1992

Expenditure and Revenue Patterns of State Mental Health Agencies from 1981 to 1987

Trevor R Hadley, *University of Pennsylvania*
Dennis P Culhane, *University of Pennsylvania*
Fred Snyder, *University of Pennsylvania*
Theodore Lutterman, *University of Pennsylvania*

Administration & Policy in Mental
Health, 19(3), 1992

Returned For Full

Expenditure and Revenue Patterns of State Mental Health Agencies, from 1981 to 1987[1,2]

Trevor R. Hadley, Dennis P. Culhane, Fredrick J. Snyder
University of Pennsylvania
Section of Public Psychiatry and Mental Health Services Research

Theodore C. Lutterman
National Association of State Mental Health Program Directors
Research Institute, Inc.

Running Head: EXPENDITURES AND REVENUES

Abstract

This paper documents expenditure and revenue patterns of state mental health agencies from 1981 to 1987. Expenditure data show an overall decline of mental health expenditures of 4.9% over this period. States with declining overall expenditures were more likely to make deep cuts in hospital expenditures and little or no increases in community programs, while the few states with increasing expenditures showed substantial increases in community programs and constant funding for hospitals. A relatively more dramatic shift was noted across states of shifting expenditures from inpatient to ambulatory care. Revenue data reveal that federal support for state mental health agencies increased slightly during this period, but solely as a function of the introduction of the Block Grant in 1982. However, once introduced, both the Block Grant and other federal sources show steady losses against inflation. State sources also show a decline of 4% during this period, most of which was felt between 1981 and 1983, after which there has been no further decreases. Interstate variability in percapita spending on mental health is described and found to be significant even beyond adjustments for costs of services. Expenditures on mental health also show relatively greater declines compared to overall state budgets and state health and welfare budgets during this period, suggesting an increasingly lower priority for mental health services in the state budget allocation process.

Expenditure and Revenue Patterns of State Mental Health Agencies, from 1981 to 1987

Trevor R. Hadley, Dennis P. Culhane, Fredrick J. Snyder, & Theodore C. Lutterman

Introduction

Since the 19th century, state government has had the primary responsibility for the funding and delivery of mental health services, particularly to individuals who have a serious and persistent mental illness. In the absence of a universal federal health or mental health system, the role of the states in providing and paying for public mental health services is critical. Because of this central role, state mental health agency (SMHA) directors have long been interested in developing and maintaining data on the funding of services. The task of analyzing SMHA expenditures and revenues, however, is complicated by the fact that states organize their mental health systems in highly variable ways and the costs of providing services vary dramatically in different parts of the country.

In 1988, Lutterman, et al. reported on the expenditures and revenues of SMHA's for 1981-1985 and suggested that further analyses of the raw data might lead to a better understanding of the total public mental health system. Therefore, this paper reports on the continuing trends in the financing of public mental health services from 1981 to 1987, and along with another paper in this issue (see Schinaar, Rothbard & Yin, 1991) provides analyses of SMHA-controlled revenue and expenditure patterns.

The Data Base and Data Compilation Procedures

Since 1982, the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. have collected and published information about SMHA controlled expenditures and revenues (NASMHPD, 1990). This national data base includes a summary of mental health revenues and expenditures under the direct control of each SMHA for Fiscal Years 1981, 1983, 1985, and 1987. The data base documents the total funds under the direct administrative control of the SMHAs for all (a) SMHA operated programs and (b) SMHA funded programs. Within these program categories, data are collected for four administrative auspices, defined as state mental hospitals, other inpatient services, community based programs, and SMHA support services (including prevention, research, training, and SMHA administration). In addition, figures are provided for specific services (or activities) within each of the four auspices. These services/activities include: inpatient services, residential programs, ambulatory care, prevention programs, and other treatment modalities. For some states these service expenditures are also portrayed with reference to children and adolescents, adults, and elderly persons (NASMHPD, 1990).

In each of the four reporting years (1981, 1983, 1985 and 1987), information was obtained from archival sources that portrayed actual expenditures and revenues under the direct control of the SMHA. Using archival data was considered necessary to obtain reliable data. The archival data used in the data base included SMHA expenditure reports, annual state budget documents, year-end compilations of revenue sources, internal SMHA working

documents, published audits, and other financial documents.

Federal, state, county, and local payments, payments from first and third parties, and any other funds that were not controlled by or did not flow through the SMHAs were not included in this study. Organizations whose total revenues and expenditures are not reflected in the data base may include agencies such as local community mental health centers; county or multi-county mental health and mental retardation service boards; general hospitals; local clinics; and/or other entities, programs, services, or facilities not directly operated or administered by the SMHA.

The project has utilized two primary means for accumulating and depicting data: (a) analysis and coding of state expenditure data; and (b) follow-up discussion with appropriate SMHA officials to clarify items in the state's data base, request supplemental budget documents, and/or request review of allocations made to the various revenue and expenditure categories.

Generally, the following steps were followed to obtain final revenue and expenditure figures for each of the years:

1) SMHA staff were contacted and requested either to forward revenue and expenditure data archival documents and/or to make initial dollar allocations to cells on the tables and forward these data to the NASMHPD Research Institute.

2) SMHA-controlled revenues and expenditures were separated into four classifications: (1) mental health, (2) mental retardation/developmental disabilities (MR/DD), (3) drug programs, and (4) alcohol programs. Expenditures for MR/DD,

alcohol, and drug programs were categorized by "Administrative Auspice" and retained in the files. However, the funds of MR/DD, drug, and alcohol programs were removed from the final data base used for this analysis.

