

APPROPRIATIONS

RECOMMENDATIONS

FOR FY 2002

MENTAL

HEALTH

LIAISON

GROUP



National

Organizations

Representing

Consumers,

Family Members,

Advocates,

Professionals

and Providers

FOR THE

National Institute of Mental Health

National Institute on Drug Abuse

National Institute on Alcohol Abuse & Alcoholism, and

Center for Mental Health Services & Related Agencies

MAY 2001



MENTAL

The Mental Health Liaison Group represents over fifty national professional, research, voluntary health, consumer, and citizen advocacy organizations concerned about mental health, mental illness, and addictions disorders.

HEALTH

For Further Information Contact:

Lizbet Boroughs
American Psychiatric Association
1400 K Street NW
Washington, DC 20005
(202) 682-6060

Tom Leibfried
National Council for
Community Behavioral Healthcare
12300 Twinbrook Parkway
Suite 320
Rockville, MD 20852
(301) 984-6200

LIAISON

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GROUP

Cindy Grooms, National Council for Community Behavioral Healthcare
Ralph Ibson, National Mental Health Association
Pat Johnston, National Association of Psychiatric Treatment Centers for Children
Trina Osher, Federation of Families for Children's Mental Health



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Endorsing Organizations

Mental Health Liaison Group Member Organizations

Alliance for Children and Families
American Academy of Child and Adolescent Psychiatry
American Association for Marriage and Family Therapy
American Association for Psychosocial Rehabilitation
American Association of Private Practice Psychiatrists
American Counseling Association
American Group Psychotherapy Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Orthopsychiatric Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association
Anxiety Disorders Association of America
Bazelon Center for Mental Health Law
Child Welfare League of America
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Federation
Corporation for the Advancement of Psychiatry
Federation of Behavioral, Psychological and Cognitive Sciences
Federation of Families for Children's Mental Health
International Association of Psychosocial Rehabilitation Services
MentalHealthAMERICA, Inc.
National Association for Rural Mental Health
National Association of Anorexia Nervosa and Associated Disorders
National Association of County Behavioral Health Directors
National Association of Protection and Advocacy Systems
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Depressive and Manic-Depressive Association
National Mental Health Association
Tourette Syndrome Association

Mental Health Liaison Group Observer Organizations

National Coalition for the Homeless

Introduction to the Issue

One in every five adults, or about 44 million Americans, experiences some type of mental disorder every year. For about 5 percent of the population, the mental disorder is a severe and persistent mental illness (sometimes called a “serious mental illness”), such as schizophrenia, bipolar disorder, or major depression.

Mental illness is a critical public health issue which if left untreated has enormous consequences:

- In the United States, mental illness is the second leading cause of disability and premature mortality.
- Among adolescents ages 15-19, suicide is the second leading cause of death.

The economic costs of mental health and addictive disorders are staggering. The combined costs of these disorders are more than \$400 billion. Undiagnosed and untreated mental and addictive disorders are fueling health care, crime, welfare, and social services costs at unprecedented levels. Yet, these disorders are treatable and preventable. Scientific research leading to effective treatment and prevention has saved lives, improved public health services, and saved billions of taxpayers’ dollars. A serious and sustained investment in research and its applications will allow further major improvements in the treatment and prevention of these disorders.

The Case for Federal Funding

Support for Services in the Public Mental Health System

While the costs of mental and substance abuse disorders can seem overwhelming, the fact is that most mental illnesses and substance abuse disorders can be effectively treated. In most cases, this treatment can be provided in community settings. Nonetheless, a significant gap exists between the number of people who could benefit from services and the number of people who receive them.

The first-ever U.S. Surgeon General’s Report on Mental Health, released in December, 1999, provided clear scientific evidence demonstrating the effectiveness of mental health treatment. The Report specifically noted that diagnoses of mental disorders using specific criteria are as reliable as those for general medical disorders. In fact, treatment outcomes for people with serious mental illnesses such as bipolar disorder and schizophrenia have higher success rates (60-80 percent) than well-established general medical or surgical treatments for heart disease such as angioplasty.

Despite this evidence of effectiveness, however, fewer than one-third of adults and one-fifth of children who need mental health services receive treatment. (*Mental Health: A Report of the Surgeon General*, 1999) The reasons for this treatment gap include: (1) the historical stigma surrounding mental illness and treatment; (2) financial barriers, including discriminatory provisions in both private and public health insurance plans that limit access to mental health treatment.

Over the last several decades, the public mental health system has shifted its emphasis from institution-based care to less expensive community-based care, finding care provided in the community to be the most effective way to promote recovery among many people with mental illnesses. While inpatient hospital services remain an important part of the continuum of care, state mental health agencies now spend approximately two-thirds of their resources to provide community services. Similarly, most alcohol and drug treatment services are community-based.

There is broad consensus in the mental health field, however, that funding for mental health services is not adequate. Historic unwillingness on the part of private insurers to pay for mental health and substance abuse services at a level equal to that paid for other healthcare services has led to a two-tiered system: a set of privately-funded services which tends to serve people who are not seriously disabled as a result of their disorder, and a public safety net for individuals who have used up all of their benefits or were uninsured. Nation wide, mental health services receive about 57 percent of their funding from public sources, while all other health care received only 46 percent of its funding from public sources. (SAMHSA 1997)

In comparing spending trends over a ten year period from 1987 to 1997, spending for mental health increased more slowly at four percent than the rate for all health care, five percent. (SAMHSA, 1997) This is especially significant since mental health has been in a catch-up situation for decades—a situation which was acknowledged by the nation as early as 1963 with the enactment of the Community Mental Health Centers Act .

The nation's failure to provide adequate support for mental health services has broad societal implications and results in added expenditures for other governmental services. For example, the Bureau of Justice Statistics estimates that as many as 16 percent of local jail, state prison, and federal prison inmates—approximately 284,000 people—have a mental disorder. Many of these are incarcerated for non-violent, misdemeanor offenses. Criminal justice and corrections officials have called for stronger community mental health service systems in order to prevent this unnecessary and costly “criminalization” of people with mental illnesses.

Support for Mental Health and Substance Abuse Research

The Surgeon General's Report on Mental Health synthesized a large body of scientific evidence regarding the treatment, diagnosis, and prevention of mental disorders. In brief, the Report found that: (1) mental illnesses are diseases with a clear biological (and often genetic) component; (2) treatment is effective; and (3) the Report concluded, “The nation has realized immense dividends from five decades of investment in research focused on mental illness and mental health.”

As genetic and behavioral research moves forward, scientists are successfully identifying specific genetic predispositions that can trigger mental illness, alcohol and drug abuse, alcoholism, and drug addiction. Increased research on how brain functioning affects mental health and creates cravings for alcohol and other drugs is providing fundamental information critical to better treatment and prevention efforts. In addition, breakthrough research conducted in the 1990s has given us some important windows to understand human brain development, especially in infancy and childhood, with important implications for the development of effective preventive and early interventions.

