Southeast (HHS Region 4)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Mental Health Priorities, Strengths, and Needs of the State Mental Health Agencies in the Southeast

INTERIM NEEDS ASSESSMENT REPORT

Prepared by the Southeast Mental Health Technology Transfer Center

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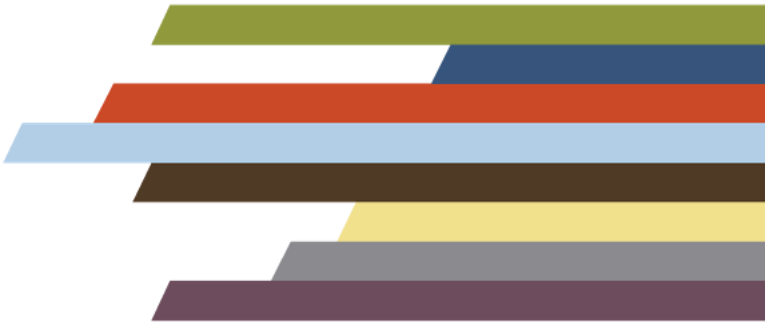

Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA) created the Mental Health Technology Transfer Center (MHTTC) Network to facilitate the dissemination and implementation of evidence-based mental health services in the United States (U.S.). The newly established Southeast Mental Health Technology Transfer Center (Southeast MHTTC) serves the eight states in Region IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Kentucky.

The Southeast MHTTC conducted a needs assessment to better understand the landscape of public mental health in the Southeast. We focused on examining the demographic, clinical, and mental health system characteristics of the region; available mental health-related trainings and resources; and states' mental health priorities, strengths, and needs. We used a mixed-methods approach of compiling data through document review, quantitative analysis of available data, and stakeholder interviews.

- Document Review: Information about state mental health systems, financing for mental health services, and available resources and trainings were gathered from state mental health agency (SMHA) websites, online searches, reports, and other resources.
- Quantitative Analysis: Publically available data from the SAMHSA Treatment Locator and Area Health Resources File were used to gather information about the mental health workforce and state mental health systems across Region IV.
- Stakeholder Interviews: We spoke with state mental health commissioners and other SMHA leaders to gain a deeper understanding of the structure of the state mental health system; the state's mental health priorities, key initiatives, and areas of need; previous experiences with technical assistance; available technical assistance and trainings; strategies to reach target audiences for future trainings; and potential future MHTTC activities.
- Triangulation of Findings: We examined the findings from the three data sources, with a focus on the priorities, needs, and initiatives within the states and across the region. We used the findings to identify regional mental health priority areas.

Region IV comprises a large geographic area with a diverse population that has a variety of mental health needs. Through the needs assessment process we sought to gain a broad perspective on regional needs, strengths, resources, and training priorities, while being attuned to the state-specific strengths and needs. The main findings of the needs assessment include the following insights into mental health in Region IV:

1. **Region IV Population and State Mental Health Systems**
   - With 8 states and 20% of the U.S. population, Region IV is the largest HHS region. The population and demographic profiles of the Region IV states vary greatly in terms

of total population, racial and ethnic diversity, and percentage of the population living in rural areas. Compared to the U.S., the southeast states have a larger proportion of individuals living in poverty. Almost all of the states in Region IV have higher rates of unemployment and uninsurance compared to the overall U.S. rates.

- Individuals in the southeast experience a significant burden of mental illness. The Region IV SMHAs serve over one million clients per year, which ranges from 1.2-3.8% of the states' population. States across Region IV experience shortages in the behavioral health workforce and school mental health workforce.

- The Region IV SMHAs vary in terms of organization, structure, financing, and services offered. Most Region IV states operate an independent department of mental health, but some house their SMHA within other state government agencies. The SMHAs vary in the mechanisms used to fund and administer community-based mental health services, with some states using multiple mechanisms. The main mechanisms to fund community services include: SMHA directly provides services; SMHA funds but does not operate service provider organizations; and SMHA funds local authorities, who oversee and manage mental health service provision.

2. Available Mental Health Resources in Region IV

- A variety of mental health-related trainings and resources for the mental health workforce and other professionals are available in the Region IV states. Trainings are offered by a number of different entities, including SMHAs, other state and local agencies, healthcare organizations, non-profit organizations, and universities.

- Trainings primarily focus on clinical topics, but also include school mental health, mental health first aid, assessing suicide risk, and cultural competency. Additionally, all states provide certification in peer services, as well as training in suicide prevention and crisis intervention training for law enforcement officials.

- The trainings in Region IV state include both distance learning and in-person training opportunities. Trainings typically target healthcare providers, including counselors, social workers, nurses, and peer specialists.

3. Strengths and Needs of SMHAs in Region IV

- We identified strengths and needs based on the stakeholder interviews and other data. Needs were mental health topics that state leaders identified as areas their state was currently working to address or would like to address in the future. Strengths and initiatives were mental health areas in which SMHAs currently have key programs.
- All of the SMHAs had a variety of established and new initiatives to address an array of mental health topics. Common areas of focus across the SMHAs include: children's and school-based mental health, suicide prevention, peer services and workforce, first episode psychosis, crisis services, assertive community treatment, criminal justice and mental health, supported employment, and supported housing.

Examples of Current Initiatives and Needs of Region IV SMHAs

	Example Initiatives	Related Needs
Alabama	School-based mental health collaboration between the Departments of Mental Health and Education and local education agencies	Expanding school-based mental health services throughout the state
Florida	State suicide prevention plan	Need for expanded suicide prevention services among veterans
Georgia	Peer Support Whole Health Initiative	Plan to roll out a toolkit on supervision of peers
Kentucky	Zero Suicide Program	Expansion of services
Mississippi	Jail-based competence restoration and Juvenile outreach programs for youth involved in the justice system	Expanded education of judges and sheriffs
North Carolina	Fidelity monitoring of Individual Placement and Support (supported employment) services	Working with network on quality, fidelity, and outcomes
South Carolina	PATH program for supported housing	Expansion of housing support
Tennessee	Peer Wellness Initiative	Expansion of peer workforce capacity

4. Regional Mental Health Priority Areas

- Given the large size and diversity of the region, the Southeast MHTTC sought to identify priorities across states to guide future training and technical assistance activities. The regional priority mental health areas typically addressed topics that most or all states had initiatives for, but where a gap still exists between current available services and needs to be filled.

- We identified 5 regional mental health priority areas:
    - **Peer Workforce: The Region IV states are at variable levels of development of their peer workforce.** All of the SMHAs in Region IV work with organizations that provide training and certification for peer specialists. SMHAs described two main needs related to peer services: 1) expanding the capacity of the peer workforce to work effectively in specialty settings; and 2) educating providers and managers at CMHCs and hospitals on the role and value of peer specialists. Many states are looking to further integrate their peer workforce into the behavioral healthcare system and specialty services.