3) The net revenue and expenditure figures (representing only "mental health" programs) were then separated into "Administrative Auspice" and "Service/Activity" categories.

4) Following preliminary completion and review of the tables by project staff, the tables, footnotes, glossary, and cover letter (including special questions and notes) were sent to a specially designated SMHA fiscal contact person and to the SMHA director. These persons were requested to respond to any questions, verify the tables, and make appropriate modifications in the final data base.

Findings: Expenditures

Overall Trends

One primary concern to public policy makers is the overall pattern of SMHA expenditures. Total SMHA controlled expenditures have increased in raw dollars from $6.1 billion in 1981 to $9.2 billion in 1987. However, when adjusted for inflation, these expenditures reflect an actual decline of 4.9% in purchasing power, from $6.1 billion in 1981 to $5.8 billion in 1987.

This decline can also be seen on a per capita basis. For 1981, the national SMHA per capita expenditures were $26.79. When adjusted for inflation, they declined 9.4% to $24.27 for 1987. This $2.52 decline is also reflected in an even steeper decline of median expenditures: from $22.36 in 1981 to $19.08 by 1987.

Apparently, when adjusted for inflation, declines outpaced any increases, across states.

Insert Tables 1 & 2 about here

This shift might well be explained by an overall decline in total state expenditures by state governments, or by a decline in state government expenditures specifically for health and welfare services. However, the data in Table 1 indicate that overall state budgets increased by 10.7% after inflation between 1981 and 1987, and that state health and welfare expenditures increased by 7.3% over that same period (National Governors Association, 1990). Therefore, state mental health expenditures not only fell behind inflation, but declined even more sharply relative to the growth in overall state expenditures and other expenditures for health and welfare programs.

Further analysis of these data reveals that total mental health expenditures constituted 2.2% of total state government budgets in 1981 and only 1.9% in 1987. Similarly, mental health expenditures as a proportion of health and welfare expenditures show an overall decline from approximately 12% in 1981 to approximately 10.6% in 1987. Overall, these declines appear to reflect a lower priority for mental health services in the states.

Trends in Types of Services

In addition to interest in the general expenditures trends from 1981 to 1987, there has been considerable interest in the

pattern of expenditures for particular types of services and the settings in which these services are provided. Since 1981 there has been a major policy emphasis by SMHA's on the development of community-based mental health programs and ambulatory services which has been accompanied by a reduction in reliance on inpatient services in state psychiatric hospitals, long-term care psychiatric facilities, and local inpatient units. The success of this policy initiative is reflected by the data. When examining the service expenditure data from 1981 to 1987, irrespective of organizational location, national per capita inpatient expenditures have declined from $17.26 to $15.06 (adjusted for inflation), a loss of $2.20, representing an overall decline of 13%. In contrast, per capita ambulatory expenditures (adjusted for inflation) have grown from $3.26 per capita in 1981 to $7.60 per capita in 1987, a 133% increase. This growth in ambulatory expenditures is in sharp contrast to the overall decline in both overall SMHA and state hospital per capita expenditures.

Likewise, a change has occurred in service setting expenditures (organizational location) when comparing the state hospital with community-based program expenditures, although this change reflects much less cost-shifting than in service type. Per capita inflation-adjusted state hospital expenditures declined from $18.02 in 1981 to $15.38 in 1987, a decline of 14.7%. In contrast, community-based expenditures were essentially unchanged, going from $7.71 in 1981 to $7.78 in 1987, an increase of $.08 or 1%. Hence, states have made substantial cuts in hospital-based programs, and have maintained their level of funding for community-based

services.

Insert Tables 3 & 4 about here

The overall shift described above is a function of services growth in some states and selective relocation of services in others. In states whose total adjusted mental health expenditures increased ("gainers"), and in states whose total adjusted mental health expenditures declined ("decliners") differing patterns of movement from state hospital inpatient care to community and ambulatory care are clear. When overall expenditures are adjusted for inflation and population, 11 states showed increases from 1981 to 1987, 38 states showed declines, and 1 state had no change. Comparing states that gained with those that declined on "service setting," the gainers showed significantly greater increases in community programs (+49%) than declining states (+9%) ($t = -2.61$, $df=47$, $p = .012$). Moreover, states that gained maintained state hospital-based program funding (up only 2%) while declining states dramatically reduced state hospital expenditures (-19%) ($t = -3.91$, $df = 47$, $p = .0001$). Hence, gainers were more likely to fund community-based programs with new money while maintaining state hospital funding levels, and decliners were more likely to maintain or increase community-based programs by reducing state hospital expenditures.

Differences between gainer and declining states are also observed when examining inpatient services. Declining states showed significant reductions (-24%) in inpatient services compared

with gainer states, which show a slight increase (+8%) in inpatient service expenditures ($t = -4.78$, $df = 45$, $p = .0001$). A comparison of ambulatory service expenditures was not possible because 1981 baseline data was so small in many cases as to produce out-of-range or extreme values, particularly among the "gainer" states. However, of the ten states which showed declines in ambulatory expenditures, nine were states with declines in total expenditures.

Inter-State Variability

Another area of interest to policy makers has been the wide variation among the states in the pattern of SMHA expenditures for mental health services. In 1987, for example, the mean state per capita expenditure was approximately $34, the median was $30.45, and the range was from a low of $12 to a high of $99. This variation has often been viewed by some as a direct reflection of the commitment of states to mental health services. However, this variability is also very possibly affected by variations in the local costs of services, variations in need, differences in political environment, and broader tax and spending policies of the states.