The important research of the last decade must be continued with an aggressive research agenda focused on such areas as: (1) the interaction between genes and the environment in triggering mental illness and addiction; (2) development of new medications; (3) effective behavioral treatment approaches for mental illness and substance abuse; and (4) effective preventive interventions. Each of these research areas represents the natural extension of previous findings and each will yield important results necessary for understanding and solving these treatable disorders.

The National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism—three institutes at the National Institutes of Health (NIH)—are the leading federal agencies supporting basic biomedical and behavioral research related to mental illness and substance abuse disorders. Strong support for research conducted at these institutes is an essential component of any comprehensive mental health agenda.

Recommendations

The Mental Health Liaison Group supports the professional judgment budget recommendations outlined in this document. These funding levels will facilitate implementation of the promising research and effective treatment approaches documented in the Surgeon General's Report on Mental Health. We must address the significant unmet need for mental health and substance abuse treatment and further the research that fuels new and more effective treatments. In the words of the Surgeon General's Report, we must "overcome the gaps in what is known and remove the barriers that keep people from—obtaining—treatments."

Mental Health Research

Fiscal Year 2002
Funding Recommendations

for the

National Institute of Mental Health

National Institute on Drug Abuse

National Institute on Alcohol Abuse & Alcoholism

National Institutes of Health (NIH)

The National Institutes of Health (NIH) is the world's premier medical research institution, supporting more than 50,000 scientists at 1,700 research universities, medical schools, teaching hospitals, independent research institutions, and industrial organizations throughout the United States. It is comprised of 25 distinct institutes, centers and divisions. Each of the NIH institutes and centers was created by Congress with an explicit mission directed to the advancement of an aspect of the biomedical and behavioral sciences. An institute or center's focal point may be a given disease, a particular organ, or a stage of development. The three institutes which focus their research on mental illness and addictive disorders are the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Mental Health Liaison Group (MHLG) FY 2002

**Appropriation Recommendations for
Mental and Addictive Disorder Research at the NIH**

	(DOLLARS IN MILLIONS)		
	FUNDING FY 2001	PRESIDENT'S BUDGET FY 2002	PROFESSIONAL JUDGEMENT BUDGET FY 2002
NIMH			
Research*	\$1,012.898	\$1,135.903	\$1,220.458
Research Training*	49.339	52.793	56.451
Research Management/ Support*	44.492	49.609	51.166
TOTAL	\$1,106.729	\$1,238.305	\$1,328.075
NIDA			
Research	\$725.265	\$844.476	\$924.544
Research Training	16.773	18.115	20.000
Research Management/ Support	38.937	44.778	47.114
TOTAL	\$780.975	\$907.369	\$991.658
NIAAA			
Research	\$314.284	\$353.128	\$387.900
Research Training	8.868	9.547	9.800
Research Management/ Support	17.301	19.291	22.300
TOTAL	\$340.453	\$381.966	\$420.000

NOTE: Some numbers do not "add up" because each line item has been rounded.
* See following pages for explanation of these categories.

The professional judgement budget recommendations contained in this document outline the funding required to allow continuous progress on the many research advances we have made in understanding the origins of mental illnesses, advances which are hastening the development of improved treatment and prevention strategies. We must take advantage of rapidly expanding scientific opportunities at this time of escalating medical costs and constrained national resources.

Understanding the Line Item Recommendations:

The Difference Between Research, Research Training, and Management & Support

Research

Basic Research. Investigator-initiated research, primarily supported through research project grants to scientists across the country, is the engine that drives the nation's biomedical and behavioral research enterprise. The development of an evolving, dynamic base of knowledge through an investment in fundamental, basic research is central to our understanding of mental and addictive disorders.

The research grant process begins when scientists submit their best research ideas in a written application. Each grant application undergoes a peer review process: first by a panel of technical experts from outside the federal government who determine its scientific merit, then by a national advisory council composed of members of the public and highly qualified and respected scientists. Institute directors agree that to insure that top quality opportunities are not missed, one-third of the competing research project grant applications received should be funded.

Clinical Research. The acquisition of fundamental knowledge through basic research is only the first step toward the ultimate conquest of a disease. This information must be applied to the diagnosis, treatment, and prevention of the disease or disorder. Clinical research activities include efforts to translate knowledge gained in the laboratory to realize more effective treatment for patients. For example, clinical research is necessary to understand the mechanisms that underlie individual conditions, to study disease management, to identify segments of the population at special risk for diseases, and to assess health care delivery. At the same time, clinical research often provides important leads to identify further basic research opportunities.

Research Training

A robust and diverse talent base is particularly critical to the present and future success of the research enterprise. Training programs assist and extend the training of beginning scientists preparing for research and academic careers in fundamental, preclinical, clinical, public health, and other disciplines related to the interests of the institutes. Training grants are awarded to support individuals at the undergraduate, pre- and post-doctoral levels.

Management and Support

Research Management and Support provides staff and resources for the administrative management and scientific direction of the Institutes. This includes staff responsible for scientific planning, direction, administration, and review and approval functions of the Institutes' research grant, contract and training programs.

National Institute for Mental Health (NIMH)

(DOLLARS IN MILLIONS)	
APPROPRIATION FY 2001	MHLG RECOMMENDATION
\$1,107.0	\$1328.1

Mental Health in America

The National Institute of Mental Health (NIMH) leads the Federal effort to identify the causes and most effective treatments for mental illnesses. Mental disorders are common. An estimated 22.1 percent of Americans ages 18 and over—about 1 in 5 adults—suffers from a diagnosable mental disorder in a given year. This figure translates to 44.3 million people. In addition, 4 of the 10 leading causes of disability in the U.S. and other developed countries are attributed to mental disorders: major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. Many people, moreover, suffer from more than one mental disorder at a given time. The most severe disorders affect nearly 5 million adults. In addition, 10-12 percent of children and adolescents have mental and behavioral conditions. The Surgeon General recently has acknowledged the vital importance of mental health to total health with the release of four reports: “Mental Health: A Report of the Surgeon General,” a “National Action Agenda for Children’s Mental Health,” “The Surgeon General’s Call To Action To Prevent Suicide,” and “Youth Violence: A Report of the Surgeon General.” The overall health and well being of a Nation is essential to the strength and prosperity of its people.

NIMH supports and conducts research focused on the brain and its interactions with its biological, psychological, and social environments. NIMH will capitalize on neuroscience, basic behavioral science, clinical research and health services research that explores brain and behavioral processes to determine what goes wrong in the brain in mental illnesses leading to treatments and ultimately prevention. NIMH’s initiatives include large-scale multi-site clinical trials in new atypical antipsychotics in schizophrenia and Alzheimer’s disease; bipolar disorder; treatment alternatives for managing especially difficult to treat depression; and treatment of adolescents with depression. These trials address fundamental questions about the effectiveness of treatments, which while shown effective in rigorous clinical trial settings have

not been fully assessed in the day-to-day care of people with mental illnesses.

