corrections, state mental health facilities, etc. The team works with the offender to develop a comprehensive transition plan.
Illinois	Public Act 93-0495	Establishes a Children's Mental Health Partnership and 25 member task force appointed by the Governor. The Partnership is responsible for developing and monitoring the implementation of the Children's Mental Health Plan.
Kentucky	HB843, 2000	Establishes a commission to address the need for a comprehensive state plan to serve Kentuckians who suffer from mental illness, a substance abuse disorder, or both. It also established a planning process that put emphasis on local participation and decision making.
Nevada	SB301, 2003	Develops the Nevada Mental Health Plan Commission, which is tasked with formulating strategies to move the state toward the goals laid out in the President's New Freedom Commission on Mental Health.

Legislative Language from Advocacy Organizations

Organization	Title	Description
NAMI-North Carolina	Mental Illness Recovery Act	www.naminc.org/omira.htm —NAMI has proposed model legislation called the Omnibus Mental Illness Recovery Act (OMIRA) to establish across the country a baseline of care and to spur a national movement toward improved care for individuals with mental illnesses. NAMI North Carolina is working to implement the goals of OMIRA over the next five years.
The Bazelon Center for Mental Health Law	A New Vision on Public Mental Health	www.bazelon.org/issues/general/publications/newvision/ —The Bazelon Center has set out to reshape the debate about mental health system reform by developing and disseminating a model law for adaptation by states and localities.



Maximizing Media Coverage for Mental Health Transformation

by Nancy Coffey, Media Spotlight

For state leaders interested in changing their state’s mental health system, the task can be daunting. Media coverage is crucial for attracting attention to the need for transformation of mental health care and for building support for systemic change. Consider a dual approach: take your story directly to the news media through news conferences and briefings but also attract their coverage of the actual events and steps you are taking

to advance your issues. Invite them to cover hearings and town hall meetings, working sessions with stakeholders and advocacy groups, and floor action on legislation or resolutions. Provided below are some considerations for state leaders in developing a communications strategy and engaging the media on this issue.

Key Idea:

Reporters just want a good story. The challenge to you is how to make reporters want your good story.

Persuading the media of the need for reforming or enlarging the state’s role in providing quality mental health care will require grabbing their attention and then holding it with messages that evoke drama, emotion and public spirit but also appeal to self interest. The public knows mental illness is a problem that has serious costs to society: homelessness, unemployment, and crime among them. But the public and media remain skeptical that anyone ever recovers from serious mental illness, or that state mental illness programs can have a positive impact. You will have to prove your point in public events, opinion pieces, background briefings, and editorial board meetings. And, you will have to demonstrate your progress by continuing to gain allies.

Key Idea:

Have simple, concise, compelling messages and good back-up.

The media’s time is short and the space allotted to your issue may be less than you hope. You will need to synthesize this difficult issue into three or four compelling messages. Be prepared to tell your story the way the media does; headlining or summarizing the most interesting, affecting and newsworthy information first and then backing it up with what we know is your overwhelming evidence. None of this supplemental information will have any impact unless you can effectively encapsulate your key points and make them come alive. Your information packet should give reporters all the background and resources they need to write stories about your message. Be sure to provide easy-to-follow fact sheets and summaries that will put into context the other information in your packet. Those materials would include white papers, reports, statistics, articles and legislative proposals.

Key Idea:

Be quotable.

The most news savvy communicators know they can’t wing effective sound bites. Before they meet with reporters, they write at least a couple of effective sentences they know will be quotable and then practice their delivery. These good quotes can be metaphors or analogies that capture the imagination, or lively language that drives home the commonality or common sense of the issue. You can quote someone famous or link the issue to a popular trend or word play. Sentence structure should be simple using active verbs and colorful language that paints a picture.

Key Idea:

Nothing succeeds like success.

There are two levels of success that will be of interest to reporters and the public: people who had serious mental illness and are in recovery; and programs you have identified as “best practices” that have actually delivered successes. The most important and compelling success stories are told by real people. This is important to demonstrate to the skeptics that people do recover, and it embodies elements that the media find attractive. “Real people” put a sympathetic human face on the issue and help the public relate. They also provide emotion and drama, especially in light of the continuing stigma of mental illness. Because of that stigma, in some cases family members may have to speak for their loved ones, but there will also be other ways for reporters to tell this story that will protect an individual’s

Key Idea, *continued*
Nothing succeeds like success.

Key Strategies for Communicating Your Plan

identity. In addition, find ways to let reporters cover programs that use the successful evidence-based practices. Your allies in the treatment and patient community can help you identify effective programs and individuals.

News Release: Provide ample back up and examples but make sure your press release is only one or two uncluttered pages that hits the most newsworthy highlights.

News Conference: You are probably a good judge of how reporters view bill introduction news conferences in your state; they may not consider them worthy of attention unless you can bring some additional dimension to the event. Do you have a strong bipartisan coalition or a pairing of political odd bed-fellows who have come together for something crucial to the public? Do you have interesting poll results that you can release? Can you bring together individuals and groups that can dramatically illustrate the problem and solution? Remember to include “real people.” Reporters are generally on tight deadlines, so be sure that all participants have brief pithy statements and that you start taking questions within 20 minutes or less.

Background Briefings: These are useful when you have important complex issues that you want reporters to understand and write about. By labeling it background and scheduling it at a convenient time and place; you are signaling the reporter that you are not promising “news” for that day necessarily but something that they will want to cover in depth. Breakfast or lunch briefings can make the meeting more informal. You will want to invite key allies or experts to add depth and dimension to the session. You might also want to make individual appointments with reporters and visit them at their offices to brief them. Called **Deskside Briefings**, these are aimed at particular reporters you consider essential to good coverage .