For example, in community programs and (to a lesser extent) in state hospitals, wages and benefits comprise 80% or more of these facilities' total budgets. Therefore, unadjusted SMHA expenditures, uncontrolled by wage rates, do not truly reflect the relative priority given to mental health services in state budgets. When mental health expenditures are adjusted by wage rates (U.S. Department of Labor, 1990), the per capita range of $12 to $99 dollars can be adjusted to a smaller range from $7 to $48 dollars,

with a mean of $18, and a median of $17. This attempt to equalize or standardize expenditure patterns substantially reduces the range of variability in per capita expenditures on a national basis. However, the significant variability which remains is an important subject for research. Schinnar, Rothbard and Yin (1991), also in this issue, provide an investigation into the issue of inter-state variability.

Conclusion

In general, the trend of SMHA expenditures for mental health services is quite clear. State mental health agency expenditures have grown from 1981 to 1987 by almost 50% in raw dollars, but have declined by 4.9% when adjusted for inflation, and nearly 10% on a per capita basis. It must be emphasized that in a period of increased demand for services, state mental health agencies appear to be losing ground in the overall resource allocation process of state governments. This is best reflected in both the decline in the proportion of total state government dollars for mental health from 1981 to 1987, and in the decline of mental health as a proportion of state health and welfare expenditures for the same period. During this same period, the overall inpatient share of total SMHA funds has declined relatively dramatically. Correspondingly, SMHA funds for ambulatory care have grown during this period despite the decrease in the SMHA's share of total state government budgets.

In 1988, Lutterman, et. al. (Lutterman, Mazade, Wurster & Glover, 1988) reported on this data base for the period of 1981 to 1985 and noted this trend towards community and ambulatory

services. This current analysis which includes fiscal year 1987, reinforces those earlier findings by confirming an overall shift of SMHA's away from inpatient and state hospital programs toward ambulatory and other community-based programs. However, some differences among the states are noteworthy. Specifically, in this analysis, states with growing budgets were found to be more likely to increase funding of community programs (and to a greater extent than states with declining budgets), while leaving state hospital funding constant. States with declining budgets, on the other hand, made more modest increases in community programs, but usually did so after cutting deeply into state hospital expenditures.

Findings: Revenues

Overall Trends

What are the sources of this overall decline in SMHA expenditures? This section examines patterns of revenue change that account for this shift in available resources. And like that found for expenditures, revenues for SMHA-funded mental health services increased nationally from $6.2 billion in 1981 to $9.3 billion in 1987. However, when adjusted for inflation (to 1981 dollars), SMHA revenues actually declined to $5.9 billion in 1987, representing a 4.8% decrease.

Revenues to state mental health agencies derive largely from two sources: state taxes and federal reimbursements for services under the Medicaid and Medicare programs. State tax dollars account for almost 80% of the total. Federal reimbursements, primarily through Medicaid and Medicare, contribute another 15%. Other revenues, including the Federal Alcohol, Drug Abuse and

Mental Health Block Grant, local government, and first and third party payments, constitute less than 5% of total revenues that flow directly through state mental health agencies.

From 1981 to 1987, revenues to state mental health agencies from **state** government sources increased from $5 billion dollars to approximately $7.5 billion (a 50% increase). However, when adjusted for inflation, this apparent increase actually represents a decline of 5% over this same period. It should be noted, however, that from the period 1981 to 1983 (a difficult economic period) SMHAs experienced an adjusted 10.2% decline in state government revenues. From the period 1983 to 1985, SMHAs increased revenues by 5.1%, and from 1986 to 1987 by .8%. This indicates that for the last several years, there has been some increase in overall state revenues to the SMHA, although such increases have not compensated for the decline from 1981 to 1983.

Insert Tables 5 and 6 about here

The pattern for federal revenues to the SMHAs is significantly different. From 1981 to 1987, total federal revenues increased from approximately $.78 billion to $.85 billion, an overall increase of approximately 9% when adjusted for inflation. However, it must be noted that this is entirely a function of the Federal Block Grant program which began in 1982, to supplant direct federal grants to local community mental health centers by providing Block Grant funds to the SMHAs. With this exception, other federal

revenues to the SMHAs declined from 1981 to 1987 by nearly 12%, as shown in Table 5. Combined federal revenues to the SMHA increased by 25% between 1981 and 1983 due to the Block Grant. Other federal sources began a steady decline during that same time period. The Block Grant initially helped to buffer these overall federal declines, although Block Grant levels also declined by 29% from 1983 to 1987, after adjusting for inflation. Federal revenues as a percentage of total SMHA revenues increased from 13.5% to 14.7% during this period while the state government revenues to the SMHA declined proportionately.

From the total $1.34 billion contribution of federal revenues to state mental health agencies for 1987, almost $1 billion (76%) was from federal Medicaid and Medicare reimbursements. Of that amount, over $600 million was received for services delivered in state psychiatric hospitals with the remaining $400 million for ambulatory and community-based programs. This reflects the overall pattern wherein Medicaid and Medicare reimbursed "facility-based" programs (typically inpatient), and where, in many systems, Medicaid payments were paid by the state Medicaid agency directly to local mental health programs, and consequently, did not show as a revenue to the state mental health agency.

In addition to the overall pattern of SMHA revenues from state and federal sources, it is interesting to note the pattern of federal revenues used for state psychiatric hospital and community-based programs. Although total revenues to state psychiatric hospitals increased from $450 million to approximately $650 million

in raw dollars from 1981 to 1987, this represents an overall decline of almost 20% when adjusted for inflation. Revenues to community-based programs rose from $330 million in 1983 to slightly over $400 million in 1987, representing an overall decline of approximately 4% when adjusted for inflation.