In addition, NIMH has launched a human genetics initiative that will help provide new understanding of the causes and potential cures for mental disorders. Under the initiative, genetic material will be collected for distribution to the scientific community – with procedures to assure that individuals must consent and that their privacy will be guaranteed. With new funds, NIMH will continue to augment data collection for this national resource, and will launch a new initiative to further encourage sharing of these and other human genetics resources.

Primary care is an important gate-keeping system for mental health care. Another new initiative in FY 2002 will strengthen the research base on the quality of service delivery in primary care for children, adolescents, and adults, placing emphasis on developing treatment and preventive interventions for primary care settings; on improving the linkages between the primary care system, schools and community mental health clinics; and on studying the effectiveness, impact, and cost of these strategies that can be implemented in primary care.

New funds will advance the development of animal models of human psychopathology, which will in turn accelerate the discovery of neural systems and pathways that are involved in the development of mental disorders. The development of new therapeutic compounds is expected to follow.

NIMH is supporting research networks for the implementation of new collaborations to translate basic science findings into research and practice that benefit patients and service providers. Translational research centers for comprehensive, large-scale programs with multiple components represent the capstone of the initiative.

Scientific Opportunities

The MHLG enthusiastically supports NIMH’s research portfolio and supports a funding level of \$1.3 billion for FY 2002 to take advantage of the major opportunities for important advances in mental illness research.

NIMH Success Story

NIMH research has improved if not saved the lives of countless Americans suffering from mental disorders. To give just one example, Kathleen who suffered from schizophrenia explains: "Today I am happy to be alive. Taking a new anti-psychotic drug (olanzapine) has changed my life and my attitude." NIMH researchers helped build the groundwork for development of this new generation of atypical anti-psychotic medications.

Kathleen says "the fifteen years before I found this medication were not easy." At age 31, Kathleen started to have schizophrenic episodes. "My husband divorced me...my children became ashamed of me," Kathleen explains, "I lost my family, my home and nearly my life."

In 1993, Kathleen started taking a new drug called olanzapine. She no longer suffers from symptoms of schizophrenia. Her family is together again and proud of her recovery. "I am ever so thankful for my success in overcoming my mental illness with this drug."

(Source: *National Mental Health Association*). Additional funding is needed for NIMH so more individuals like Katherine can lead healthy, productive lives.

National Institute on Drug Abuse (NIDA)

(DOLLARS IN MILLIONS)	
APPROPRIATION FY 2001	MHLG RECOMMENDATION
\$781.3	\$991.7

Background

The cost of illegal drug abuse for our nation is estimated at a staggering \$110 billion per year, when one adds the cost of the Nation’s deadliest addiction—use of tobacco products, the cost soars up to \$248 billion annually. Beyond these tremendous economic costs are the societal costs. Illicit drug use is inextricably linked with the spread of infectious diseases such as HIV / AIDS, tuberculosis, and hepatitis C, and is also associated with domestic violence, child abuse, and other violent behavior. In fact, recent statistics show that 60 to 70 percent of male arrestees tested positive for drugs of abuse.

Dramatic scientific advances over the past quarter century, supported largely by the National Institute on Drug Abuse (NIDA), have revolutionized our understanding of drug abuse and addiction. NIDA conducts and funds over 85 percent of the world’s research on drug abuse and addiction including all licit and illicit drugs, with the exception of research that focuses primarily on alcohol. NIDA addresses the most fundamental and essential questions about drug abuse, ranging from detecting and responding to emerging drug use trends to understanding how drugs work in the brain to developing and testing new treatment and prevention approaches. In large part because of the comprehensive research portfolio supported by NIDA, we now know that drug abuse is a preventable behavior and that drug addiction is a chronic brain disease that can be treated just as effectively as many other chronic disorders.

Research Priorities

NIDA supports a rich and diverse scientific portfolio that is grounded in basic neuroscience research. As NIDA-funded neuroscientists examine the ways in which drugs of abuse act upon the brain, our un-

derstanding of the brain continues to progress dramatically. Key research priorities for NIDA include: understanding the transition from drug use to addiction; studying the genetic and environmental components of vulnerability to addiction; predicting, preventing, and combating emerging drug problems, such as increases in use of “club drugs” and steroids; developing new pharmacological and behavioral treatments for addiction, including new treatments for nicotine addiction; supporting research that focuses on children and adolescents; and reducing health disparities.

One of NIDA’s top priorities is ensuring that new pharmacological and behavioral treatments are developed, tested, and adaptable for use in community settings that serve diverse patient populations. NIDA is testing treatment approaches shown to be effective under controlled conditions through its National Drug Abuse Treatment Clinical Trials Network (CTN). This cooperative undertaking of NIDA, clinical researchers, and community treatment providers will aid in the blending of research and clinical practice by providing a forum for the two-way exchange of information among these partners. The CTN will rapidly transfer research results to treatment providers and their patients to improve the quality of drug abuse treatment throughout the country. In turn, these providers will share vital results and insights that will help drive the design of new treatment studies that meet the real-world needs of the clinic.

Structurally, the CTN has grown since its 1999 inception to include 14 regional research and training centers, or nodes, that each partner with several community treatment programs. There is a need to

Scientific Opportunities

The Mental Health Liaison Group supports a funding level of \$992 million for FY 2002 for funding for the National Institute on Drug Abuse to take advantage of many promising scientific opportunities.

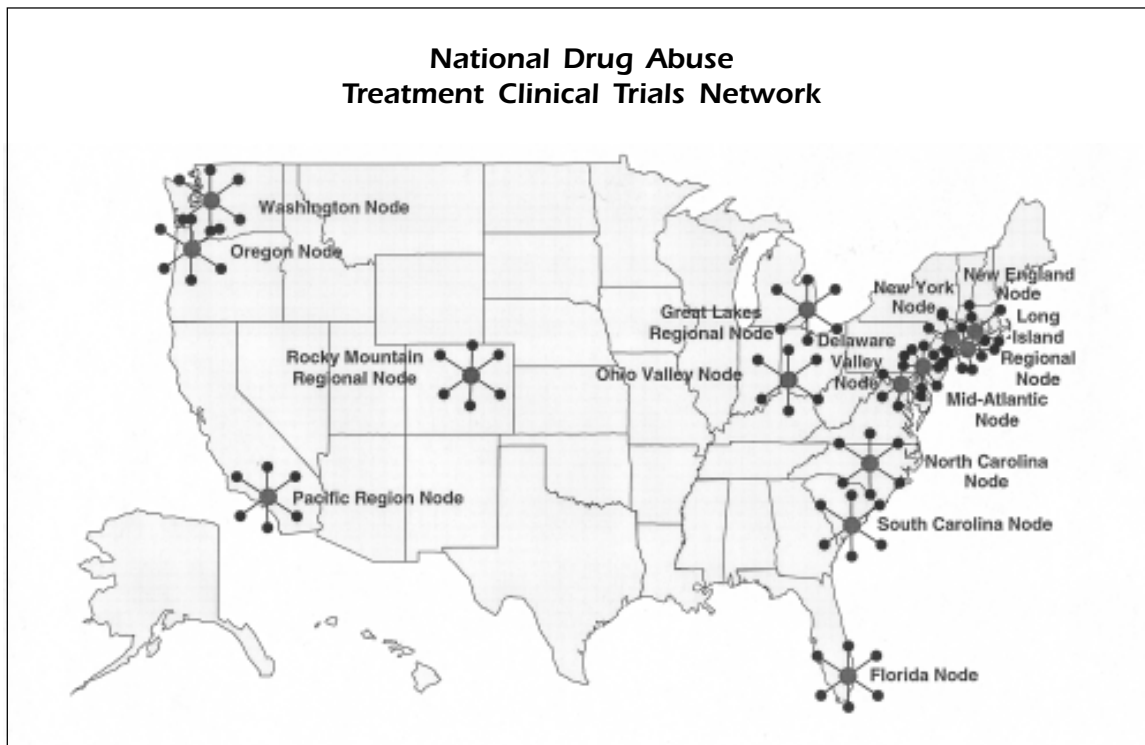
expand the CTN further to reach an even more diverse patient population in as many geographical regions as possible. The network has begun enrollment in its first seven protocols and new research-based concepts are already being proposed and approved for testing. Expansion will enable the network to more efficiently test treatments for all drugs of abuse including nicotine.