    - **Suicide Prevention: Most SMHAs currently have initiatives for suicide prevention and state suicide prevention plans**. Key needs related to suicide prevention include expansion of services and strategies to address suicide prevention among veterans. Many states continue to refine and implement state suicide plans, as well as integrate suicide prevention into school-based mental health initiatives.

    - **School-based Mental Health: School-based mental health is a major focus across the Region IV states.** Seven states have recently passed school safety legislation and many states currently have legislation pending. Identified needs included expanding services in schools, improved coordination between

schools and community mental health services, identifying and implementing behavioral health assessments in schools, and financing. Many states are looking to expand capacity of school districts to provide coordinated mental health care and further develop the school-based workforce.

- **Criminal Justice and Mental Health: Addressing the mental health needs of individuals in the criminal justice system is the focus of initiatives across the region.** Almost all of the SMHAs partner with other state agencies on training for crisis intervention teams (CIT), pre-arrest diversion programs, and reintegration programs. Further development in this priority area could include improvement of mental health-related trainings for criminal justice professionals, strengthening of collaborations with state justice agencies, and expansion of programs.
- **Supported Housing: Almost all SMHAs have new or ongoing supported housing initiatives to improve transitions to housing and housing stability for individuals with mental illness**. Areas for development in supported housing could include the expansion of housing services, improved integration and coordination with mental health services, and financing.

5. **Training and Technical Assistance Strategies**
   - The findings of the needs assessment will also be used to determine strategies for efficiently delivering training and technical assistance within and across the Region IV states.
   - State stakeholders are open to various delivery methods, both in-person and online, for training and technical assistance. Trade-offs exist for different delivery methods. In-person training allows for hands-on learning and relationship building among various groups, while online options can extend the Southeast MHTTC's reach across the region. Given the large geographic area of Region IV, distance-learning opportunities, particularly those that incorporate engaging learning strategies, may be necessary to reach a wide array of professionals.
   - Learning collaborative models can provide the opportunity for state SMHAs to share strengths and lessons learned with each other. The SMHAs could benefit from the opportunity to learn from each other and to problem-solve through learning collaboratives.

The goal of Southeast MHTTC is to provide effective training and technical assistance that is valuable to Region IV as a whole and also addresses the variation within and across states. The needs assessment findings provide an overview of the demographic and clinical characteristics of the states, the public mental health systems, and the needs and strengths of the SMHAs. From these findings, we identified regional mental health priorities and strategies for delivering training and technical assistance that will inform the future activities of the Southeast MHTTC.

Southeast Mental Health Technology Transfer Center

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Needs Assessment for the Southeast Mental Health Technology Transfer Center

In 2018, the Substance Abuse and Mental Health Services Administration (SAMHSA) created the Mental Health Technology Transfer Center (MHTTC) Network to facilitate the dissemination and implementation of evidence-based mental health services in the United States (US). The MHTTC Network includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office. This network is part of SAMHSA's overall goal to modernize the provision of services for mental and substance use disorders throughout the US.[1]

The Southeast Mental Health Technology Transfer Center (Southeast MHTTC) serves the eight states in Region IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Kentucky. We are housed in the Rollins School of Public Health at Emory University in Atlanta, Georgia. The vision and mission of the Southeast MHTTC are:[2]

Vision

- Widespread access to evidence-based mental health services for those in need

Mission

- To promote the implementation and sustainability of evidence-based mental health services in the Southeastern United States

The goals of the Southeast MHTTC are to:

1. Accelerate the adoption and implementation of mental health-related EBPs within the Southeast.
2. Heighten the awareness, knowledge, and skills of the Region IV mental health workforce.
3. Foster alliances among culturally diverse practitioners, researchers, policy makers, family members and consumers of mental health services in the Southeast.
4. Deliver training to states, communities and providers within the Southeast.

We use a public health approach to build leadership capacity and train providers, agencies, and communities with the goal of improving care for individuals with mental health conditions across the Southeast.[3]

Needs Assessment Purpose

Region IV comprises a large geographic area with a diverse population that has a variety of mental health needs. In order to design training and technical assistance opportunities that will be valuable for the Region IV states, we first undertook a needs assessment to better understand the landscape of public mental health in the Southeast. The purpose of this needs assessment is to examine the demographic, clinical, and public mental health system characteristics of the region; available mental health-related trainings and resources; key stakeholders; and states' mental health priorities, strengths, and needs. This information will be used to inform training priorities for the Southeast MHTTC.

Needs Assessment Questions

1. What are the demographic and clinical characteristics of the states in the region?
2. What is the structure of the public mental health system in each of the states?
3. What mental health-related trainings and resources are currently available in the region?
4. What are the mental health training priorities in the region?

Needs Assessment Methods

We used a mixed-methods approach to compile the data needed to answer the needs assessment questions. The three main data collection methods were document review, quantitative analysis of available data, and stakeholder interviews.

Document Review

Information about state mental health systems, financing for mental health services, and available resources and trainings were gathered from state department of mental health websites, online searches, reports, and other resources.

Information about the state mental health systems were compiled mainly from state mental health department websites. Annual reports, presentations, and announcements were referenced for information on each state mental health agency's (SMHA) governance, mental health care structure, and current initiatives.

Information on state Medicaid financing of mental health services was gathered from state Medicaid program websites, state managed care websites, and Medicaid.gov for information on covered populations, services, and plan types. Henry J. Kaiser Family Foundation State Health Fact sheets provided information on Federal Poverty Level eligibility criteria. Searches of Google news were used to identify current Medicaid news by state.

Available mental health resources and training in the region were compiled through a series of internet searches. For each state, a Google search was conducted with the state's name and the key phrase "mental health provider training". Relevant sources were identified through a review of all links that came up in the search results; the search was halted when two pages of results in a row had only irrelevant results. The websites of all relevant links were examined and added to a spreadsheet if the resource included: online training, in-person training, technical assistance services, information/resources, or symposiums/conferences. Additional resources and trainings that we uncovered during the document review process were added to the spreadsheet. For each resource, the following information was abstracted into the spreadsheet: name of the organization, the web address, contact information, main topics and information covered, and any associated costs. The identified resources were categorized by type of offering, target audience, topic, and opportunity for continuing education credit. While we identified numerous training opportunities, we recognize that we may have missed trainings that did not come up with our search terms or that are not listed online.

Quantitative Analysis

Publically available data were used to gather information about the mental health workforce and state mental health systems across Region IV. Data sources included:

- SAMHSA Treatment Locator: A search was conducted for each state to identify all outpatient mental health facilities and gather facility characteristics, including

geographic location and whether or not the facility accepts Medicaid, individuals under the age of 18, and/or co-occurring substance use disorders.
- Area Health Resources File (AHRF): We downloaded county-level information on mental health professional shortage areas and number of mental health professionals per capita.