Despite the increased federal emphasis on expansion of community-based resources through the State Comprehensive Mental Health Plan Act of 1986, P.L. 99-660, coupled with SMHAs' deemphasis on state psychiatric hospitals in favor of community-based services, federal support to SMHAs (particularly federal support for community services) has not substantially increased during the period of 1983 to 1987. If the initiation of the Block Grant is viewed largely as a transfer of funds rather than an increase, overall federal revenues have declined dramatically.

Mental Health Revenues Relative to State Tax Capacity

Since state tax dollars constitute an overwhelming proportion of the revenues to SMHAs (nearly 80%), it is important to evaluate revenues (particularly state revenues) with regard to per capita dollars and in light of the SMHAs' ability to capture potentially available funds. On a per capita basis adjusted for inflation, SMHA revenues have declined from $22.13 in 1981 to $19.89 in 1987.

Although per capita income is widely used as a measure in federal grant formulas, and elsewhere as an indicator of state fiscal capacity, the Advisory Commission on Intergovernmental Relations (ACIR) has utilized a different indicator, the Representative Tax System (RTS) (Advisory Commission on

Intergovernmental Relations, 1986). Recently, the ACIR has also developed the Representative Revenue System (RRS) -- as a parallel measure to the Representative Tax System (RTS) --to illustrate the states' capacity to collect taxes and non-tax revenues. In general, this method defines revenue capacity as the dollar amount of revenue that each state and local government would raise if they applied a national, uniform set of tax rates to a commonly used set of tax bases. Since the same tax rates are used for every state, estimated revenue yields vary due to differences in each state's underlying tax bases. Thus, the RRS system provides a means to create a standardized measure of revenue capacity, which, in turn, facilitates comparative evaluations of state tax effort by computing the ratio of actual revenue to estimated capacity.

Using these factors, it is possible to compare a state's state mental health agency revenues to the total tax effort and revenue capacity of that state. State mental health revenues from state government sources in 1981 constituted 2.1% of total tax effort, but in 1987 it had declined to 1.7% of tax effort. This decline was reflected in previous studies of SMHA expenditures which showed that total percapita expenditures as a percentage of total state government budgets declined from 1981 to 1987. In addition, fiscal year 1981 state government revenues to state mental health agencies as a percentage of the state's total revenue capacities was approximately 2%, but by 1987, these revenues had declined to approximately 1.64%. This finding suggests that in addition to a reduced proportion of the overall state budgets, SMHAs received a

substantially smaller percentage of both state revenue capacity and state tax effort from 1981 through 1987.

Conclusion

The period 1981 to 1983 was a turbulent period for state government in general and SMHAs in particular. In addition to the initiation of the ADAMHA Block Grant which resulted in actual reductions in overall federal support to SMHA programs, state tax dollars substantially declined, possibly as a function of additional federal budget reductions in other state government programs. Since 1983, state funds (adjusted for inflation) have increased by approximately 6%, but federal revenues to SMHAs have declined sharply.

In summary, the decline in federal revenues to SMHAs is part of a decline in all categories of revenue. The Federal Block Grant increases have not kept pace with inflation, and the states' policy of moving away from state psychiatric hospital inpatient care to community-based alternatives has not been supported by the federal government in any substantive way from either Medicaid or Medicare, which has resulted in overall decreased federal support. Consequently, the states continue to assume the vast responsibility for generating revenues for SMHA-funded mental health services, a challenge which has been met with great difficulty, and which has not been able to compensate for losses from the federal government.

Discussion

State Mental Health Authorities had less revenue from 1981 to 1987, and consequently, had to accommodate by making shifts in

programming. The period under study, therefore, provides an example of how policy changes occur under conditions of serious fiscal constraint.

Generally speaking, cuts in federal revenues have forced an overall reduction in expenditures on hospital services but have created a no-growth situation for community services. Particularly for those states with declining overall revenues, expenditure patterns reveal deep cuts in hospital expenditures and little to no increases in community programs. However, those few states with increasing revenues show a slightly different pattern, with substantial increases in community-based services, and with no cuts or at least no-growth in hospital services. It appears then that the federal bias to support hospital-based programs leads to cuts in inpatient services during times of federal expenditure reductions, but that this does not necessarily lead to an increase in community programs. Only those states which are able to compensate for federal losses are able to fund significantly more community programs.

Apart from the organizational location of programs, a more dramatic shift in program types has occurred across state mental health agencies. In particular, there has been a 133% increase in ambulatory service expenditures from 1981 to 1987. This shift reflects the relatively greater ability of SMHA's to shift funding for program types <u>within</u> organizational setting, rather than to shift organizational setting. An apparent expansion of services offered within hospital settings has enabled this relatively

greater shifting of funds from inpatient to ambulatory care.

Future research should continue to monitor these trends, and assess the ability of states to make policy changes under varying fiscal conditions. Future studies could explore the degree to which the increase in ambulatory expenditures reflects a substitution for supporting hospitals with declining inpatient expenditures. Studies could also examine the relationship between federal cutbacks and reductions in hospital expenditures, and the long-term effect of this shift on the burden of states in paying for a community-based mental health system.

References

Advisory Commission on Intergovernmental Relations (1986). State Fiscal Capacity and Effort. Washington, DC: U.S. Advisory Commission on Intergovernmental Relations.

Hudson, C. & Dubey, S. (1986). Decision-Making under the ADAMHA Block Grant: Four case studies. Administration in Mental Health, 14(2), p. 97-116.