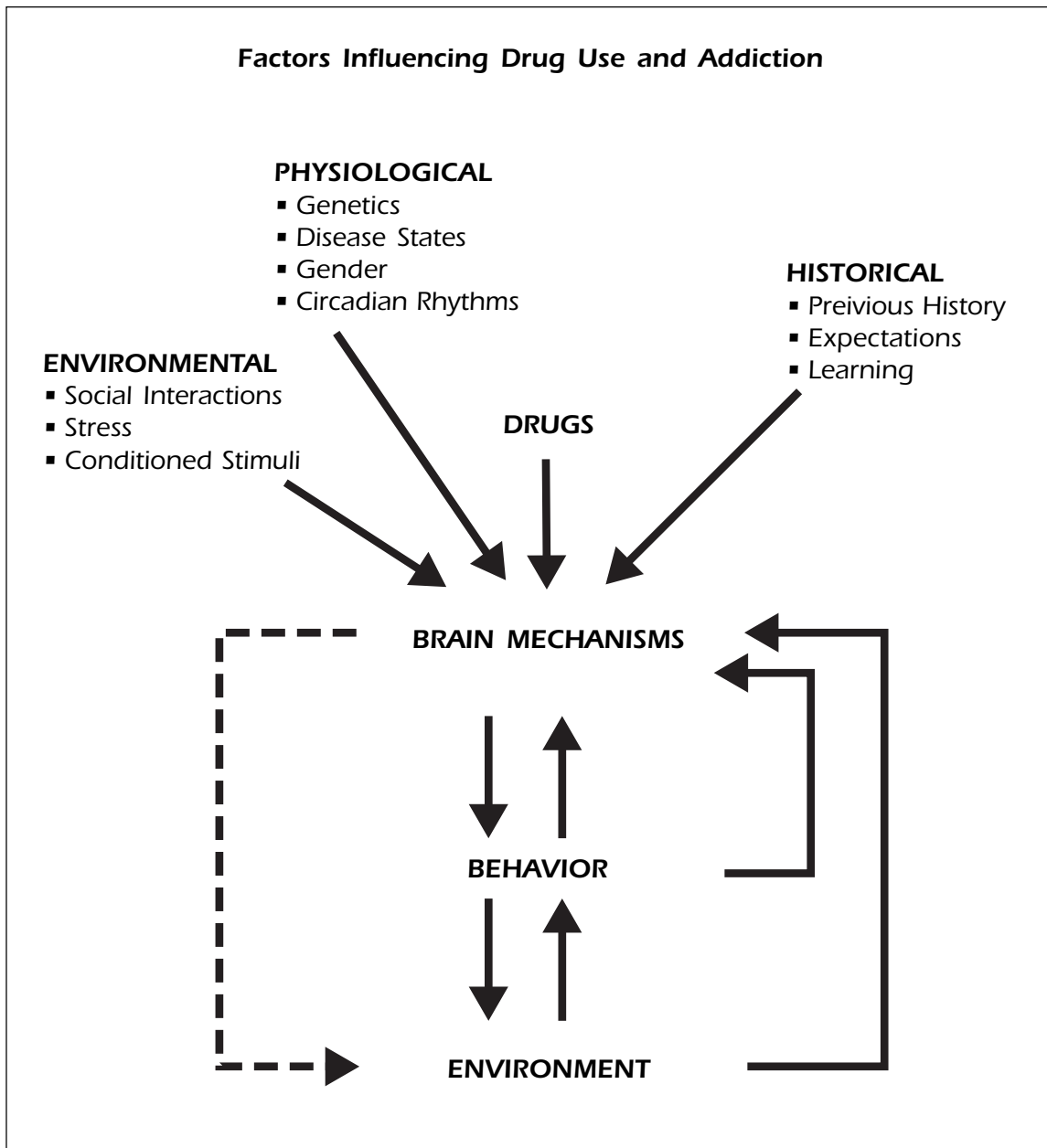
The MHLG supports NIDA’s commitment to the expansion of its CTN, and the development and/or expansion of many other important initiatives including:

- expanding our efforts to identify genes that increase or decrease a person’s vulnerability to addiction;
- continuing to encourage new directions and approaches in prevention research;

- understanding the developmental consequences of prenatal drug exposure, particularly for emerging drug problems such as MDMA (ecstasy) and methamphetamine;
- using rapidly developing technologies such as microarrays and neuroimaging to discover the mechanisms underlying the transition from use to addiction.

These initiatives build upon NIDA’s core programs—basic neuroscience, epidemiology, neuroimaging, prevention, treatment development, behavioral research, health services research, and research on AIDS and other medical consequences of drug abuse—together they will continue to provide us with new and crucial insights into how best to prevent and treat drug abuse and addiction.





SOURCE: National Institute on Drug Abuse

Addiction is a Brain Disease with Imbedded Behavioral and Social Context Aspects

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

(DOLLARS IN MILLIONS)	
APPROPRIATION FY 2001	MHLG RECOMMENDATION
\$340.8	\$420.0

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is the lead Federal entity for biomedical and behavioral research focused on uncovering the causes, and improving prevention and treatment of alcohol abuse, alcoholism and related disorders. Approximately 14 million Americans meet the medical criteria for a diagnosis of alcohol abuse and alcoholism, and 40 percent of Americans have direct family experience with this issue. NIAAA funds 90% of all alcohol research in the United States designed to reduce the enormous health, social, and economic consequences caused by abusive drinking.