Editorial Board Meetings: These are sessions at newspapers with editorial writers and sometimes the beat reporter that will be covering your issue. You are there to give them background and information on what to expect as you push your agenda. This is another example of taking your story to the newspaper in the hope of winning favorable editorial support and consistent coverage.

Facility Tours: Can you provide reporters access to some of the programs that have proved their worth? Of course you will have to take steps to protect an individual’s privacy, but letting reporters talk to the people on the front lines of this fight will be important to you and of interest to reporters.

Opinion Page Editorials (Op Eds): Opinion pieces aimed at persuading the public to support your issue should touch on both the emotional and the practical. It is important that the public understand that people can recover from serious illness and that the state has a crucial role to play. Start out if you can with a brief story of someone in your state that has recovered and gone on to become a contributing member of society or highlight a program with a real track record. Groups in your state should help you identify these success stories.

Hearings: This is another opportunity to highlight your issue for reporters and the public. Be sure to call witnesses who emblemize the possibility for success. Often you will get even better coverage of your issue if you can package it for TV. If you can offer a television station the opportunity to spend some time alone with one of your witnesses before they testify, the station may put together a moving effective piece that will emphasize the importance of your legislation.

Floor Speeches: Make sure your speech has several memorable sound bites that you deliver with emphasis. This might also be a good opportunity to read portions of emotional letters from individuals who have suffered from mental illness or their families.

Be Opportunistic: Look for ways to link your issue to breaking news or legislative developments. Consider holding town hall style meetings on this issue or organizing volunteers in creative ways that might also attract news coverage. Update reporters when you gain an important ally or a prominent individual joins your cause. This can be done through press releases, news conference or even a simple phone call.

Nancy Coffey is president of Media Spotlight, a communications consulting firm in Washington, D.C. Prior to forming Media Spotlight, Ms. Coffey was senior vice president and director of Ketchum’s Communications Training Center in Washington, D.C., responsible for providing high-level, high-value executive education programs. Ms. Coffey formerly served as deputy assistant secretary for public affairs for the Department of Labor. For nine years she was a top aide to a U.S. senator serving as communication director and later chief of staff. Ms. Coffey’s previous positions in the media also included broadcast news management in both radio and television in several major markets and service as a national radio correspondent covering Capitol Hill and the White House.

About the Author

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Listing of National and State Mental Health Agencies, Organizations and Programs

National Organizations

U.S. Dept. of Health and Human Services
Substance Abuse and Mental Health
Services Association
P.O. Box 42557
Washington, DC 20015
1 (800) 789-2647
www.samhsa.gov

National Institute of Mental Health
Office of Communications
6001 Executive Blvd., Room 8184, MSC 9663
Bethesda, MD 20892-9663
(301) 443-4513
1 (866) 615-6464 (toll-free)
www.nimh.nih.gov

Bazelon Center for Mental Health Law
1101 15th St., N.W., Suite 1212
Washington, DC 20005
(202) 467-5730
www.bazelon.org

National Alliance for Mental Illness
Colonial Place Three
2107 Wilson Blvd., Suite 300
Arlington, VA 22201-3042
(703) 524-7600
www.nami.org

The National Mental Health Association
2001 N. Beauregard St., 12th Floor
Alexandria, VA 22311
1 (800) 969-NMHA
www.nmha.org

**The National Association of State Mental
Health Program Directors**
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
(703) 739-9333
www.nasmhpd.org

American Psychiatric Association
1000 Wilson Blvd, Suite 1825
Arlington, VA 22209-3901
(703) 907-7300
www.psych.org

American Psychological Association
750 First St., N.E.
Washington, DC 20002-4242
1 (800) 374-2721
www.apa.org/

Alabama

Alabama State Mental Health Program
Department of Mental Health
and Mental Retardation
RSA Union Building
100 N. Union St.
P.O. Box 301410
Montgomery, AL 36130-3417
(334) 242-3107
www.mh.state.al.us/

Alabama Mental Health Association
1116 South Hull St.
Montgomery, Alabama 36104
(334) 262-5500
www.mha-montgomery.org

NAMI Alabama
6900 Sixth Ave. S., Suite B
Birmingham, AL 35212-1902
1 (800) 626-4199
namialabama.org

Alabama Psychiatric Society
Judy R. Lovelady, Executive Director
P.O. Box 1900
Montgomery, AL 36102
334-954-2579
Fax: 334-269-5200
jlulvady@bellsouth.net

Alaska

Alaska State Mental Health Program
Department of Health and Social Services
P.O. Box 110620
Juneau, AK 99811-0620
(907) 465-3370
www.hss.state.ak.us/dbh/

Mental Health Association in Alaska
4045 Lake Otis Pkwy., Suite 209
Anchorage, AK 99508
(907) 563-0880
www.alaska.net/~mhaa/indexnfn.html

NAMI Alaska
144 W. 15th Ave
Anchorage, AK 99501-5106
(907) 277-1300
www.nami.org/sites/alaska

Alaska District Branch
Kay Schaugard, Executive Secretary
P.O. Box 231147
Anchorage, AK 99523-1147
(907) 566-7800
Fax: (907) 522-3802
schaugard@gci.net