Lutterman, T., Mazade, N., Wurster, C. & Glover, R. (1988). Expenditures and Revenues of State Mental Health Agencies, 1981-1985. Hospital and Community Psychiatry, 39(7), p. 758-762.

NASMHPD (1990a). Expenditure Patterns of State Mental Health Agencies 1981-1987. Alexandria, VA: National Association of State Mental Health Program Directors.

NASMHPD (1990b). Funding Sources and Expenditures of State Mental Health Agencies: Revenue/Expenditure Study Results, Fiscal Year 1987. Alexandria, VA: National Association of State Mental Health Program Directors.

National Governor's Association (1990). The Book of the States, 1988-1989. Washington, DC: National Governor's Association.

State Comprehensive Mental Health Plan Act of 1986 (1986). Public Law 99-660, Title V.

U.S. Department of Labor, Bureau of Labor Statistics (1990). Employment and Earnings, Monthly Data for 1982-1988. Washington, DC: Government Printing Office.

Footnotes

[1] This research was conducted under contract No. 278-88-0021 from the Division of Applied and Services Research, National Institute of Mental Health.

[2] The authors wish to acknowledge Noel Mazade, Ph.D. and Cecil Wurster of the NASMHPD Research Institute, Inc. for their review of earlier drafts of this paper.

TABLE 1

Total State Government, State Health & Welfare,
and State Mental Health Agency Budgets

Raw and Adjusted Dollars, % Change in Inflation Adjusted Dollars,
and Per Capita, From 1981 to 1987 in Billions of Dollars

	RAW DOLLARS	INFLATION ADJUSTED	PERCENT CHANGE	PER CAPITA
TOTAL STATE BUDGET				
1981	276.9	276.9	X	$1,390.00
1983	357.6	294.8	6.46%	$1,480.00
1985	438.9	320.7	8.79%	$1,529.00
1987	481.1	306.6	-4.40%	$1,415.00
CHANGE 1981-1987			10.73%	
TOTAL HEALTH+WELFARE				
1981	50.8	50.8	X	$201.00
1983	66.5	54.8	7.87%	$213.00
1985	78.8	57.6	5.11%	$221.00
1987	85.5	54.5	-5.38%	$205.00
CHANGE 1981-1987			7.28%	
TOTAL MENTAL HEALTH				
1981	6.1	6.1	X	$26.79
1983	7.1	5.8	-4.92%	$25.38
1985	8.3	6.1	5.17%	$25.76
1987	9.2	5.8	-4.92%	$24.27
CHANGE 1981-1987			-4.92%	

Table 2
State Government Expenditures, 1981 and 1987, By State
Adjusted for Inflation (In Millions)

STATE	1981 State Budget	1981 Health & Welfare	1981 Mental Health	1987 (adjusted) State Budget	% change	1987 (adjusted) Health & Welfare	% change	1987 (adjusted) Mental Health	% change
ALASKA	3,230	160	15	3,896	0.21	218	0.36	16	0.07
ALABAMA	4,154	648	78	4,333	0.04	599	-0.08	75	-0.03
ARKANSAS	3,187	395	39	2,308	-0.28	379	-0.04	36	-0.08
ARIZONA	2,295	208	28	3,847	0.68	390	0.88	35	0.25
CALIFORNIA	36,087	8,427	680	40,771	0.13	8,572	0.02	516	-0.24
COLORADO	3,366	445	70	3,820	0.13	580	0.30	61	-0.13
CONNECTICUT	3,472	694	99	4,439	0.28	738	0.06	114	0.15
DELAWARE	970	119	26	1,151	0.19	109	-0.08	17	-0.35
FLORIDA	8,223	1,032	201	10,077	0.23	1,550	0.50	191	-0.05
GEORGIA	5,194	868	138	5,984	0.15	1,000	0.15	127	-0.08
HAWAII	1,895	296	17	1,876	-0.01	232	-0.22	17	-0.02
IOWA	3,479	545	23	3,386	-0.03	541	-0.01	21	-0.08
IDAHO	1,108	146	13	1,111	0.00	121	-0.17	11	-0.17
ILLINOIS	12,730	2,768	204	12,385	-0.03	2,651	-0.04	181	-0.11
INDIANA	4,794	694	103	5,406	0.13	844	0.22	108	0.05
KANSAS	2,419	397	41	2,516	0.04	349	-0.12	43	0.04
KENTUCKY	4,168	743	54	4,275	0.03	686	-0.08	55	0.01
LOUISIANA	5,412	727	80	5,326	-0.02	740	0.02	71	-0.12
MASSACHUSETTS	7,457	2,277	183	8,360	0.12	2,152	-0.05	230	0.26
MARYLAND	5,564	892	139	5,824	0.05	1,012	0.13	140	0.01
MAINE	1,369	197	28	1,522	0.11	337	0.71	31	0.12
MICHIGAN	12,357	3,212	299	13,066	0.06	3,225	0.00	359	0.20
MINNESOTA	5,700	921	70	6,079	0.07	1,050	0.14	114	0.64
MISSOURI	4,258	756	116	4,773	0.12	759	0.00	102	-0.12
MISSISSIPPI	2,885	453	35	2,825	-0.02	394	-0.13	36	0.06
MONTANA	1,153	120	17	1,118	-0.03	156	0.31	14	-0.18
NORTH CAROLINA	6,202	892	138	6,882	0.11	880	-0.01	165	0.19
NORTH DAKOTA	1,013	65	25	997	-0.02	132	1.04	18	-0.29
NEBRASKA	1,506	228	26	1,487	-0.01	270	0.19	22	-0.17
NEW HAMPSHIRE	894	153	32	986	0.10	179	0.17	32	-0.01
NEW JERSEY	8,822	1,624	194	11,187	0.27	1,737	0.07	208	0.07
NEW MEXICO	2,183	222	31	2,501	0.15	246	0.11	23	-0.27
NEVADA	1,221	100	18	1,523	0.25	102	0.03	18	-0.02
NEW YORK	27,199	5,805	1,172	32,438	0.19	7,414	0.28	1,122	-0.04
OHIO	12,180	2,094	267	14,668	0.20	2,525	0.21	231	-0.14
OKLAHOMA	3,433	596	68	3,762	0.10	590	-0.01	61	-0.10
OREGON	4,041	540	55	3,520	-0.13	427	-0.21	49	-0.10
PENNSYLVANIA	14,004	3,033	481	14,094	0.01	2,942	-0.03	382	-0.21
RHODE ISLAND	1,393	425	34	1,505	0.08	346	-0.19	25	-0.26
SOUTH CAROLINA	3,484	467	96	4,054	0.16	538	0.15	97	0.01
SOUTH DAKOTA	762	127	12	791	0.04	112	-0.12	12	0.02
TENNESSEE	4,028	695	82	4,341	0.08	792	0.14	75	-0.09
TEXAS	12,924	1,659	191	14,721	0.14	1,693	0.02	196	0.02
UTAH	1,889	225	20	2,110	0.12	285	0.27	21	0.03
VIRGINIA	5,656	868	120	6,349	0.12	803	-0.07	128	0.07
VERMONT	711	122	17	755	0.06	139	0.14	15	-0.07
WASHINGTON	6,324	917	74	6,797	0.07	1,037	0.13	105	0.41
WISCONSIN	6,588	1,397	106	6,936	0.05	1,464	0.05	95	-0.10
WEST VIRGINIA	2,640	298	38	2,435	-0.08	346	0.16	28	-0.28
WYOMING	937	59	11	1,277	0.36	99	0.67	9	-0.18
TOTAL	276,960	50,750	6,104	306,592	0.11	54,487	0.07	5,858	-0.04