The data were merged and descriptive statistics were run in SAS. We used Arc GIS to produce maps of treatment facilities and mental health professional shortage areas in the Region IV states.

Stakeholder Interviews

State mental health commissioners or their designees in Region IV were contacted to schedule a meeting or call with the Southeast MHTTC team to introduce the center and learn more about the state mental health programs. These key stakeholders were asked to identify a person or persons in the state mental health agency who could be a contact for the Southeast MHTTC and who would be willing to talk more in-depth in a follow-up call. Topics for the follow-up calls included: structure of the state mental health system; the state's mental health priorities, key initiatives, and areas of need; previous experiences with technical assistance; available technical assistance and trainings; strategies to reach target audiences for future trainings; and potential future MHTTC activities. Southeast MHTTC members on the calls took detailed notes, which were typed up and reviewed for priorities, needs, and key initiatives.

Triangulation of Data

We examined the findings from the document review, quantitative data analysis, and stakeholder interviews to identify commonalities and differences across the data sources. In particular, we examined the priorities, needs, and initiatives described by the stakeholders and integrated supporting information from other data sources. We defined priorities, needs, and initiatives/strengths as:

- Priorities – mental health topics that state leaders identified as important areas of focus for their state.
- Needs – mental health topics that state leaders identified as areas their state was currently working to address or would like to address in the future.
- Strengths and initiatives – stakeholders identified mental health topics in which their state has initiatives and are seen as strengths. Initiatives and key programs were also identified through the document review process.

Regional priority areas were identified by examining common mental health topic areas across the Region IV states. The regional priority areas typically addressed topics that most or all states had initiatives for, but where a gap still exists between current available services and needs to be filled.

Demographic and Clinical Characteristics of the Southeast

With 8 states and 20% of the U.S. population, Region IV is the largest HHS region. The population and demographic profiles of the Region IV states vary greatly in terms of total population, racial and ethnic diversity, and percentage of the population living in rural areas. Table 1 provides an overview of the demographic characteristics of the states in Region IV.

Approximately 65.7 million people live in the 8 southeast states.[4] Three of the states – Florida, Georgia, and North Carolina are among the top 10 most populous states in the U.S., while the other 5 states are much less populous.[5] Almost all of the states have a larger proportion of Black/African American residents and a lower proportion of Hispanic/Latino residents compared to the U.S.as a whole. The exceptions are Kentucky, which has fewer than 10% Black/African American residents, and Florida, which has a large percentage of Hispanic/Latino residents at almost 25%.[6] All of the states, except for Florida, have large percentages of their population (25-50%) living in rural areas.[7] Compared to the U.S.as a whole, all of the Southeast states have larger proportions of all residents and children under the age of 18 who are living under the federal poverty level. Similarly, almost all of the states have a higher unemployment rate compared to the national rate.[8] Finally, only Florida has a life expectancy at birth that is higher than the national average.

Table 1. Region IV Demographic Characteristics

State	Total Population (Millions)[4]	% Black or African American[6]	% Hispanic/ Latino[6] (of any race)	% Rural[7]	% Living below the FPL[8]	% Under 18 living below the FPL[8]	% Unemployment[8]	Life expectancy at birth[9] (years)
Alabama	4.9	27.4	4.1	41.0	18.0	26.0	7.4	75.4
Florida	21.0	17.4	24.7	8.9	15.5	22.3	7.2	79.4
Georgia	10.4	32.6	9.3	24.9	16.9	24.0	7.5	77.2
Kentucky	4.5	9.3	3.4	41.6	18.3	24.7	6.8	76
Mississippi	3.0	38.3	3.0	50.7	21.5	30.2	8.8	75
North Carolina	10.3	22.9	9.1	33.9	16.1	22.9	7.2	77.8
South Carolina	5.0	28.4	5.5	33.7	16.6	24.5	7.2	77
Tennessee	6.7	17.8	5.2	33.6	16.7	24.3	6.6	76.3
US	326	13.9	17.6	19.3	14.6	20.3	6.6	78.9

Sources: US Census Bureau;[4,6,7] Kaiser Family Foundation[9]
Abbreviations: FPL – Federal Poverty Level

Table 2 presents the health insurance characteristics of the states in Region IV. Most Southeast states have higher rates of uninsurance in the total population and among adults compared to the U.S. overall. Notably, in Kentucky only 6% of the total population is uninsured.[10] Kentucky is one of 37 states in the U.S. and the only state in Region IV that adopted Medicaid expansion under the Affordable Care Act.[11] After adoption of Medicaid

expansion in 2014, the uninsured rate in Kentucky dropped dramatically.[12] The percentage of uninsured children is relatively constant between the states and compared to the U.S. overall.

Table 2. Region IV Health Insurance Characteristics

State	Total Population[10]			Adults, ages 19-64[13]		Children, ages 0-18[14]		Medicaid Expansion[11]
	% Uninsured	% Medicaid	% Medicare	% Uninsured	% Medicaid	% Uninsured	% Medicaid	
Alabama	10	21	16	15	12	3	46	No
Florida	13	19	17	19	11	7	43	No
Georgia	13	17	12	19	9	7	38	No
Kentucky	6	27	15	7	24	4	44	Yes
Mississippi	12	24	13	18	14	5	51	No
North Carolina	11	18	15	16	11	5	42	No
South Carolina	11	19	16	17	12	5	42	No
Tennessee	9	21	15	14	14	4	41	No
US	9	21	14	12	15	5	39	-

Sources: Kaiser Family Foundation[10,11,13,14]

Table 3 provides an overview of mental health indicators in the Southeast. Estimates from the National Survey on Drug Use and Health show that percentages of any mental illness (AMI), serious mental illness (SMI), major depressive episode, substance use disorder (SUD), and suicidal ideation in the Region IV states are generally comparable to the U.S. overall. Estimates of AMI and SMI are higher in Kentucky compared to the U.S. percentages. Reported rates of suicidal ideation are lower in Florida compared to the U.S. as a whole. Additionally, Georgia had a lower percentage of children with major depressive episode and adults with SUD compared to the U.S..[15] Five of the 8 Region IV states have an age-adjusted suicide rate that is higher than the U.S. rate, with Kentucky, Tennessee, South Carolina, and Alabama all having rates above 15 per 100,000.[16]

Mental Health America is an advocacy group that ranks all states and the District of Columbia based on prevalence of mental illness and degree of access to mental health care. All of the Region IV states, except for Kentucky, fall in the lower half of rankings, indicating poorer access to mental health care.[17]