Arizona

Arizona State Mental Health Program
Division of Behavioral Health Services
150 N. 18th Ave., #200
Phoenix, AZ 85007
(602) 364-4558
www.hs.state.az.us/bhs/index.htm

Mental Health Association of Arizona
6411 E. Thomas Rd.
Scottsdale, AZ 85251
(480) 994-4407
www.mhaarizona.org/

NAMI Arizona

2210 N. Seventh St.
Phoenix, AZ 85006-1604
(602) 244-8166
az.nami.org/

Arizona Psychiatric Society

PMB 101
4730 East Indian School Rd. #120
Phoenix, AZ 85018
(602) 808-9558
exec@azpsych.org
www.azpsych.org

Arkansas

Arkansas State Mental Health Program

Division of Mental Health Services
Department of Human Services
4313 W. Markham St.
Little Rock, AR 72205-4096
(501) 686-9164
www.state.ar.us/dhs/dmhs/

Mental Health Council of Arkansas

501 S. Woodlane, Suite 104
Little Rock, AR 72201
(501) 372-7062
www.mhca.org/

NAMI Arkansas

712 W. Third St., Suite 200
Little Rock, AR 72201-2222
(501) 661-1548
ar.nami.org

Arkansas Psychiatric Society

Barbara Stockton, Executive Director
P.O. Box 250910
Little Rock, AR 72225
(501) 663-6182
Fax: (501) 663-6182
arkpsyche@aol.com

California

California State Mental Health Program

Department of Mental Health
Health and Welfare Agency
1600 Ninth St., Room 151
Sacramento, CA 95814
(916) 654-3565
www.dmh.cahwnet.gov

California Mental Health Association

1127 11th St., Suite 925
Sacramento, CA 95814
(916) 557-1167
www.mhac.org/

NAMI California

1111 Howe Ave., Suite 475
Sacramento, CA 95825-8541
(916) 567-0163
www.namicalifornia.org

Central California Psychiatric Society

Josephine Coy, Executive Director
P.O. Box 1071
Fresno, CA 93714-1071
(559) 228-6140
Fax: (559) 227-1463
jcoy@pesc.com
www.cencalpsych.org

Colorado

Colorado State Mental Health Program

3824 West Princeton Circle
Denver, CO 80236
(303) 866-7400
www.cdhs.state.co.us/ohr/mhs/

Mental Health Association of Colorado

6795 E. Tennessee Ave., Suite 425
Denver, CO 80224
(303) 377-3040
www.mhacolorado.org

Colorado Psychiatric Society

Laura F. Michaels, J.D., Executive Director
6000 E. Evans Ave.
Building 1, Suite 140
Denver, CO 80222
(303) 692-8783
(303) 692-8823
cps@nilenet.com
www.coloradopsychiatric.org

Connecticut

Connecticut State Mental Health Program

410 Capitol Ave.
Hartford, CT 06106
(860) 418-6700
1 (800) 446-7348 (toll free)
Fax: (860) 418-6691
www.dmhas.state.ct.us

Mental Health Association of Connecticut

20–30 Beaver Rd.
Wethersfield, CT 06109
(860) 529-1970
www.mhact.org

NAMI of Connecticut, Inc.

30 Jordan Ln., 3rd Floor
Wethersfield, CT 06109
(860) 882-0236
www.namict.org/

Connecticut Psychiatric Society

Jacquelyn Coleman, Executive Director
One Regency Dr.
P.O. Box 30
Bloomfield, CT 06002
860-243-3977
Fax: 860-286-0787
cps@ssmgt.com

Delaware

Delaware State Mental Health Program

1901 N. DuPont Hwy., Main Building
New Castle, DE 19720
(302) 255-9399
www.state.de.us/dhss/dsamh/dmhhome.htm

Mental Health Association in Delaware

100 W. 10th St., Suite 600
Wilmington, DE 19801
(302) 654-6833
www.mhainde.org

Psychiatric Society of Delaware

Carolyn J. Barczak, Executive Secretary
131 Continental Dr., #405
Newark, DE 19713-4308
(302) 658-7596
Fax: (302) 658-9669
cjb@medsocdel.org

Florida

Florida State Mental Health Program

1317 Winewood Blvd.
Building 1, Room 202
Tallahassee, FL 32399-0700
(850) 487-1111
Fax: (850) 922-2993
www.state.fl.us/cf_web/

Mental Health Association of Central Florida

7120 Lake Ellenor Dr.
Orlando, FL 32809
(407) 855-0888
www.mhacf.com

NAMI Florida

911 E. Park Ave.
Tallahassee, FL 32301
(850) 671-4445
www.namifl.org

Florida Psychiatric Society

Margo S. Adams, Executive Director
521 E. Park Ave.
Tallahassee, FL 32301-2524
1 (800) 521-7465 (toll free)
Fax: (850) 224-8406
margo@floridapsych.org
www.floridapsych.org

Georgia

Georgia State Mental Health Program

Department of Human Resources
2 Peachtree St., N.W., Suite 22-224
Atlanta, GA 30303
(404) 657-2168
www2.state.ga.us/departments/dhr/mhmrsa/index.html

NMHA of Georgia

100 Edgewood Ave., N.E., Suite 502
Atlanta, GA 30303
(404) 527-7175
www.nmhag.org

NAMI Georgia

3050 Presidential Dr., Suite 202
Atlanta, GA 30340-3916
(770) 234-0855
nami-ga.org

Georgia Psychiatric Physicians Association, Inc.