TABLE 3

State Mental Health Agency Controlled Per Capita Expenditures
For Mental Health Services, 1981 - 1987
By Category of Service and Organizational Location

	1981 ADJUSTED	1983 ADJUSTED	PERCENT CHANGE	1985 ADJUSTED	PERCENT CHANGE	1987 ADJUSTED	PERCENT CHANGE	1981-1987 CHANGE
TOTAL MENTAL HEALTH	26.79	25.38	-5.26%	25.76	1.50%	24.27	-5.78%	-9.41%
TOTAL INPATIENT	17.26	16.11	-6.66%	16.58	2.92%	15.06	-9.17%	-12.75%
TOTAL AMBULATORY	3.26	5.38	65.03%	6.55	21.75%	7.6	16.03%	133.13%
TOTAL HOSPITAL	18.02	16.72	-7.21%	16.76	0.24%	15.38	-8.23%	-14.65%
TOTAL COMMUNITY	7.71	7.61	-1.30%	8.12	6.70%	7.78	-4.19%	0.91%

Table 4

State Agency Controlled Mental Health Expenditures, by Category of Service, 1981 and 1987 (adjusted)

In Thousands

STATE	1981 Total	Ambulatory	Inpatient	1987 (adjusted) Total	% change	Ambulatory	% change	Inpatient	% change
ALASKA	14,887		9,829	15,977	7.32%	0		8,618	-12.32%
ALABAMA	77,765		61,814	75,347	-3.11%	0		NA	NA
ARKANSAS	38,533	14,037	16,293	35,529	-7.80%	8,417	-40.04%	21,019	29.01%
ARIZONA	27,818		16,485	34,829	25.20%	12,152		17,076	3.58%
CALIFORNIA	680,274	240,796	322,927	516,243	-24.11%	153,534	-36.24%	250,416	-22.45%
COLORADO	69,997	18,515	45,915	61,091	-12.72%	13,292	-28.21%	41,357	-9.93%
CONNECTICUT	98,787		66,934	113,867	15.27%	16,351		80,153	19.75%
DELAWARE	26,183	2,239	23,516	16,891	-35.49%	379	-83.07%	13,166	-44.01%
FLORIDA	200,781		139,831	191,483	-4.63%	33,708		134,573	-3.76%
GEORGIA	138,105	6,139	125,316	127,300	-7.82%	15,720	156.09%	99,654	-20.48%
HAWAII	17,457	8,834	7,153	17,029	-2.45%	7,740	-12.38%	6,815	-4.73%
IOWA	23,022		0	21,153	-8.12%	920		19,344	NA
IDAHO	12,831		7,378	10,647	-17.02%	3,460		5,711	-22.60%
ILLINOIS	203,715	41,392	148,224	180,632	-11.33%	54,472	31.60%	104,408	-29.56%
INDIANA	103,207	19,347	74,809	107,914	4.56%	24,356	25.89%	72,431	-3.18%
KANSAS	41,235	945	34,433	43,029	4.35%	1,139	20.51%	35,603	3.40%
KENTUCKY	54,090		32,070	54,550	0.85%	19,112		32,557	1.52%
LOUISIANA	80,400		59,986	71,043	-11.64%	18,158		50,271	-16.20%
MASSACHUSETTS	182,692	59,266	79,595	230,132	25.97%	65,696	10.85%	114,468	43.81%
MARYLAND	138,897	3,543	116,387	139,707	0.58%	18,739	428.86%	95,218	-18.19%
MAINE	28,213	207	20,058	31,491	11.62%	6,106	2852.98%	20,174	0.58%
MICHIGAN	298,900		0	358,742	20.02%	72,364		217,006	NA
MINNESOTA	69,529		39,739	114,357	64.47%	24,791		58,212	46.49%
MISSOURI	115,839	4,966	72,059	102,138	-11.83%	13,952	180.95%	43,157	-40.11%
MISSISSIPPI	34,571	2,477	31,007	36,484	5.53%	0	-100.00%	29,488	-4.90%
MONTANA	17,314		13,178	14,179	-18.11%	2,200		11,005	-16.49%