Alcohol remains the most commonly abused drug by youth and adults alike in the United States. The financial burden from alcohol abuse and alcoholism on our nation is estimated at \$185 billion annually, a cost to society that is 52 percent greater than the estimated cost of all illegal drug abuse, and 21 percent greater than the estimated cost of smoking. More than 70 percent of the \$185 billion cost born by society relates to the enormous losses to productivity because of alcohol-related illnesses and the loss of earnings due to premature deaths. Up to 40 percent, or almost half, of patients in urban hospital beds are there for treatment of conditions caused or exacerbated by alcohol including diseases of the brain, liver, certain cancers, and trauma caused by accidents and violence.

Alcohol misuse is associated with increased risk of accidents and injuries including motor vehicle crashes, suicides, domestic violence, child abuse, fires, falls, rapes, robbery and assaults. Almost 25 percent of victims of violent crime report that the offender was

under the influence of alcohol. Homicides are even more likely to involve alcohol (at 50 percent) than less serious crimes, and the severity of injuries is also increased. In addition, 67 percent of all domestic attacks involve alcohol. For juvenile populations, alcohol has an equally severe impact. Alcohol-related traffic crashes are the number one leading cause of teen deaths, and alcohol is also involved in suicides and homicides, the second and third leading causes of teen deaths respectively.

Additional investments are required to pursue a number of key NIAAA initiatives including efforts to accelerate discoveries about nerve cell networks and their application to clinical issues surrounding tolerance, physical dependence, physical withdrawal and relapse, by integrating the efforts and findings of investigators from various scientific fields and disciplines. Other research opportunities involve using new technologies to advance identification of the genes likely to influence the risk for alcoholism; and acquiring scientific expertise in the areas of novel biosensors for the measurement of alcohol, computational neurobiology of alcohol, and geomapping to improve policies surrounding alcohol prevention. Of equal importance is NIAAA's agenda on health disparities and conducting research on high alcohol content malt and wine specialty consumption and its health and social impacts on minority communities. The initiatives targeted at underage drinking also require additional attention for epidemiological studies and evaluation of intervention and outreach programs on college campuses.

Scientific Opportunities

The Mental Health Liaison Group (MHLG) supports a FY 2002 funding level of \$420 million for NIAAA to take advantage of promising research opportunities.

NIAAA Success Story

Acamprosate medication for the treatment of alcoholism is being studied in a new research project supported by NIAAA. Acamprosate appears to act by normalizing brain pathways that can be hyperactive for up to one year after alcohol withdrawal. Acamprosate is widely available by prescription internationally. Scientific studies in Europe found no significant side effects and report that patients treated with acamprosate and counseling generally abstain from alcohol at a significantly higher rate than those who receive counseling alone.

One 44-year old man who was an active alcoholic for over 12 years reported significant positive benefits from taking the medication that NIAAA is currently evaluating. Trained as an architect, he was working as a pizza delivery man, living alone, and drinking over 60 drinks a week at the time he enrolled in a study of acamprosate and counseling. He remained completely abstinent over the six-month study, stopped smoking, secured a managerial position, and formed a stable relationship with a new girlfriend. He says, "I am enjoying life more, sleeping well, and finding time to exercise." He expresses great appreciation for his treatment program's effectiveness, and reports, "I have a very positive outlook on life."

Mental Health Services

**Fiscal Year 2002
Funding Recommendations**

for the

**Substance Abuse & Mental Health Services Administration
Center for Mental Health Services**

**Substance Abuse & Mental Health
Services Administration (SAMHSA)
and
Center for Mental Health Services (CMHS)**

The role of Substance Abuse and Mental Health Services Administration (SAMHSA) is to provide national leadership in improving mental health and substance abuse services by designing performance measures, advancing service-related knowledge development, and facilitating the exchange of technical assistance. SAMHSA fosters the development of standards of care for service providers in collaboration with states, communities, managed care organizations, and consumer groups, and it assists in the development of information and data systems for services evaluation. SAMHSA also provides crucial resources to provide safety net mental health services to the under- or uninsured in every state.

SAMHSA Acting Administrator:

Joseph Autry III, M.D. (301) 443-4795

CMHS Director:

Bernard Arons, M.D. (301) 443-0001

CMHS Legislative Contact:

Joe Faha (301) 443-4640

Understanding the Line Item Recommendations:

Services for the Benefit of Communities

The Substance Abuse and Mental Health Services Administration (SAMHSA) evolved from the former Alcohol, Drug and Mental Health Administration (ADAMHA) as a result of P.L. 94-123. The Children's Health Act (P.L. 106-310), enacted in October 2000, reauthorized most of SAMHSA's ongoing programs and added programs to address emerging national priorities. This document addresses appropriations recommendations for the Center for Mental Health Services (CMHS) within SAMHSA. The recommendations are derived from recommendations of state and local mental health services authorities, providers and researchers.

The Mental Health Liaison Group arrived at its recommendations for appropriations based on its analysis of policy priorities for mental health services and its estimate of the public need for certain kinds of services. For instance, MHLG is recommending a significant increase in the appropriations for the Community Mental Health Performance Partnership Grant, the Projects for Assistance in Transition from Homelessness (PATH) and the Children's Mental Health Services Program because of their key roles in delivering services to underserved populations. Other programs directed at important policy priorities include the Youth Violence Prevention Program and the Mental Health Jail Diversion Program.

The Mental Health Performance Partnership Grant provides a substantial portion of funds for state mental health authorities. The program received a significant increase in FY 2001 in response to the growing pressure on state mental health budgets from federal cuts in Medicaid Disproportionate Share Hospital funding and the growing need for supports and services resulting from cuts in the Supplemental Security Income (SSI) program. CMHS awards these grants to all 50 states and a number of territories. The states, counties and cities participating in the Performance Partnership Grant program are counting on substantial federal assistance to match the already pledged local and state dollars.

More than 51 million Americans have a mental disorder in a single year (CMHS, 1994). Given the growing population of people who work but do not have private health insurance and are unable to qualify for Medicaid, the need for publicly funded health services is expanding. The federal government plays a critical leadership role in this effort.

Mental Health Liaison Group (MHLG) FY 2002
Appropriation Recommendations
for the Center for Mental Health Services

(DOLLARS IN MILLIONS)	APPROPRIATION FY2001	MHLG RECOMMENDATION FY2002
Mental Health Performance Partnership Block Grant	\$420.00	\$670.0
PATH Homeless Program	\$36.88	\$56.0
Children's Mental Health Services Program	\$91.76	\$140.0
Protection and Advocacy (PAIMI)	\$30.00	\$40.0
Youth Violence Prevention**	\$90.00*	\$130.0
Aftercare for Youth Offenders**		\$20.0
Juvenile Justice: Interagency Research, Training and Technical Assistance**		\$4.0
Mental Health and Child Welfare Services Integration**		\$10.0
Addressing Child and Adolescent Post-Traumatic Stress**	\$10.00*	\$10.0
Jail Diversion Grants**		\$40.0
Treatment for Co-occurring Mental Illness and Addictions Disorders**		\$40.0
Training for Teachers and Emergency Services Personnel**		\$5.0
Suicide Prevention for Children and Adolescents**		\$10.0
Emergency Mental Health Centers**		\$10.0
Other Programs of Regional and National Significance**	\$203.67	\$204.0

* The Conference Report for FY 2001 earmarked funds for these programs. These earmarks pertain to funds in other lines and do not represent separately appropriated funds.