Lasa Joiner, Interim Executive Director
487 Winn Way, #100
Decatur, GA 30030
(404) 298-7100
Fax: (404) 299-7029
info@gapsychiatry.org
www.gapsychiatry.org

Hawaii

Hawaii State Mental Health Program

Department of Health
1250 Punchbowl, #256
Honolulu, HI 96813
(808) 586-4686
Fax: (808) 586-4745
admin@amhd.org
www.amhd.org

NAMI Hawaii State

84-1170 Farrington Hwy., C-1
Waianae, HI 96792-2025
(808) 524-5900
namihawaii@hawaii.rr.com

Mental Health Association of Hawaii

200 N. Vineyard Blvd., Suite 300
Honolulu, HI 96817
www.mhahawaii.org

Hawaii Psychiatric Medical Association

Lydia Hardie, Executive Director
5090 Likini St., #1601
Honolulu, HI 96818
(808) 839-3070
Fax: (808) 839-5867
lydiahpma@aol.com
www.hawaiiipsychiatric.org

Idaho

Idaho State Mental Health Program

Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5528
Fax: (208) 334-6699
www2.state.id.us/dhw/mentalhealth/

NAMI of Idaho

P.O. Box 68
362 West St.
Albion, ID 83311-0068
(208) 673-6672
www.nami.org/sites.NAMIIDAHO

Idaho Psychiatric Association

Suzette Driscoll, Executive Secretary
Business Psychology Associates
300 E. Mallard Dr., #350
Boise, ID 83706
(208) 947-1318
suzetted@bpahealth.com

Illinois

Illinois State Mental Health Program

Department of Human Services
319 E. Madison St., Centrum Building, 3rd Floor
Springfield, IL 62701
(217) 785-6023
Fax: (217) 785-3066
www.dhs.state.il.us/mhdd/mh/

Illinois Mental Health Association

188 W. Randolph St., Suite 2225
Chicago, IL 60601
(312) 368-9070
www.mhai.org/

Mental Health Association in Illinois

188 W. Randolph St., Suite 2225
Chicago, IL 60601
(312) 368-9070
www.mhai.org

NAMI Illinois

218 W. Lawrence Ave.
Springfield, IL 62704-2612
(217) 552-1403
www.il.nami.org

Illinois Psychiatric Society

Marsha Holub, Executive Director
20 N. Michigan Ave., Suite 700
Chicago, IL 60602
(312) 263-7391
(312) 782-0553
holub@isms.org
www.illinoispsychiatricsociety.org

Indiana

Indiana State Mental Health Program

Division of Mental Health
Department of Family and Social
Services Administration
402 W. Washington St., Room W-353
Indianapolis, IN 46204-2739
(317) 232-7844
Fax: (317) 233-3472
dfss@state.in.us
www.in.gov/ipas/paimi.html

NAMI Indiana

P.O. Box 22697
Indianapolis, IN 46222-0697
(317) 925-9399
www.namiindiana.org

Indiana Psychiatric Society

Bev Hurt, Secretary
631 E. New York St.
Indianapolis, IN 46202
(317) 639-3406
Fax: (317) 262-5609
ims@imsonline.org
www.indianapsych.org

Iowa

Iowa State Mental Health Program

Iowa Department of Human Services—
Bureau of Protective Services
1305 E. Walnut, 5th Floor
Des Moines, IA 50319-0114
(515) 281-6004
jchesni@dhs.state.ia.us
www.dhs.state.ia.us/mhdd/

NAMI Iowa

Margaret Stout
591 I Meredith Dr., Suite E.
Des Moines, IA 50322-1903
(515) 254-0417
amiiowa@aol.com

Iowa Psychiatric Society

Karen Loihl, Executive Director
PMB 338
2643 Beaver Ave.
Des Moines, IA 50310-3909
(515) 633-0341
Fax: (515) 279-5206
iowapsych@mchsi.com
www.iowapsych.org

Kansas

Kansas State Mental Health Program

915 S.W. Harrison St.
Topeka, KS 66612
(785) 296-3959
www.srskansas.org/

NAMI Kansas

112 S.W. Sixth Ave., Suite 505
P.O. Box 675
Topeka, KS 66601-0675
(785) 233-0755
www.namikansas.org

Kansas Mental Health Association

3745 S.W. Wanamaker Rd.
Topeka, KS 66610
(620) 325.3938
asknbeg@terraworld.net

Kansas Psychiatric Society

Steve Kearney, Executive Director
1200 S.W. 10th Ave.
Topeka, KS 66604
(785) 233-7154
(785) 234-2433
skearney@epiphanyworks.com

Kentucky

Kentucky State Mental Health Program

The Kentucky Department for Mental Health and Mental Retardation Services
c/o The Commissioner's Office
100 Fair Oaks Ln., 4E-B
Frankfort, KY 40621
mhmr.ky.gov/

Mental Health Association of Kentucky

120 Sears Ave., Suite 213
Louisville, KY 40207
(502) 638.3501
www.mhaky.org

NAMI Kentucky

10510 Lagrange Rd., Building 103
Louisville, KY 40223-1277
ky.nami.org

Kentucky Psychiatric Medical Association

Theresa Walton, Executive Director
P.O. Box 198
Frankfort, KY 40602
(502) 695-4843
Fax: (502) 695-4441
waltonkpa@aol.com
www.kypsych.org

Louisiana

Louisiana State Mental Health Program

Louisiana Department of Health & Hospitals
1201 Capitol Access Rd.
P.O. Box 629
Baton Rouge, LA 70821-0629
(225) 342-9500
www.dhh.state.la.us/offices/?ID=62