Table 3. Region IV Mental Health Indicators

State	% AMI[15] (Ages 18+)	% SMI[15] (Ages 18+)	% MDE[15] (Ages 18+)	% MDE[15] (Ages 12-17)	% Suicidal Ideation[15] (Ages 18+)	Age-adjusted Suicide Rate[16]	% SUD (Ages 18+)	% SUD (Ages 12-17)	MHA 2018 State Ranking[17]
Alabama	18.5	4.2	6.7	11.2	3.6	15.6	8.6	3.9	41
Florida	17.3	3.6	6.1	12.8	3.3	13.3	7.4	4.3	33
Georgia	17.7	4.2	6.7	10.1	3.9	13.9	6.5	3.7	26
Kentucky	22.1	5.3	7.6	11.7	5.1	16.8	8.1	4.1	22
Mississippi	17.5	3.9	6.0	10.8	3.8	12.7	6.7	3.9	50
North Carolina	19.0	4.7	7.1	11.7	4.2	13.0	7.0	4.1	32
South Carolina	18.1	4.0	6.5	10.8	3.7	15.7	8.1	4.3	45
Tennessee	19.6	5.0	7.1	12.1	4.6	16.3	7.1	4.0	46
US	18.1	4.1	6.7	12.6	4.0	13.4	7.9	4.6	-

Sources: National Survey on Drug Use and Health,[15] Kaiser Family Foundation,[16] Mental Health America[17]

Abbreviations: AMI – Any Mental Illness; MDE – Major Depressive Episode; MHA – Mental Health America; SMI – Serious Mental Illness; SUD – Substance Use Disorder

State Public Mental Health Systems in the Southeast

Every state in Region IV has a state mental health agency (SMHA) that is responsible for the organization, financing, and delivery of mental health services. The public mental health systems vary across the states in terms of organization, structure, financing, and services offered. Table 4 provides an overview of the structure of the SMHA in each state.

A majority of the Region IV states (AL, GA, SC, MS, TN) operate an independent department of mental health, but some house their SMHA within other state government agencies such as the state's Health Department (KY), Department of Human Services (FL), or Health and Human Services (NC). In most states, there is at least one administrative level between the commissioner or director of the SMHA and the Governor. In Georgia, Alabama, and Tennessee, the commissioner serves as a member of the Governor's cabinet.[18]

SMHAs collaborate with other state agencies to efficiently provide services, often to particular populations such as individuals with substance use disorders or intellectual disabilities. All of the Region IV SMHAs, except for North Carolina and South Carolina, include responsibility for substance use services. In North Carolina, substance use is under the umbrella of Health and Human Services, like the SMHA. South Carolina has the Department of Alcohol and Other Drug Abuse Services, which is separate from the Department of Mental Health. Responsibility for intellectual disabilities falls under the SMHA in 4 states (AL, GA, KY, and MS), the same umbrella in North Carolina, and under a different state agency in 3 states (FL, SC, and TN). State Medicaid agencies are separate from the SMHA in all Region IV states, though Medicaid is located under the same umbrella for North Carolina. Similarly, responsibility for children's mental health services is shared with other agencies in most Region IV states (AL, FL, GA, SC, and TN). In Kentucky, Mississippi, and North Carolina, children's services fall under the responsibility of the SMHA.[18]

Table 4. Region IV State Mental Health Agency Structure

State	SMHA	SMHA located in State Department	Levels between Commissioner and Governor	Relationship with other State Agencies			Responsibility for children's mental health services
				Substance Use	Intellectual Disabilities	Medicaid	
Alabama	Department of Mental Health	Independent	0	Combined	Combined	Other agency	Shared
Florida	Florida Office of Substance Abuse & Mental Health	Human Services	3	Combined	Other agency	Other agency	Shared
Georgia	Department of Behavioral Health and Developmental Disabilities	Independent	0	Combined	Combined	Other agency	Shared
Kentucky	Department for Behavioral Health, Developmental and Intellectual Disabilities	Health Department	1	Combined	Combined	Other agency	Part of SMHA
Mississippi	Department of Mental Health	Independent	1	Combined	Combined	Other agency	Part of SMHA
North Carolina	Division of Mental Health, Developmental Disabilities, and Substance Abuse	Health and Human Services	2	Same umbrella	Same umbrella	Same umbrella	Part of SMHA
South Carolina	Department of Mental Health	Independent	1	Other agency	Other agency	Other agency	Shared
Tennessee	Department of Mental Health and Substance Use Services	Independent	0	Combined	Other agency	Other agency	Shared

Source: Substance Abuse and Mental Health Services Administration[18]

Abbreviations: SMHA – State mental health agency

All Region IV SMHAs provide community-based mental health services and operate psychiatric hospitals that provide in-patient care. The SMHAs vary in the mechanisms used to fund and administer community-based mental health services, with some states using multiple mechanisms. Table 5 provides an overview of the mechanisms used in each state. The South Carolina Department of Mental Health is the only SMHA in Region IV that directly operates its community-based programs. Three SMHAs (AL, KY, TN) fund local community-based providers, but do not operate those programs. For example, in Alabama, the 19 community mental health centers (CMHCs) contract with the Department of Mental Health to provide services. In addition to providing services required by the Department of Mental Health, CMHCs have the flexibility to programs to their communities[19]. North Carolina funds local authorities, called Local Management Entities-Managed Care Organizations (LME-MCOs), to provide community-based services. The seven regional LME-MCOs are public entities that plan, implement, and monitor mental health services to local areas.[20,21] The remaining 3 states (FL, GA, and MS), both directly fund, but do not operate, community-based agencies and provide funds to local authorities.[18] In Mississippi, 14 regional commissions appointed by county-level officials supervise the operation of CMHCs.[22]

The Region IV SMHAs each oversee between 3 and 7 state psychiatric hospitals. The majority of SMHAs operate the state psychiatric hospitals; Florida and Kentucky also fund additional hospitals that they do not operate.