** Newly authorized under the SAMHSA reauthorization sections of the Children's Health Act of 2000 (PL. 106-310).

Federal Dollars Help to Finance Community-Based Care in the Nation's Public Mental Health System

In the 1990s, our nation's public mental health system underwent tremendous change. Since 1990, states have reduced public inpatient hospital beds at a rate higher than during the deinstitutionalization that occurred in the 1960s and 1970s (NASMHPD). In addition, a growing number of states have privatized their public mental health systems through Medicaid managed care for persons with severe mental illness.

Since 1995, changes in state and federal policy have served to compound the strain on state and local public mental health systems. Reform of the eligibility rules for the Supplemental Security Income (SSI) program impacting both children and persons whose disability was originally based on substance abuse has shifted a tremendous and growing burden to local communities. In addition, changes to the Medicaid Disproportionate Share (DSH) program has left states scrambling to make up for lost federal resources. A 1997 U.S. Supreme Court decision allowing states to place sexually violent offenders in state psychiatric hospitals after having completed their criminal sentences is likely to place a new and expensive burden on state mental health programs. Finally, in the wake of the 1999 Supreme Court *Olmstead* decision—which found that unjustified institutionalization of individuals with mental illness constitutes unlawful discrimination under the Americans with Disabilities Act—the contributions of individual states to community-based services have increased to the tune of \$3 - \$30 million a year.

As a result of these trends, the federal investment in community-based care is growing in importance. For example, recent estimates show that the \$420 million in federal funds flowing through the Mental Health Performance Partnership Grant (formerly known as the Community Mental Health Block Grant) administered by SAMHSA's Center for Mental Health Services (CMHS) is an increasingly critical source of funding for state and local mental health departments. Surveys have found that the Mental Health Block Grant constitutes as much as 39.5% of all non-institutional services spending in some states. Moreover, these federal dollars are being used to fund a wider and more diverse array of community-based services.

Local Community Mental Health Agencies provide services such as case management, emergency interventions and 24-hour hot lines to stabilize people in crisis as well as coordinate care for individuals with schizophrenia or manic depression who require extensive supports.

Psychosocial rehabilitation programs provide a comprehensive array of mental health, life skill development, case management, housing, vocational rehabilitation, and employment services for individuals with mental illnesses. Initially designed to serve persons with a history of severe psychiatric disorders, including those requiring frequent hospitalization, these programs now serve a broad range of persons with mental illness.

Partial hospitalization and day treatment services permit children with serious emotional disturbances (SED) and adults to get intensive care during working or school hours and still go home at night. Funding provided through CMHS programs has focused on the highest priority service needs in an effort to improve the value and effectiveness of community-based services delivery.

Homelessness: The PATH and ACCESS programs are the only federal programs that provide psychiatric care and test the implementation of innovative outreach services to homeless Americans, a third of whom have mental illnesses.

Children: The Children’s Mental Health Services Program develops organized systems of care for children with serious emotional disturbances in child welfare, juvenile justice and special education who often fail to receive the mental health services they require. Extensive evaluation of this program suggests that it has had a significant impact on the communities it serves. Outcomes for children and their families have improved, including symptom reduction, improvement in school performance, fewer out-of-home placements, and fewer hospitalizations.

Protection and Advocacy: The Protection and Advocacy Program for Individuals with Mental Illness (PAIMI) helps protect the legal rights of people with severe mental illnesses in nursing homes, state mental hospitals, residential settings, and in the community.

Programs of Regional and National Significance: These programs constitute a large part of SAMHSA’s efforts to address policy issues of widespread concern across the country. They allow state and local mental health authorities to access information about the most promising methods for improving the performance of programs. Current areas of importance include cross-system service coordination with schools, the criminal justice system, and state welfare agencies; and helping to support new services for persons with co-occurring mental illnesses and addictions disorders.

Community Mental Health Services Performance Partnership Block Grant

(DOLLARS IN MILLIONS)		
APPROPRIATION FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
\$420.0	Such Sums as Necessary	\$670.0

What Is the Community Mental Health Services Block Grant?

The Community Mental Health Services Performance Partnership Block Grant is the principal federal discretionary program of community-based mental health services for adults and children. States may utilize block grant dollars for a range of critical services for adults with serious mental illnesses and children with serious emotional disturbances, including community-based treatment (such as Assertive Community Treatment), case management, and outreach to people who are homeless.

The Mental Health Block Grant is a flexible source of funding that is used to support new services and programs, expand or enhance access under existing programs, and leverage additional state and community dollars. In addition, the Block Grant provides stability for community-based service providers, many of which are non-profit and require a reliable source of funding to ensure continuity of care.

Why is the Mental Health Block Grant Important?

Over the last three decades, the number of people in state psychiatric hospitals declined significantly, from about 700,000 in the late 1960s to about 60,000 today. Reflecting this important trend, state mental health agencies shifted significant portions of their funding from inpatient hospitals into community programs. About two-thirds of state mental health agency budgets are now used to support community-based care.

The first-ever U.S. Surgeon General’s Report on Mental Health provides clear scientific evidence demonstrating the effectiveness and desirability of these community-based options.

The Mental Health Block Grant is the only major federal discretionary program designed to support community-based services for people with mental illnesses. More importantly, because it is a block grant rather

than categorical funding, it gives states critical flexibility to: (1) fund services that are tailored to meet the unique needs and priorities of consumers of the public mental health system in that state; (2) hold providers accountable for access and the quality of services provided; and (3) coordinate services and blend funding streams to help finance the broad range of supports—medical and social services—that individuals with mental illnesses need to live safely and effectively in the community.

What Justifies Federal Spending for the Mental Health Block Grant?

In July, 1999, the U.S. Supreme Court issued a decision finding that unjustified institutionalization of individuals with mental illnesses constitutes discrimination under the Americans with Disabilities Act (ADA). The decision in *Olmstead v. L.C. and E.W.*, was strongly supported by the U.S. Department of HHS, which developed policies and mechanisms to ensure compliance by states.

As part of a “New Freedom Initiative” announced in January, 2001, the Bush Administration pledged support for expanding community-based services to implement the *Olmstead* decision.

Despite increasing pressure from the federal government to expand community-based services for people with mental illnesses, however, the federal government’s financial support is limited. Medicaid provides coverage for important services that states can opt to include in their state plans, but technical barriers exist for states that seek to use Medicaid waivers to provide these services. In addition, many essential elements of effective community-based care are non-medical in nature—such as housing, employment services, and peer support—and generally are not reimbursable under Medicaid. **Therefore, Block Grant funding is the principal vehicle for federal financial support for comprehensive community-based services for people with serious mental illnesses.**

The MHLG attaches a high priority to increasing Mental Health Block Grant funding and ensuring that the Block Grant provides evidence-based community services for populations most in need of services. These populations include:

Adults with severe mental illness who:

- have a history of repeated psychiatric hospitalizations or repeated use of intensive community services;
- are dually diagnosed with a mental illness and a substance use disorder;
- are currently homeless.