NAMI Louisiana

11762 S. Harrells Ferry Rd., Suite D
Baton Rouge, LA 70816
(225) 292-6928
la.nami.org

Mental Health Association in Louisiana

263 Third St., Suite 103
Baton Rouge, Louisiana 70801
(225) 343-1921
MHAL15@aol.com

Louisiana Psychiatric Medical Association

Charlene Smith, Executive Director
P.O. Box 15765
New Orleans, LA 70175
(504) 891-1030
Fax: (504) 891-1077
lpma@lpma.net
www.lpma.net

Maine

Maine State Mental Health Program

State of Maine Department of Behavioral and Developmental Services
40 State House Station
Augusta, ME 04333-0040
(270) 287-4200
www.state.me.us/dmhmrsl/Contact.html

NAMI—Maine

1 Bangor St
Augusta, ME 04330-4701
(207) 622-5767
me.nami.org

Maine Psychiatric Association

Warene Chase-Eldridge, Executive Secretary
c/o Maine Medical Association
P.O. Box 190
Manchester, ME 04351-0190
(207) 622-7743
Fax: (207) 622-3332
weldridge@mainemed.com
www.mainepsych.org

Maryland

Maryland State Mental Health Program

Mental Hygiene Administration
Spring Grove Hospital Center
55 Wade Ave., Dix Building
Catonsville, MD 21228
(410) 402-8300
www.dhmd.state.md.us/mhal/

NAMI Maryland

711 W. 40th St., Suite 451
Baltimore, MD 21211
(410) 467-7100
www.md.nami.org

MHA of Maryland

711 West 40th St., Suite 460
Baltimore, MD 21211
(410) 235-1178
www.mhamd.org

Maryland Psychiatric Society, Inc.

Judy Jacobson, Executive Director
1101 St. Paul St., #305
Baltimore, MD 21202
(410) 625-0232
Fax: (410) 625-0277
jjacobson@mdpsych.org
www.mdpsych.org

Massachusetts

Massachusetts State Mental Health Program

Department of Mental Health
Central Office
25 Staniford St.
Boston, MA 02114
(617) 626-8000
www.mass.gov/dmh/_MainLineMissionStatement.HTM

NAMI Massachusetts

400 W. Cummings Park, Suite 6650
Woburn, MA 01801-6528
www.namimass.org

Massachusetts Psychiatric Society

Cheryl Davenport, Executive Director
40 Washington St., #201
Wellesley Hills, MA 02481
(781) 237-8100
(781) 237-7625
cdavenport@psychiatry-mps.org
www.psychiatry-mps.org

Michigan

Michigan State Mental Health Program

320 South Walnut St.
6th Floor, Lewis Cass Building
Lansing, Michigan 48913
(517) 373-3740
www.michigan.gov/mdch

Mental Health Association in Michigan

30233 Southfield Rd., Suite 220
Southfield, MI 48076
(248) 647-1711
www.mha-mi.org/

NAMI Michigan

921 N. Washington
Lansing, MI 48906
1 (800) 331-4264 (toll free)
(517) 485-4049
Fax: (517) 485-2333
mi.nami.org/

Michigan Psychiatric Society

Kathleen Gross, Executive Director
271 Woodland Pass, #125
East Lansing, MI 48823
(517) 333-0838
Fax: (517) 333-0220
kgross@mpsonline.org
www.mpsonline.org

Minnesota

Minnesota State Mental Health Program

Minnesota Department of Human Services
444 Lafayette Rd., N.
Saint Paul, MN 55155
www.dhs.state.mn.us/main/groups/agencywide/documents/pub/dhs_Home_Page.hcsp

NAMI Minnesota

970 Raymond Ave., Suite 105
 Saint Paul, MN 55114
 (651) 645-2948
www.nami.org/namimn

Minnesota Psychiatric Society

Linda Vukelich, Executive Director
 4707 Hwy. 61, #232
 St. Paul, MN 55110-3227
 (651) 407-1873
 Fax: (651) 407-1754
l.vukelich@comcast.net
www.mnpsychsoc.org

Mississippi**Mississippi State Mental Health Program Department**

1101 Robert E. Lee Building
 239 N. Lamar St.
 Jackson, MS 39201
 (601) 359-1288
www.dmh.state.ms.us/

NAMI Mississippi

411 Briarwood Dr., Suite 401
 Jackson, MS 39206-3058
 (601) 899-9058
www.nami.org/about/amims

MHA of Mississippi

P.O. Box 7329
 Gulfport, MS 39506
 (228) 864-6274
brandih@excite.com

Mississippi Psychiatric Association, Inc

Angela Ladner, Executive Director
 411 Briarwood Dr., #401
 Jackson, MS 39206
 (601) 957-9800
 Fax: (601) 956-6380
mpa39206@aol.com

Missouri**Missouri State Mental Health Program**

Missouri Department of Mental Health
 P.O. Box 687
 Jefferson City, MO 65101
 1 (800) 364-9687 (toll free)
www.dmh.missouri.gov/

Mental Health Association of Greater St. Louis

1905 S. Grand Blvd.
 St. Louis, MO 63104
www.mhagstl.org

NAMI Missouri

1001 Southwest Blvd., Suite E
 Jefferson City, MO 65109
 (573) 761-5636
mocami@aol.com
mo.nami.org/

Montana**Montana State Mental Health Program**

111 N. Sanders
 P.O. Box 4210
 Helena, MT 59604-4210
 (406) 444-5622
www.dphhs.state.mt.us/

NAMI Montana

554 Toole Ct.
 Helena, MT 59602
 (406) 443-7871
www.namimt.org

Mental Health Association of Montana

Montana Mental Health Association
 25 S. Ewing, Suite 206
 Helena, Montana 59601
 (406) 442-4276
www.mhamontana.org/