Table 5. Mechanisms to Deliver Mental Health Services in Region IV

State	Mechanisms to fund community services			State Psychiatric Hospitals	
	SMHA directly operates	SMHA funds, does not operate	SMHA funds local authorities	SMHA operates	SMHA funds
Alabama	N	Y	N	3	0
Florida	N	Y	Y - primary	3	4
Georgia	N	Y - primary	Y	5	0
Kentucky	N	Y	N	2	1
Mississippi	N	Y	Y - primary	4	0
North Carolina	N	N	Y	3	0
South Carolina	Y	N	N	4	0
Tennessee	N	Y	N	4	0

Source: Substance Abuse and Mental Health Services Administration[18]
Abbreviations: SMHA – State mental health agency

The Region IV states vary in total SMHA expenditures and per capita mental health treatment spending. Table 6 provides an overview of expenditures and funding sources. The total mental health expenditures by SMHAs in fiscal year 2014 totaled $4.4 billion across the region. Compared to the median per capita mental health spending in the US ($105 per person), the per capita spending was lower in 5 states (AL, FL, GA, KY, SC) and around the US median in 3 states (MS, NC, TN). The per capita spending is notably low in Florida ($36 per person); however the reported expenditures for Florida did not include Medicaid expenditures through fee-for-service coverage or the state Medicaid managed care program.[18]

Funding sources of the SMHAs include state general funds, state and federal Medicaid, federal block grants and other funds. In 3 states (FL, GA, KY), the majority of funding for the SMHAs comes from state funds. Medicaid provides the majority of funding in another 3 states (NC, SC, and TN). In Alabama, the Department of Mental Health is funded fairly evenly between state funds and Medicaid. The Mississippi Department of Mental Health receives funding from Medicaid, the state, and other funding sources.[18] In Mississippi, the CMHCs are part of the county government and receive millage from the counties.[23] Across the region, the funding streams for community mental health services generally parallel the breakdown for overall funding.[18]

The SMHAs in Region IV served approximately 1.3 million clients in 2014. The percentage of the states' population served ranged from 1.2% in Florida to 3.8% in Tennessee. The expenditure per client also varied across the states, with a range from $1,600 per client in Kentucky to $4500 in North Carolina.

Table 6. Region IV State Mental Health Agency Indicators

State	SMHA Mental Health Expenditures, FY 14		Percentage of total SMHA funding from Major Payment Sources, FY 14				Individuals served by SMHA			
	Total, $ (Millions)	Per Capita, $	State funds	Medicaid – State and Federal match	SAMHSA Block grants	Other funding sources	Total clients served (thousands)	% of state population	Expenditure per client, $ (thousands)	Expenditure per client rank
Alabama	360	74.62	49	47	2	3	94.5	2.0	3.8	35
Florida	714	36.05	77	16	4	2	231.8	1.2	3.1	44
Georgia	603	60.15	86	1	2	11	163.6	1.6	3.7	38
Kentucky	259	59.03	60	31	2	7	158.1	3.6	1.6	51
Mississippi	628	103.94	40	35	1	23	91.8	3.1	3.2	43
North Carolina	990	100.59	42	52	1	5	219.4	2.2	4.5	29
South Carolina	275	57.49	32	57	2	9	80.9	1.7	3.4	41
Tennessee	619	94.86	30	65	1	3	249.3	3.8	2.5	39
US average	785	133.64	47	43	1	8	140.2	2.6	4.8	-
US median	419	104.83	47	41	1	6	93.1	2.3	1.6	-

Source: Substance Abuse and Mental Health Services Administration[18]

Abbreviations: FY – fiscal year; SMHA – State mental health agency; SAMHSA – Substance Abuse and Mental Health Services Administration

States across the country, including Region IV, are experiencing shortages in the behavioral health workforce. Based on projections from the National Center for Health Workforce Analysis, Region IV has significant shortages in adult and child psychiatrists, mental health counselors, and social workers. The shortages across the region are smaller for psychiatric nurse practitioners and psychiatric physician assistants.[24] Region IV also has shortages in the school mental health workforce. The American School Counselor Association recommends a ratio of 250 students to one counselor; however, the student-to-counselor ratios in the Region IV states are higher, ranging from 336-491 students per counselor.[25] Similarly, the National Association of School Psychologists recommends no more than 500-700 students per school psychologist; however, school psychologists across the country, including in Region IV, have much higher caseloads.[26,27]

Table 7 and Figure 1 provide information on the behavioral health facilities and workforce in the Region IV states. In 6 of the states (AL, GA, KY, MS, SC, TN), the majority counties are designated as complete mental health professional shortage areas (MHPSA) by the Health Resources and Services Administration. Designation of complete MHPSA indicates that there is a shortage of behavioral health providers within the county.[28] In 5 of the states (AL, GA, KY, MS, TN), the majority of counties have less than 1 psychiatrist per 100,000 people.

Figure 1 shows a map of all mental health treatment facilities in Region IV. The mental health treatment facilities tend to cluster around major metropolitan areas. Rural areas tend to have fewer mental health treatment facilities and tend to be designated as MHPSAs. Between 45%-70% of the mental health treatment facilities in each state treat co-occurring mental health and substance use disorders.

Table 7. Region IV Mental Health Workforce Indicators

State	Counties designated complete MHPSA	Counties with <1 practicing psychiatrist per 100,000 population	Percentage of Behavioral Health Treatment Facilities that treat co-occurring disorders
Alabama	61%	66%	45%
Florida	31%	25%	51%
Georgia	68%	59%	70%
Kentucky	76%	67%	68%
Mississippi	94%	68%	57%
North Carolina	30%	38%	64%
South Carolina	52%	48%	60%
Tennessee	60%	57%	56%
Region IV	61%	55%	
US	60%	56%	

Abbreviations: MHPSA – Mental Health Professional Shortage Area[29]
Source: Area Health Resource Files

Figure 1. Map of Mental Health Treatment Facilities and Mental Healthcare Shortage Areas in Region IV