- have a history of interactions with the criminal justice system; and

Children with serious emotional disturbances who:

- are at risk of out-of-home placement;
- are dually-diagnosed with serious emotional disturbance and a substance abuse disorder; or
- as a result of their disorder, are at high risk for the following significant adverse outcomes: attempted suicide, parental relinquishment of custody, a brush with the law, behavior dangerous to themselves or others, running away, or being homeless.

Projects for Assistance in Transition from Homelessness (PATH)

(DOLLARS IN MILLIONS)	
APPROPRIATION FY 2001	MHLG RECOMMENDATION
\$36.88	\$56.0

What Does PATH Do?

The Projects for Assistance in Transition from Homelessness (PATH) formula grant program was created by Congress to help localities and nonprofits provide flexible, community-based services to persons who are homeless (or at risk of homelessness) and have serious mental illnesses or who have a dual diagnosis of serious mental illness and substance abuse disorder. The program is designed to encourage the development of local solutions to the problem of homelessness among people who have serious mental illnesses. Aggressive community outreach, case management and housing assistance are core services in most PATH projects. Other important core services include referrals for primary health services, job training, and education services. The most recent program data indicate that 366 local agencies and/or counties used FY1999 PATH funding.

Why is PATH Important?

Federal, State, and local PATH funds are often the only monies available to communities to support the three levels of service necessary for success with homeless people who have serious mental illnesses—outreach to those who are not being served, engagement of the individuals in treatment services, and transition of consumers to mainstream mental health treatment, housing and support services.

Clients receiving PATH-funded services have some of the most disabling mental disorders. Additionally, in FY 1998, fifty-nine percent of clients served had a co-occurring substance abuse disorder.

PATH builds upon the previous Community Mental Health Services for the Homeless Block Grant, first authorized in the original Stewart McKinney Homeless Assistance Act, (P.L. 100-77, 1987). In FY 1991, because of a FY 1990 “advance funding” of \$6.904 million, the

program’s appropriation was \$33.055 million. Reductions to PATH funding, which occurred in FY 1996, were disruptive, and some innovative projects closed as a result. Fortunately, funding increases since FY1998 are steps in the right direction for PATH, which has increased from \$20 million in FY 1997 to a level just over its 1991 funding, \$37 million, in FY 2001.

What Justifies Federal Spending for PATH?

Increases in federal appropriations for the PATH programs in FY2002 are recommended to reach these CMHS goals:

- contact a total of 124,000 homeless persons, targeting outreach and other services to those most in need.
- maintain at the level of at least 35%, the percentage of mentally ill homeless persons contacted who become enrolled clients, even though these persons will be more difficult to engage.
- maintain at the level of at least 84 percent, the percentage of participating agencies that offer outreach services to homeless persons with mental illness.

A PATH Success Story

“Nancy” is a 49 year-old woman whose mental illness worsened after her mother’s death and her subsequent eviction from the home they shared. An educated woman with a professional degree and strong work ethic, she refused help and remained in denial of her mental illness.

Persecutory delusions and sporadic outbursts also made it difficult for her to remain employed for long periods. While staying at a night shelter, she received employment counseling and case management services funded through the PATH program. With the help of PATH funded services, Nancy was able to ease back into the community. She is now living independently in her own apartment and is employed full-time with Chrysler Auto Corporation.

**Comprehensive Community Mental Health
Services for Children and their Families Program**

(DOLLARS IN MILLIONS)		
APPROPRIATION FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
\$91.76	Such Sums as Necessary	\$140.0

What Does the Children’s Program Do?

The Children’s Mental Health Services Program provides six-year grants to public entities to assist them in developing intensive, comprehensive community-based mental health services for children with serious emotional disturbances (SED.) These are called systems of care and use a multi-agency, multi-disciplinary approach involving both the public and private sectors. The children and adolescents eligible for services must: be under 22 years old; have a diagnosable serious emotional, behavioral, or mental disorder accompanied by functional disability that has been present or is expected to be present for at least one year; and require services from multiple agencies. A wide array of direct services are provided by systems of care including (but not limited to): diagnostic and evaluation services; outpatient services provided in a clinic, school, or office; emergency services; intensive home-based services for the children and their families; intensive day-treatment services; respite care; care coordination and case management, and services that assist the child in making the transition from the services received as a child to the services to be received as an adult.

The program was established in 1993 to support the development of home and community-based services for children with SED. Studies have shown that the lack of community services can lead to unnecessary and expensive hospitalizations. In a 1990 survey, several states reported that thousands of children were placed in out-of-state mental health facilities, a situation which cost states millions of dollars. In addition, thousands of children were treated in state hospitals—often in remote locations—despite the demonstrated effectiveness of community-based programs.

To date, grants have been awarded to 67 communities including States, political subdivisions of States, and Indian tribes or tribal organizations. Grantees are required to provide increasing levels of matching funds over the six-year period of the award.

Why is the Children’s Program Important?

It is estimated that 20 percent, or 13.7 million American children have a diagnosable mental or emotional disorder. Nearly half of these children have severe disorders—only one-fifth of whom are receiving appropriate services (NIMH, 1994). Despite the enormous need, the Children’s Mental Health Services Program serves only an approximated 50,000 children and youth.

According to the *Report of the Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda* published last year, “The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country. Growing numbers of children are suffering needlessly because their emotional, behavioral, and development needs are not being met by those very institutions which were explicitly created to take care of them.” Often, services and supports for children with serious emotional disturbance and their families who are involved with more than one child-serving system are uncoordinated and fragmented. Typically, the only options available are out-patient therapy, medication, or hospitalization. Frequently there are long wait lists for these services because they are operating at capacity, making them inaccessible for new clients, even in crisis situations.

What Justifies Federal Spending for the Children’s Program?

The outcome data collected from the 22 original grant communities show improving clinical and functional outcomes as well as reduction in systems for children and their families.

- School functioning and performance improved significantly. Students’ behaviors were less disruptive students attended school more regularly, and their grades improved. For example, in South Philadelphia, 71% of children attended school regularly—up from 59%; only

63% of children required behavioral intervention beyond the classroom routine—down from 85%; and, 45% of children were rated by their teacher as having academic performance that was commensurate with their ability—an increase from 22%.

- Contact with law enforcement declined. San Mateo County, California, for example, reported a 61% reduction in the number of crimes committed by youth on probation in the 12 months following their entry into the system of care program.