Montana Psychiatric Association

Jerri Gillibrand, Executive Secretary
 P.O. Box 87
 Warm Springs, MT 59756
 (406) 693-9073
tomnjerri@montana.com

Nebraska**Nebraska State Mental Health Program**

P.O. Box 95044
 Lincoln, NE 68509-5044
 (402) 471-2306
www.hhs.state.ne.us/beh/mhsa.htm

NAMI Nebraska

1941 S. 42nd St., Suite 517
 Omaha, NE 68105-2986
 (877) 463-6264
www.nami.org/sites/ne

Mental Health Association of Nebraska

1645 North St., Suite A
 Lincoln, NE 68508
 (402) 441-4371
www.mha-ne.org

Nebraska Psychiatric Society

Shelly Montgomery, Executive Secretary
 UNMC
 Consultation/Liaison Psych
 988470 Nebraska Med. Center
 Omaha, NE 68198-8470
 (402) 552-2117
 Fax: (402) 552-2119
smontgom@unmc.edu

Nevada**Nevada State Mental Health Program**

505 E. King St., Room 602
 Carson City, NV 89701-3790
 (775) 684-5943
www.mhds.state.nv.us/

NAMI Nevada

1170 Curti Dr.
 Reno, NV 89502
 (775) 322-1346
 Fax: (775) 329-3260
www.nami-nevada.org

Nevada Psychiatric Association

William Stone, M.D.
 1813 S. Valley View Blvd.
 Las Vegas, NV 89102-3903
 (702) 877-6000
 Fax: (702) 877-6000
nvapa@aol.com

New Hampshire**New Hampshire State Mental Health Program**

105 Pleasant St.
 Concord, NH 03301
 (603) 271-6100
www.dhhs.state.nh.us/DHHS/DHHS_SITE/default.htm

NAMI—New Hampshire

15 Green St.
 Concord, NH 03301-4020
 (603) 225-5359
www.naminh.org

New Hampshire Psychiatric Society

Ginny Cantara, Executive Secretary
 c/o New Hampshire Medical Society
 7 N. State St.
 Concord, NH 03301
 (603) 224-7083
 Fax: (603) 226-2432
gcantara@juno.com

New Jersey**New Jersey State Mental Health Program**

50 E. State St.
 P.O. Box 727
 Trenton, NJ 08625-0727
 1 (800) 382-6717
www.state.nj.us/humanservices/index.shtml

Mental Health Association in Atlantic City

1127 N. New Rd.
 Absecon, NJ 08201
 (609) 272-1700
www.mhaac.info/

NAMI New Jersey

1562 US Hwy. 130
 North Brunswick, NJ 08902-3004
 (732) 940-0991
www.naminj.org

New Jersey Psychiatric Association

Carla A. Ross, Executive Director
P.O. Box 8008
Bridgewater, NJ 08807-8008
(908) 685-0650
Fax: (908) 725-8610
psychnj@optonline.net
www.psychnj.org

New Mexico

New Mexico State Mental Health Program

Behavioral Health Services Division
Harold Runnels Building
1190 St. Francis Dr., Suite N3300
Santa Fe, NM 87502
(505) 827-2601
www.nmcares.org/

NAMI New Mexico

P.O. Box 3086
6001 Marble, N.E.
Albuquerque, NM
(505) 260-0154
nm.nami.org

Psychiatric Medical Association of New Mexico

Marsha VerPloegh, Executive Secretary
4203-C Montgomery, N.E.
Albuquerque, NM 87109
(505) 816-0157
Fax: (505) 816-0158
psychnm@aol.com
www.nmpsycho.org

New York

New York State Mental Health Program

New York State Office of Mental Health
44 Holland Ave.
Albany, New York 12229
1 (800) 597-8481 (toll free)
www.omh.state.ny.us/

Mental Health Association of New York State

194 Washington Ave., Suite 415
Albany, NY 12210
(518) 434-0439
www.mhanys.org/

NAMI New York State

260 Washington Ave.
Albany, NY 12210-1312
(518) 462-2000
www.naminys.org

New York State Capital District Branch

Nancy Sykes, Executive Director
P.O. Box 5
New Baltimore, NY 12124
(518) 756-7030
Fax: (518) 756-7030
psychs4@mhcable.com

North Carolina

North Carolina State Mental Health Program

NC Division of MH/DD/SAS
3009 Mail Service Center
Raleigh, NC 27699-3009
(919) 715-3197
www.dhhs.state.nc.us/mhddsas/

Mental Health Association of North Carolina

3820 Bland Rd.
Raleigh, NC 27609
(919) 981-0740
www.mha-nc.org/contact.htm

NAMI North Carolina

309 W. Millbrook Rd., Suite 121
Raleigh, NC 2709-4394
(919) 788-0801
www.naminc.org

North Dakota

North Dakota State Mental Health Program

North Dakota Department of Human Services
600 East Blvd. Ave., Dept. 325
Bismarck ND 58505-0250
(701) 328-2310
www.state.nd.us/humanservices/services/
mentalhealth/