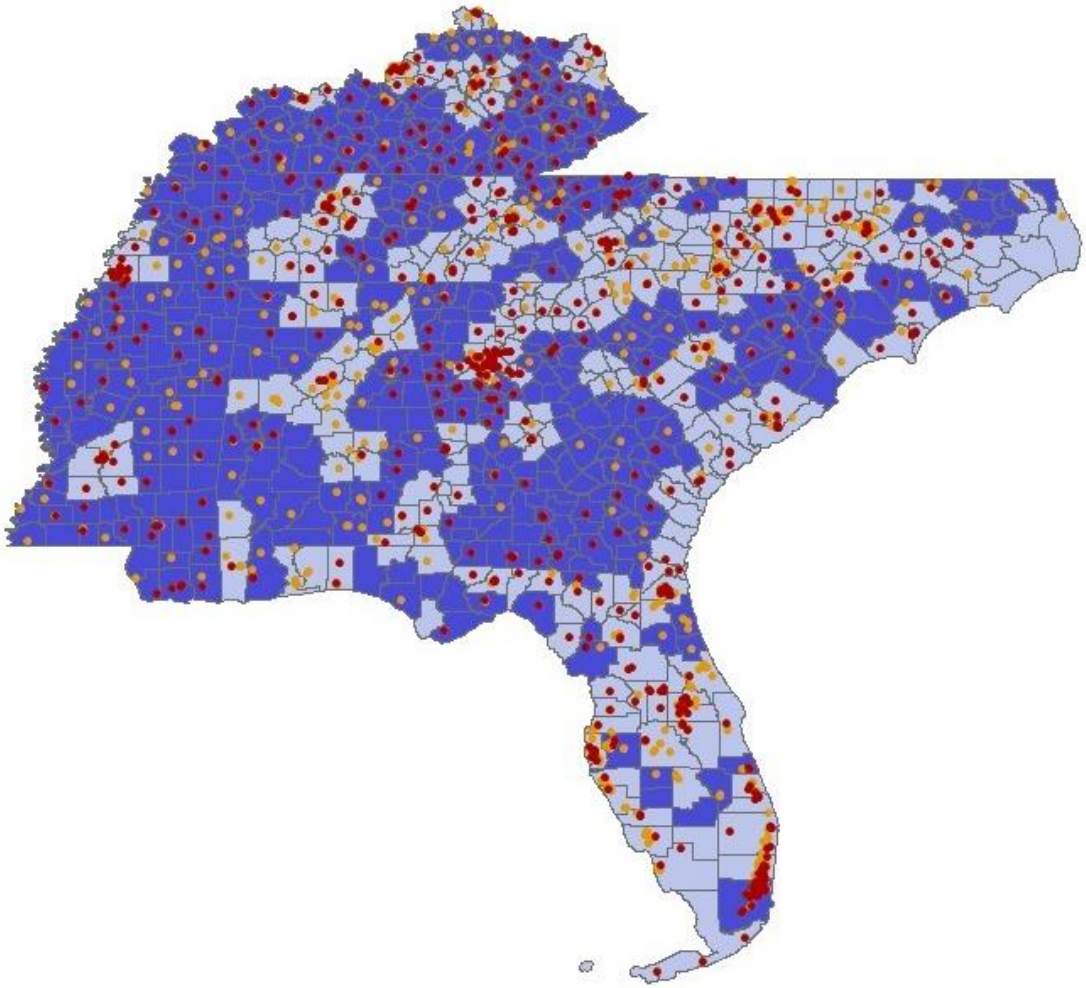

Figure Key

Mental health treatment facilities

- Mental health treatment facilities
- Mental health treatment facilities that treat co-occurring substance use disorders

Mental health shortage

- Complete county shortage
- No shortage or partial shortage

Available Mental Health Trainings and Resources

Our review of available mental health-related trainings and educational resources uncovered a variety of offerings for the mental health workforce and other professionals in the Region IV states. Trainings are offered by a number of different entities, including the state mental health agencies, other state and local agencies, healthcare organizations, non-profit organizations, and universities.

At the state-level, training offerings by mental health agencies include conferences, regularly scheduled trainings, or trainings and technical assistance by request. For example, Georgia's Department of Behavioral Health and Developmental Disabilities hosts an annual Behavioral Health Symposium.[30] The Tennessee Department of Mental Health provides online and in-person trainings on topics related to crisis services and suicide prevention.[31] The Alabama Department of Mental Health also provides a variety of online trainings on mental illness and substance use topics for community providers, employees, and the general public.[32] The South Carolina Department of Mental Health offers suicide prevention trainings for a variety of audiences, including community members, first responders, and clinicians.[33] Additionally, there are centers or organizations in some Region IV states that offer statewide training and technical assistance. Table 8 provides an overview of these organizations.

Table 8. Example Organizations in Region IV that Provide Statewide Training and Technical Assistance

State	Organization	Overview of Training and Technical Assistance Offerings
Florida	Louis de la Parte Florida Mental Health Institute at the University of South Florida[34]	• Provides training and technical assistance on a variety of topics related to mental illness, substance use, and developmental disabilities • A site for the Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center (CJMHSA TAC)[35]
Georgia	Georgia Health Policy Center at Georgia State University[36]	• Technical assistance for first episode psychosis[37] • Training and technical assistance for high fidelity wrap-around, recovery-oriented cognitive therapy, trauma-informed systems, emerging adult populations, cultural and linguistic competence[38]
North Carolina	Center for Excellence in Community Mental Health[39] and the Institute for Best Practices[40] at the University of North Carolina	• Training and technical assistance for Division of Mental Health, medical directors, mental healthcare professionals • Conducts assessments of Assertive Community Treatment and Individual Placement and Support supported employment teams[41]
South Carolina	Southeastern School Behavioral Health Community,[42] Behavioral Alliance of South Carolina[43]	• Training and resources for educators, families, and clinicians • Annual conference

Tennessee	Tennessee Association of Mental Health Organizations[44]	• Annual Conference • Partner with the Tennessee Department of Mental Health to offer trainings on such topics as co-occurring disorders, behavioral health and disaster preparedness, supported employment

Trainings primarily focus on clinical topics, such as specific types of therapeutic approaches (e.g., cognitive behavioral therapy, dialectical behavior therapy, motivational interviewing), psychopharmacology, screening and assessment, and case management. Some organizations provide training for primary care providers on the basics of depression and management. All states provide training and certification in peer services, as well as training in suicide prevention and crisis intervention training for law enforcement officials. Other training topics include school mental health, mental health first aid, assessing suicide risk, and cultural competency.

The trainings in Region IV state include both distance learning and in-person training opportunities. Trainings typically target healthcare providers, including counselors, social workers, nurses, and peer specialists. We also identified training opportunities for community members and other professionals, such as law enforcement officials and clergy. Several identified trainings offer continuing education credits to participants.

Mental Health Priorities for Region IV

Regional Priority Areas

The state mental health agencies in Region IV provide a variety of services and oversee the implementation of various initiatives to improve the health of the diverse populations in their states. Common areas of focus across the SMHAs include: children's and school-based mental health, suicide prevention, peer services and workforce, first episode psychosis, crisis services, assertive community treatment, criminal justice and mental health, supported employment, and supported housing.

We used information from the stakeholder interviews and document review to identify *regional priority areas*. Given the large size and diversity of the region, the Southeast MHTTC sought to identify priorities across states to guide our future training and technical assistance activities. Stakeholders were asked to describe areas of priority for their state, areas of unmet need or development, and current strengths and initiatives. Table 9 summarizes priorities, initiatives, and needs of each state for a variety of focus areas. Based on the patterns across states, we identified regional priority areas that represented common mental health topics. Most or all states have current initiatives to address the regional priority areas; these areas were also identified as important topics where there is a gap between available services and aspirations of where the state plans to be.

We identified 5 regional priority areas: peer services, suicide prevention, school-based mental health, supported housing, and criminal justice and mental health. These regional priority areas are further described below. Other areas of potential priority included mental health system financing, workforce development, veterans' services, and substance use.