NORTH CAROLINA	138,346		93,579	165,080	19.32%	0		93,892	0.33%
NORTH DAKOTA	24,996	7,769	15,826	17,835	-28.65%	6,250	-19.55%	10,818	-31.64%
NEBRASKA	25,879	4,116	20,610	21,568	-16.66%	2,882	-29.97%	16,969	-17.67%
NEW HAMPSHIRE	32,341		25,125	24,132	-25.38%	8,241		8,633	-65.64%
NEW JERSEY	193,955	20,512	162,484	207,712	7.09%	32,694	59.39%	152,798	-5.96%
NEW MEXICO	31,321		17,049	22,732	-27.42%	5,637		11,018	-35.38%
NEVADA	18,193		7,396	17,755	-2.41%	0		1,089	-85.28%
NEW YORK	1,171,777	133,348	915,769	1,122,431	-4.21%	207,333	55.48%	795,576	-13.12%
OHIO	266,668		167,585	230,533	-13.55%	60,200		147,605	-11.92%
OKLAHOMA	67,924	815	42,091	60,963	-10.25%	14,559	1685.52%	40,874	-2.89%
OREGON	54,546	14,287	33,077	49,211	-9.78%	15,522	8.65%	29,478	-10.88%
PENNSYLVANIA	481,111	63,975	358,087	382,321	-20.53%	52,257	-18.32%	281,668	-21.34%
RHODE ISLAND	34,080	2,978	29,904	25,323	-25.69%	6,344	113.04%	14,905	-50.16%
SOUTH CAROLINA	95,898	468	61,247	96,948	1.10%	17,130	3563.28%	55,550	-9.30%
SOUTH DAKOTA	11,701	2,001	9,163	11,937	2.01%	2,703	35.11%	8,455	-7.72%
TENNESSEE	81,984		40,782	74,684	-8.90%	17,026		40,533	-0.61%
TEXAS	191,069	12,353	126,485	195,630	2.39%	37,649	204.78%	135,566	7.18%
UTAH	20,187		9,991	20,694	2.51%	0		9,815	-1.76%
VIRGINIA	119,613	14,746	99,738	127,672	6.74%	20,859	41.46%	62,308	-37.53%
VERMONT	16,607	6,184	8,893	15,386	-7.35%	6,046	-2.24%	6,358	-28.50%
WASHINGTON	74,458	79	36,269	105,157	41.23%	20,253	25391.69%	55,810	53.88%
WISCONSIN	106,226	37,049	53,707	95,281	-10.30%	37,216	0.45%	49,600	-7.65%
WEST VIRGINIA	38,500		24,298	27,749	-27.92%	8,154		12,584	-48.21%
WYOMING	11,335		8,620	9,343	-17.58%	2,203		6,980	-19.03%
TOTALS	6,103,758	743,382	3,932,711	5,849,860	-4.16%	1,167,917	57.11%	3,630,781	-7.68%

TABLE 5

STATE MENTAL HEALTH AGENCY CONTROLLED REVENUES

(IN BILLIONS)

		RAW DOLLARS	INFLATION ADJUSTED	PERCENT CHANGE	PER CAPITA
STATE					
	1981	5.041	5.041	X	22.22
	1983	5.489	4.525	-0.10	19.62
	1985	6.513	4.758	0.05	20.24
	1987	7.524	4.794	0.01	19.89
BLOCK GRANT					
	1981	X	X	X	X
	1983	0.259	0.214	X	0.93
	1985	0.245	0.179	-0.16	0.76
	1987	0.238	0.152	-0.15	0.63
OTHER FEDERAL					
	1981	0.781	0.781	X	3.44
	1983	0.923	0.760	-0.03	4.22
	1985	0.973	0.711	-0.06	3.78
	1987	1.103	0.703	-0.01	3.54
OTHER					
	1981	0.401	0.401	X	1.77
	1983	0.483	0.398	-0.01	1.73
	1985	0.520	0.380	-0.05	1.61
	1987	0.503	0.321	-0.16	1.33
TOTAL					
	1981	6.223	6.223	X	27.43
	1983	7.191	5.927	-0.05	25.69
	1985	8.374	6.118	0.03	26.02
	1987	9.369	5.970	-0.02	24.76

Table 6

State Mental Health Agency Controlled Revenue State and Federal Sources, 1981 and 1987