NAMI North Dakota

P.O. Box 6016
Minot, ND 58702
(701) 852-8202
jasbol@srt.com

North Dakota Psychiatric Society

David Peske, Executive Director
P.O. Box 1198
Bismarck, ND 58502-1198
(701) 223-9475
Fax: (701) 223-9476
dpeske@ndmed.com

Ohio

Ohio State Mental Health Program

30 E. Broad St., 8th Floor
Columbus, OH 43215-3430
(614) 446-2596
www.mh.state.oh.us/

NAMI Ohio

747 E. Broad St.
Columbus, OH 43205
(614) 224-2700
www.namiohio.org

Ohio Psychiatric Association

Janet Shaw, Executive Director
1350 W. 5th Ave., #218
Columbus, OH 43212
(614) 481-7555
Fax: (614) 481-7559
jshaw@ohiopsych.org
www.ohiopsych.org

Oklahoma

Oklahoma State Mental Health Program

ODMHSAS
1200 N.E. 13th St.
P.O. Box 53277
Oklahoma City, OK 73152
(405) 522-3908
www.odmhsas.org/

NAMI Oklahoma

500 N. Broadway Ave., Suite 100
Oklahoma City, OK 73102-6200
(405) 230-1900
www.ok.nami.org

Oklahoma Psychiatric Physicians Association

Renee Davenport Mixon, Executive Director
P.O. Box 1328
Norman, OK 73070
(405) 360-5066
Fax: (405) 360-5066
oklapsychiatry@yahoo.com
www.oklahomapsychiatry.org

Oregon

Oregon State Mental Health Program

Mental Health and Addiction Services
500 Summer St. N.E., E86
Salem, OR 97301
(503) 945-5763
www.dhs.state.or.us/mentalhealth/

NAMI Oregon

2620 Greenway Dr., N.E.
Salem, OR 97301
(503) 370-7774
www.nami.org/sites/NAMIOregon

Oregon Psychiatric Association

John Mc Culley, Executive Secretary
P.O. Box 2042
Salem, OR 97308
(503) 370-7019
Fax: (503) 587-8063
assoc@wvi.com

Pennsylvania

Pennsylvania State Mental Health Program

Health & Welfare Building, Room 502
P.O. Box 2675
Harrisburg, PA 17105-2675
(717) 787-6443
www.dpw.state.pa.us/omhsas/dpwmh.asp

NAMI Pennsylvania

2149 N. Second St.
Harrisburg, PA 17110-1005
(717) 238-1514
www.namipa.nami.org

Pennsylvania Psychiatric Society
Gwen Lehman, Executive Director
777 E. Park Dr.
P.O. Box 8820
Harrisburg, PA 17105-8820
(717) 558-7750
Fax: (717) 558-7841
glehman@pamedsoc.org
www.papsych.org

Rhode Island

Rhode Island State Mental Health Program
John O. Pastore Center
44 Greendale Ct., Cottage 405
Cranston, RI 02920
(401) 462-2003
www.state.ri.us/manual/data/queries/
stdept_idc?id=67

Mental Health Association of Rhode Island
1516 Atwood Ave.
Johnston, RI 02919
(401) 273-8100
www.mhari.org/advocacy.html

NAMI Rhode Island
82 Pitman St.
Providence, RI 02906-4312
(401) 331-3060
www.namiri.org

Rhode Island Psychiatric Society
Sarah Stevens, Branch Administrator
235 Promenade St., #500
Providence, RI 02908
(401) 331-1450
Fax: (401) 751-8050
sstevens@rimed.org
www.psychri.org

South Carolina

South Carolina State Mental Health Program
2414 Bull St.
Columbia, SC 29202
(803) 898-8581
www.state.sc.us/dmh/

Mental Health Association of South Carolina
1822 Gadsden St.
Columbia, SC 29201
(803) 779-5363
www.mha-sc.org/

South Carolina Psychiatric Association
Heather Black, Executive Director
P.O. Box 11188
Columbia, SC 29211
(803) 798-6207
(803) 772-6783
heather@scmanet.org

NAMI South Carolina
P.O. Box 1267
5000 Thurmond Mall Blvd., Suite 103
Columbia, SC 29202
1 (800) 798-5131
www.namisc.org

South Dakota

South Dakota State Mental Health Program
Division of Mental Health
Hillsview Plaza, E. Hwy. 34
c/o 500 East Capitol
Pierre, SD 57501-5070
(605) 773-5991
www.state.sd.us/dhs/dmh/

NAMI South Dakota
79 Second St., S.W.
Huron, SD 57350
(605) 32-4499
www.sd.nami.org

South Dakota Psychiatric Association
Kate Naylor, Executive Secretary
1400 W. 22nd St.
Sioux Falls, SD 57105
(605) 357-1585
Fax: (605) 357-1460
knaylor@usd.edu

Tennessee

Tennessee State Mental Health Program
425 Fifth Ave., N.
5th Floor, Cordell Hull Building
Nashville, TN 37243-0675
(615) 532-6610
www.state.tn.us/mental/

Mental Health Association of Tennessee
2416 21st Ave., Suite 20
Nashville, TN 37212-5318
(615) 242-7122
www.mhatn.org

NAMI Tennessee
1101 Kermit Dr., Suite 605
Nashville, TN 37217-2126
(615) 361-6608
www.tn.nami.org

Tennessee Psychiatric Association
Kimberly Settle, Executive Director
P.O. Box 690
Hendersonville, TN 37077
(615) 826-8535
(615) 822-8237
ckcsettle@aol.com