Peer Workforce

The Region IV states are at variable levels of development of their peer workforce. All of the SMHAs in Region IV work with organizations that provide training and certification for peer specialists. Additional initiatives in peer services include Georgia's Peer Support Whole Health Initiative, Mississippi's Peer Bridger Program, and Tennessee's Peer Wellness Initiative. For example, Mississippi's Peer Bridger Program aims to improve the transition from inpatient care to care in the community.[22] Georgia's Department of Behavioral Health and Developmental Disabilities created a tool kit for supervisors of certified peer specialists that they are looking to roll out.[37] North Carolina's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services is in the process of revising the peer support services definition in order to move peer supports from the (b)(3) Medicaid Waiver to the state Medicaid plan. Simultaneously, the peer support certification is being revised.[45,46]

At least 6 SMHAs identified expanding peer services as a priority. SMHAs described two main needs related to peer services: 1) expanding the capacity of the peer workforce to work effectively in specialty settings, such as hospitals, emergency rooms, and prisons; and 2) educating providers and managers at CMHCs and hospitals on the role of peer specialists, the value of peers, and how to best utilize the peer workforce. Many of the states are looking

to further integrate their peer workforce into the behavioral healthcare system and specialty services. In particular, they are looking to address specific challenges, such as transitions of care and supporting vulnerable populations.

Suicide Prevention

Most SMHAs currently have initiatives for suicide prevention. At least five states, Florida, Georgia, Kentucky, Mississippi, and North Carolina, have suicide prevention plans. Similarities across the plans include the goals to coordinate suicide prevention efforts across state agencies, provide trainings in evidence-based practices for identifying and intervening with people at risk for suicide behaviors, implement programs to promote wellness, and improve public knowledge of risk and protective factors for suicide. Some of the states also aim to promote efforts to reduce access to lethal means. Other current initiatives include trainings for educators and mental health providers in multiple states and the implementation of Zero Suicide in Florida, Kentucky, South Carolina, and Tennessee. The Mississippi Department of Mental Health is also interested in implementing Zero Suicide, but does not currently have funding to do so.[23]

At least 5 SMHAs identified suicide prevention as a priority for their state. Needs related to suicide prevention include strategies to address suicide prevention among veterans, strategies to reduce access to lethal means, evidence-based practices for state programs, and expansion of services. Many states continue to refine and implement state suicide plans, as well as integrate suicide prevention into school-based mental health initiatives.

School-based Mental Health

School-based mental health is a major focus across the Region IV states. Seven states have passed school safety legislation within the past few years and many states currently have legislation pending. Much of the school safety legislation has come in response to school shootings, particularly the shooting at Marjory Stoneman Douglas High School in Parkland, Florida on February 14, 2018. Common mental health-related elements in school safety legislation include mandatory professional development in suicide prevention for teachers and other school personnel and funding for expansion and coordination of mental health services in schools.[47-49]

A majority of SMHAs listed school-based mental health as a priority and area of ongoing development. Identified needs included expanding services in schools, improved coordination between schools and community mental health services, identifying and implementing behavioral health assessments in schools, and financing. For example, the Alabama Department of Mental Health, in partnership with the Department of Education, launched a program that places therapists in schools and provides a continuum of care in the school setting. While the program is currently in about 60 school districts, the Alabama Department of Mental Health is looking to expand to all 167 school districts in the state.[19,50] Similarly, the Mississippi Department of Mental Health and Department of Education offer web-based suicide prevention training to all school staff and all school districts are required to adopt a policy for suicide prevention.[22] The Mississippi Department of Mental Health is looking to

standardize referral forms and behavioral health assessments and expand mental health first aid trainings to schools.[23] As an example of expanding school-based mental health workforce, a partnership between the Department of Mental Health and Department of Education in South Carolina aims to have mental health staff in all schools by 2020; currently, there are mental health staff in over 700 schools.[33] Many states are looking to expand capacity of school districts to provide coordinated mental health care and further develop the school-based workforce.

Mental Health and Criminal Justice

Addressing the mental health needs of individuals in the criminal justice system is the focus of initiatives across the region. Almost all of the SMHAs partner with other state agencies on training for crisis intervention teams (CIT), pre-arrest diversion programs, and reintegration programs. For example, the Tennessee Department of Mental Health and Substance Abuse Services received state funding in 2018 for the Pre-Arrest Diversion Infrastructure Project. During the program's first year, over 3,000 law enforcement professionals received training and over 1,800 individuals were diverted from jail.[51] In Mississippi, Juvenile Outreach Programs and the Jail-based Competence Restoration Project aim to provide services to individuals in the criminal justice system.[22] The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Use developed a fidelity tool for its Critical Time Intervention program, which it uses for monitoring.

A few SMHAs mentioned criminal justice programs as a priority or need. For example, Mississippi stakeholders mentioned the need to provide education to judges and sheriffs.[23] Further development in this priority area could include improvement of trainings for mental health for criminal justice professionals, strengthening of collaborations with state justice agencies, and expansion of services and programs.

Supported Housing

Almost all of the Region IV SMHAs have new or ongoing supported housing initiatives. Supported housing models, particularly permanent supported housing, are commonly implemented to improve housing stability, stabilize or improve mental health symptoms, and increase engagement in treatment and support services.[52,53] For example, the Kentucky Division for Behavioral Health, Developmental, and Intellectual Disabilities partners with the Kentucky Housing Corporation on the Olmstead Initiative. Providers at CMHCs, state psychiatric hospitals, and other locations can refer individuals with serious mental illness to the program. The program provides housing assistance such as rental assistance, security or utility deposit assistance, furnishing, and/or moving expenses.[54]

A few states mentioned supported housing as a priority or need. For example, Alabama has a plan to start a housing initiative, but has not yet implemented this plan.[19] Areas for development in supported housing could include the expansion of housing services, improved integration and coordination with mental health services, and financing.

Delivery of Trainings and Technical Assistance

In addition to providing their own training and technical assistance, the Region IV SMHAs are receptive to the Southeast MHTTC offering training and TA opportunities in their states. State stakeholders stated that they are open to various delivery methods, both in-person and online, for training and technical assistance. Several stakeholders noted that in-person training provides the opportunity for hands-on learning and for various groups—such as state leaders, community providers, and other groups—to work collaboratively in the same room. One stakeholder commented that short webinars are appropriate for technical topics. Another stakeholder noted that a mixed approach, with an in-person training followed by an online component, has worked well for their SMHA.