Adjusted for Inflation

STATE	1981 STATE SUB-TOTAL 1981	1981 FEDERAL SUBTOTAL	1987 STATE SUB-TOTAL 1987	% change	1987 FEDERAL SUBTOTAL	% change	BLOCK GRANT
ALASKA	14,689,300	88,300	13,806,143	-0.06	2,171,045	23.59	358,026
ALABAMA	67,428,090	6,250,180	65,752,424	-0.02	8,721,031	0.40	3,432,239
ARKANSAS	19,545,892	17,849,937	23,804,680	0.22	11,315,865	-0.37	2,868,916
ARIZONA	27,899,300	722,800	33,392,014	0.20	4,103,802	4.68	2,887,045
CALIFORNIA	609,603,369	721,644	516,069,515	-0.15	10,840,520	14.02	10,840,520
COLORADO	51,792,420	12,882,252	38,473,087	-0.26	14,346,634	0.11	2,142,682
CONNECTICUT	97,319,891	1,449,651	112,039,612	0.15	19,902,074	12.73	1,812,012
DELAWARE	26,183,388	4,850,513	16,497,225	-0.37	1,911,510	-0.61	186,691
FLORIDA	149,172,931	23,344,414	164,196,422	0.10	23,588,274	0.01	11,154,693
GEORGIA	181,143,595	21,971,371	91,501,806	-0.49	10,425,636	-0.53	5,059,291
HAWAII	14,539,304	2,917,323	16,607,191	0.14	1,324,559	-0.55	1,019,987
IOWA	5,990,420	3,438,990	7,534,358	0.26	2,632,975	-0.23	176,884
IDAHO	8,996,100	1,039,200	8,079,189	-0.10	848,711	-0.18	480,057
ILLINOIS	181,014,900	18,100,000	168,797,371	-0.07	11,834,287	-0.35	6,949,040
INDIANA	104,545,973	8,287,491	90,778,133	-0.13	22,352,430	1.70	15,298,400
KANSAS	30,897,963	5,749,458	32,412,955	0.05	7,535,527	0.31	1,332,361
KENTUCKY	40,168,766	20,638,943	39,091,655	-0.03	13,365,269	-0.35	858,533
LOUISIANA	74,539,575	5,860,789	51,342,554	-0.31	17,509,898	1.99	501,525
MASSACHUSETTS	187,635,691	449,302	224,127,357	0.19	8,497,691	17.91	6,439,775
MARYLAND	137,030,795	1,411,056	137,684,466	0.00	519,007	-0.63	368,400
MAINE	27,991,926	558,989	29,332,113	0.05	2,084,120	2.73	1,253,405
MICHIGAN	298,900,000	NA	297,176,114	-0.01	31,644,414	NA	2,999,669
MINNESOTA	36,783,034	6,584,216	65,704,836	0.79	31,198,057	3.53	805,087
MISSOURI	112,768,007	3,042,829	95,302,841	-0.15	6,176,052	1.03	281,176
MISSISSIPPI	29,294,727	3,654,301	24,805,172	-0.15	8,516,787	1.33	2,538,687
MONTANA	16,609,386	609,921	13,310,831	-0.20	807,776	0.32	788,736
NORTH CAROLINA	91,803,517	17,852,298	111,644,854	0.22	18,031,214	0.01	4,186,394
NORTH DAKOTA	24,547,876	321,085	3,400,066	-0.86	6,945,635	20.63	344,106
NEBRASKA	16,928,457	3,805,120	16,439,968	-0.03	3,878,085	0.02	746,798
NEW HAMPSHIRE	25,844,577	3,152,143	29,715,895	0.15	2,729,831	-0.13	1,638,795
NEW JERSEY	134,083,000	28,772,542	153,708,032	0.15	25,621,267	-0.11	6,805,677
NEW MEXICO	31,076,431	240,760	18,345,572	-0.41	4,857,985	19.18	1,974,590
NEVADA	13,646,672	3,107,748	13,331,431	-0.02	2,697,170	-0.13	1,394,480
NEW YORK	811,627,181	304,620,000	356,201,821	0.05	251,505,308	-0.17	6,060,124
OHIO	209,884,413	44,963,805	170,740,437	-0.19	54,262,095	0.21	10,043,602
OKLAHOMA	54,465,443	10,224,993	46,522,972	-0.15	10,457,872	0.02	3,638,241
OREGON	44,129,506	7,962,567	39,641,165	-0.10	6,798,576	-0.15	1,478,069
PENNSYLVANIA	341,483,327	100,526,384	293,049,801	-0.14	81,526,546	-0.19	5,682,283
RHODE ISLAND	26,420,860	1,428,095	23,546,808	-0.11	1,776,329	0.24	1,501,141
SOUTH CAROLINA	78,052,616	14,030,905	75,736,998	-0.03	14,769,610	0.05	2,759,119
SOUTH DAKOTA	9,388,297	3,538,150	8,378,558	-0.11	3,835,555	0.08	1,560,296
TENNESSEE	66,678,966	9,993,317	58,743,801	-0.12	12,684,835	0.27	3,260,227
TEXAS	177,236,318	1,172,962	187,938,389	0.06	5,467,250	3.66	5,109,515
UTAH	16,684,527	2,086,221	14,833,128	-0.11	4,731,481	1.27	1,120,390
VIRGINIA	89,614,031	18,187,197	97,783,148	0.09	21,494,070	0.18	2,517,154
VERMONT	9,029,858	7,687,872	10,798,246	0.20	4,458,424	-0.42	1,532,262
WASHINGTON	64,983,493	9,207,261	84,812,036	0.31	24,007,119	1.61	3,119,187
WISCONSIN	45,183,601	13,307,865	72,181,290	0.60	13,875,150	0.04	691,457
WEST VIRGINIA	35,330,798	1,921,840	20,339,343	-0.42	3,591,158	0.87	1,583,244
WYOMING	10,231,743	148,836	8,396,762	-0.18	392,803	1.64	82,665
TOTAL	4,980,840,251	781,033,836	4,794,350,586	-0.04	854,569,317	0.09	151,663,551