Texas

Texas State Mental Health Program
Texas Department of Mental Health and
Mental Retardation
Central Office
909 W. 45th St.
Austin, TX 78751
(512) 454-3761
www.mhmr.state.tx.us/CentralOffice/
BehavioralHealthServices/olderadult.html

Mental Health Association of Texas
8401 Shoal Creek Blvd.
Austin, TX 78757
(512) 454-3706
www.Mhatexas.Org/

NAMI Texas
Fountain Park Plaza III
2800 S. IH35, Suite 140
Austin, TX 78704
(512) 693-2000
www.namitexas.org

Texas Society of Psychiatric Physicians
John Bush, Executive Director
401 W.15th St., #675
Austin, TX 78701
(512) 478-0605
(512) 478-5223
tsppofc@aol.com
www.txpsych.org

Utah

Utah State Mental Health Program
Utah Division of Mental Health
120 N. 200 W., #415
Salt Lake City, UT
Fax: (801) 538-4270
www.hsmh.state.ut.us/default.htm

Mental Health Association of Utah
1800 S.W. Temple, Suite 501
Salt Lake City, UT 84115
(801) 596-3705
www.xmission.com/~mhaut/

NAMI Utah
309 E. 100, S.
Salt Lake City, UT 84111-1701
(801) 323-9900
www.namiut.org

Utah Psychiatric Association
Paige De Mille, Executive Director
540 E. 500, S.
Salt Lake City, UT 84102
(801) 355-7477
Fax: (801) 532-1550
paige@utahmed.org

Vermont

Vermont State Mental Health Program
Department of Developmental and
Mental Health Services
103 S. Main St., Weeks Building
Waterbury, VT 05671-1601
(802) 241-2214
www.state.vt.us/dmhl/

NAMI Vermont
132 S. Main St.
Waterbury, VT 05676-1519
(802) 244-1396
www.namivt.org

Vermont Association for Mental Health
43 State St., 2nd Floor
Montpelier, VT 05602
(802) 223-6263
www.vamh.org/

Vermont Psychiatric Association
Vermont Medical Society
P.O. Box 1457
Montpelier, VT 05601
(802) 223-7898
Fax: (802) 223-1201
jblock@vtmd.org
www.vtmd.org/VPA/vpamainpage.html

Virginia

Virginia State Mental Health Program
P.O. Box 1797
Richmond, VA, 23218
(804) 786-3921
www.dmhmrzas.state.va.us/

MHA of Virginia
503 E. Main St., Suite 707
Richmond, VA 23219
(804) 225-5591
www.mhav.org/v02/index.html

NAMI Virginia
P.O. Box 1903
1 N. Fifth St.
Richmond, VA 23218-1903
(804) 225-8264
www.namivirginia.org

Psychiatric Society of Virginia, Inc.
Sandra Peterson, Executive Director
P.O. Box 71656
Richmond, VA 23255-1656
(804) 754-1200
Fax: (804) 754-2321
spetersonpsv@comcast.net
www.psva.org

Washington

Washington State Mental Health Program
Mental Health Division
P.O. Box 45320
Olympia WA 98504-5320
(360) 902-8070
www1.dshs.wa.gov/mentalhealth/

NAMI Washington
500 108th Ave. N.E., Suite 800
Bellevue, WA 98004-5580
(425) 990-6404

Washington State Psychiatric Association
Shirley Bishop, Executive Director
2150 N. 107th St., #205
Seattle, WA 98133-9009
(206) 367-8704
Fax: (206) 367-8777
wspa@sbims.com
www.wapsychiatry.org

West Virginia

West Virginia State Mental Health Program
MHA in Monongalia County
P.O. Box 1533
354 High St., Suite 224
Morgantown, WV 26507
(304) 292-0525
mhamc224@aol.com
www.wvdhhr.org/bhhf/adultmh.asp

NAMI West Virginia
P.O. Box 2706
Charleston, WV 25330-2706
(304) 342-0497
www.namiwv.org

West Virginia Psychiatric Association
Susan Engle, Executive Secretary
Chestnut Ridge Hospital
930 Chestnut Ridge Rd.
Morgantown, WV 26505
(304) 293-5312
Fax: (304) 293-8724
sengle@mail.hsc.wvu.edu

Wisconsin

Wisconsin State Mental Health Program
Department of Health and Family Services
1 W. Wilson St.
Madison, WI 53702
(608) 266-1865
www.dhfs.state.wi.us/mentalhealth/

**Mental Health Association in
Milwaukee County**
734 N. Fourth St., Suite 200
Milwaukee, WI 53203-2102
www.mhamilw.org

NAMI Wisconsin
4233 W. Beltline Hwy.
Madison, WI 53711-3814
(608) 268-6000
www.namiwisconsin.org

Wisconsin Psychiatric Association
Edward Levin, Executive Director
P.O. Box 1109
Madison, WI 53701
1 (800) 762-8967
(608) 283-5424
wpa@smswi.org
www.thewpa.org

Wyoming

Wyoming State Mental Health Program
Mental Health Division
6101 Yellowstone Rd., Room 2598
Cheyenne, WY 82002
(307) 777-7094
mentalhealth.state.wy.us/about/contact.html

NAMI Wyoming
100 W. B
P.O. Box 391
Casper, WY 82602
(307) 234-0440
www.wyami.org

Wyoming Psychiatric Society
Jean Davies, Executive Secretary
2521 E. 15th St.
Casper, WY 82609
(307) 237-7444
Fax: (307) 473-7144
cwd@coffey.com