Given the large geographic area of Region IV, distance-learning opportunities, particularly those that incorporate engaging learning strategies, may be necessary to reach a wide array of professionals. A recent review of web-based trainings on evidence-based practices for mental health providers identified a variety of training approaches such as virtual classrooms where sessions are led by facilitators, self-paced online programs, and simulation training. Almost 30% of the identified training methods included ongoing support. Overall, the web-based trainings were effective in improving knowledge and skills, and were generally comparable to face-to-face methods.[55] As noted by the stakeholders, there are pros and cons to in-person and distance learning delivery methods. Online trainings, particularly those that are self-directed, provide flexibility that may facilitate participation for some participants; however, other professionals may prefer the accountability of in-person trainings.[56] Other facilitators to attending training trainings reported by mental health professionals include the topic being a good fit with their work, low or no cost, and availability of continuing education credits.[56,57]

In addition to providing training and TA to mental health professionals, a focus of the Southeast MHTTC is to develop leadership and workforce capacity at the systems and state levels. Given the key initiatives and strengths of each Region IV state, the SMHAs offer assets that could serve as example for other states. The SMHAs could benefit from the opportunity to learn from each other and to problem-solve through learning collaboratives. Learning collaboratives are a method for providing training and ongoing support for the purpose of quality improvement, organizational-level change, and/or implementation of evidence-based practices. This approach has been applied in healthcare systems more broadly, and in mental healthcare contexts.[58] Stakeholders in Region IV stated that they are interested in participating in learning collaboratives where they could meet, virtually and/or in-person, with their counterparts from other states and learn from each other.

Table 9. Mental Health Priorities, Initiatives, and Needs in Region IV

Table Key

	Priority	Important areas of focus for SMHAs.
	Initiatives and strengths	Mental health areas in which have key programs and/or were identified as strengths.
	Need	Areas that state leaders identified are currently working to address or would like to address in the future.

	Alabama	Florida	Georgia	Kentucky	Mississippi	North Carolina	South Carolina	Tennessee
Data sources	• **Commissioner call** • **Follow-up call** • **Website**[50,59,60]	• **Commissioner call** • **Follow-up call** • **Website**[61,62]	• **Commissioner meeting** • **Follow-up call** • **Website**[60]	• **Commissioner call** • **Website**[54,63]	• **Commissioner call** • **Follow-up call** • **Website** • **Progress Update Report**[22]	• **Commissioner call** • **Follow-up call** • **Website**[21,64]	• **SCDMH call** • **Follow-up call** • **Website**[65]	• **Commissioner call** • **Follow-up call** • **Website**[66] • **Joint Annual Report**[51]
Access to services					Priority Need			
Children's/School-based MH	Priority Initiative – SBMH collaboration Need – expand services	Priority Initiative – school-based MH, community action teams, systems of care Need	Priority Initiative – APEX program Need – expand services offered through APEX program	Initiative – educator training on suicide prevention	Priority Initiative – taskforce Need – behavioral health assessment	Initiative – systems of care	Priority Initiative – mental health staff in schools Need - financing	Priority Initiative – services in schools Need - financing
Veterans' services	Need – veteran suicide prevention	Need – veteran suicide prevention	Priority Need					Initiative – AIM High Need – veteran suicide prevention
Elder mental health			Priority Need					
Financing	Priority		Priority – program					

			funding and sustainability					
	Need	Need – Medicaid, collaborative systems of care	Need			Need – value-based purchasing	Need – financing for school-based mental health	
Workforce		Need – salary issues	Need – limited mental health providers in rural areas	Need – reduce turnover	Need		Need – recruitment and retention of mental health providers	Need
Linguistic and cultural competency			Priority Need					
Suicide prevention	Priority		Priority		Priority		Priority	Priority
		Initiative – suicide prevention plan, Zero Suicide	Initiative – policy work, suicide prevention plan	Initiative – suicide prevention plan, Zero Suicide, educator and provider training	Initiative – suicide prevention plan	Initiative – suicide prevention plan	Initiative - Young Lives Matter Project, Zero Suicide, trainings	Initiative – Zero Suicide
	Need – veteran suicide prevention	Need – veteran suicide prevention, expand services		Need	Need – lethal means, EBPs for hospital/state programs	Need – EPBs for assessing risk		Need – veteran suicide prevention, expand services
Peer services and workforce	Priority		Priority			Priority	Priority	Priority
	Initiative – peer certification	Initiative – peer certification	Initiative – peer certification, Peer Support Whole Health Initiative	Initiative – peer certification	Initiative – peer certification, Peer Bridger Program	Initiative – revising peer certification and peer service definition	Initiative – peer certification	Initiative – peer certification, Peer Wellness Initiative

	Need – expand workforce	Need – increase peer supports	Need – toolkit rollout		Need – expand programming	Need – expand implementation and workforce development		Need – expand workforce
Integrated care			Priority			Priority Initiative – SAMHSA grant		
Continuum of care			Priority		Need			Strength
Transitions of care		Need						Priority Strength
First episode psychosis	Initiative – NOVA program		Strength		Initiative – Navigate program		Strength	Initiative – First Episode Psychosis Initiative, OnTrackTN program
Trauma informed care					Need			
Crisis services	Priority Initiative	Initiative – crisis stabilization, mobile crisis	Initiative – mobile crisis services, crisis stabilization units		Initiative – stabilization beds, mobile response teams	Initiative – mobile crisis services, crisis stabilization units, behavioral health urgent care	Initiative – mobile crisis response	Initiative – mobile crisis services, crisis stabilization units
ACT		Initiative – ACT	Initiative – ACT	Initiative – modified ACT	Initiative – PACT teams	Initiative – ACT, fidelity monitoring tool		Strength
Community support teams			Strength					

Criminal justice and mental health	Priority Initiative – Stepping Up	Initiative – CIT training, diversion programs, mental health courts Need	Initiative – CIT training, Forensic Peer Mentor Project	Initiative – CIT training, behavioral health jail triage system, reintegration, Forensic Assertive Community Treatment	Initiative – CIT training, jail-based competence restoration, Juvenile Outreach Programs Need – educating judges and sheriffs	Initiative – CIT training, Critical Time Intervention, jail diversion	Initiative – embedding providers in courts	Initiative – CIT training, Pre-arrest diversion Need
Supported employment	Initiative – Individual Placement and Support as part of FEP program			Initiative	Initiative – pilot program	Initiative – Individual Placement and Support	Initiative – Individual Placement and Support	Initiative – Individual Placement and Support Need
Supported education			Priority Initiative – emerging programs					
Supported housing	Initiative – upcoming trainings Need – have a plan but have not yet implemented		Priority Initiative – PATH program Need	Initiative – Olmstead Housing Initiative, SOAR program	Initiative – CHOICE program	Initiative – Critical Time Intervention	Initiative - Path Need	Initiative – MOVE initiative, Creating Affordable Housing Program
Substance Use		Priority – opioids						

		Initiative – services, education, training Need			Initiative – Opioid town hall meetings; Stand Up, Mississippi			Initiative – opioid response grants and programs Need – opioid use
Co-occurring disorders					Initiative – Second change re-entry program			
Intellectual and developmental disabilities					Priority			

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