In addition, communities and states are making changes in policy based on the successful work of the grantee communities. For instance:

- 1997 and 1998: two CMHS—funded grantee communities were instrumental in designing the Home and Community Medicaid Waiver for the State of Kansas.
- 1998: outcome data from the Wings Program in Maine supported the passage of a state law instituting a system of care approach throughout the state.
- 1997: the Rhode Island State legislature, using the Reach Program as a model, created two pilot programs, one rural and one urban to keep children with serious emotional disturbances in their home school districts and their own neighborhood schools, rather than placing them outside their communities.

Child and Family Profile

Seth is a 13 year-old boy whose complex mental health challenges have been apparent his whole life. He has the Tourette’s Syndrome triad of severely impulsive behavior, obsessive-compulsive symptoms, and tics. As a toddler, his mother knew something was wrong when the discipline strategies she used for her two older children did not work for him. As a preschooler, he was involved in a partial hospitalization program. At the beginning of second grade, after starting in a new school, his behavior became extremely hard to control. Conventional behavioral interventions failed because they did not address his underlying mental health issues. He was just seven years old but at imminent risk of being removed from his home because of his aggressive, impulsive behaviors. The family wanted very much to keep him at home, but needed supports to succeed. The Children’s Services grantee in Stark County, Ohio implemented a Wraparound process for Seth and his family. Seth received not only conventional clinical interventions and medication management, but also an intensive home-based program that involved support workers coming to the home every day before and after school. To keep him in his regular school, he had a one-on-one “tag” to help him stay on task. These intensive interventions were faded out over time as Seth’s self-control improved. Mentors have also helped Seth develop positive social skills. Although they continue to struggle with Seth’s mental illness as he traverses adolescence, the family’s major goals—to stay together at home and to keep Seth in school—have been realized.

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

(DOLLARS IN MILLIONS)	
APPROPRIATION FY 2001	MHLG RECOMMENDATION
\$30.0	\$40.0

What Does PAIMI Do?

The Protection and Advocacy System for Individuals with Mental Illness (PAIMI) provides services for persons with a significant mental illness or emotional impairment who are inpatients or residents of a facility rendering care or treatment. This mandate to protect people with mental disorders covers a very broad range of public and private facilities, including general and psychiatric hospitals, nursing homes, board and care homes, community housing, juvenile detention facilities, homeless shelters, and jails and prisons. PAIMI services are also available with regard to matters arising within 90 days following an individual’s discharge from such a facility. In addition, the Children’s Health Act of 2000 expanded the authority of state P&A systems to include providing services to people living in the community, including their own homes.

During FY 1999, PAIMI programs nationwide addressed 26,474 abuse, neglect, and rights violation complaints. PAIMI staff also provided information and referral services to approximately 60,528 people, and education, training and outreach services to hundreds of thousands more.

Why Is PAIMI Important?

PAIMI staff maintain a presence in facilities that care for people with mental disabilities and investigate and remedy any abuse and neglectful conditions, including sexual assault, excessive restraint and seclusion, inappropriate use of medication and the failure to carry out treatment programs and provide adequate nutrition. PAIMI staff also assist such individuals in making the transition to community living.

What justifies Increased Federal Spending for PAIMI?

The Children’s Health Act of 2000 authorized P&A systems to take on an expanded role to include providing services for persons residing in the community and establishing a Native American PAIMI Program. With the appropriation of \$30 million for the PAIMI program in FY 2001, state P&A systems now have the authority to assume this expanded role.

Additional appropriations are needed to aid the PAIMI Program with meeting its federal mandate of serving individuals with mental illness in institutional settings while jointly meeting the needs of the community. It is anticipated that the Program will realize an estimated 50% increase in cases in order to address the unmet needs of under/unserved populations—which include individuals who reside in rural, urban, inner-city, and economically disadvantaged communities and are of varying ethnic and racial backgrounds.

There is a critical need to develop additional resources to adequately advocate, monitor and investigate inappropriate treatment, placement, and abuse and neglect in both institutional and community settings as a result of the following developments:

- expanded authority to serve people in the community;
- new federal statutory and regulatory mandates regarding the use of restraint and seclusion by mental health facilities and reporting of related deaths and injuries for investigation under the PAIMI Program; and
- a new Native American component of the Program.

Defending the Rights of People with Mental Illness

Twenty-four residents of an adult care home in New York were victims of “assembly-line” prostate surgery. None of these residents received urological examinations prior to the surgery, and the condition for which the surgery was conducted—expanded prostate glands—had not been definitively diagnosed. Nonetheless, the twenty-four residents were ushered from their rooms over a period of five days to a local hospital where they were coerced into signing consent forms that authorized surgery. All of the men had a mental illness, and many of the men were reported to be lethargic and confused prior to the surgery.

Complications from the surgery involving severe incontinence have plagued six of the men. In response, the P&A System of New York, Disability Advocates, has filed a lawsuit against the owner and operator of the home. Disability Advocates is using its PAIMI Authority to safeguard the people of New York who live with disabilities against exploitation.

Programs of Regional and National Significance (PRNS)

CMHS addresses priority mental health care needs of regional and national significance by developing and applying best practices, providing training and technical assistance, providing targeted capacity expansion, and changing the service delivery system through family, client-oriented and consumer-run activities. CMHS employs a strategic approach to service development. The strategy provides for three broad steps: (1) developing an evidence base about what services and service delivery mechanisms work; (2) promoting community readiness to adopt evidence based practices; and (3) supporting capacity development. The Children’s Health Act (P.L. 106-310), enacted in October 2000, reauthorized most of CMHS’s system-improvement activities, and it authorized new programs, many of which are included in CMHS’s Programs of Regional and National Significance.

The **Programs of Regional and National Significance (PRNS)** includes the programs in its Knowledge Development and Application Program (KDA), its Targeted Capacity Expansion Program (TCE), as well as a number of other programs. On pages 30–42, we describe the salient importance of the following PRNS programs:

- Youth Violence Prevention Initiatives
- Statewide Family Network Grants
- Juvenile Justice: Aftercare for Youth Offenders
- Juvenile Justice: Youth Interagency Research, Training, and Technical Assistance Centers
- Improving Mental Health and Child Welfare Services Integration
- Addressing the Needs of Children and Adolescents with Post-Traumatic Stress
- Jail Diversion Grants
- Grants to Provide Integrated Treatment for Co-occurring Serious Mental Illness and Substance Abuse Disorders
- Training on Mental Disorders for Teachers and Emergency Services Personnel
- Suicide Prevention for Children and Adolescents
- Emergency Mental Health Centers
- Emergency Response Initiatives
- Data Collection and Infrastructure Program

Youth Violence Prevention Initiatives

(DOLLARS IN MILLIONS)		
EARMARK FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
\$90.0	Such Sums as Necessary	\$130.0

What Do the Youth Violence Prevention Initiatives Do?

Safe Schools / Healthy Students Initiative: The Center for Mental Health Services (CMHS), within the Substance Abuse and Mental Health Services Administration, has devoted the majority of its violence prevention and intervention funds to a program entitled the Safe Schools/Healthy Students (SSHS) Initiative. This Initiative provides three-year grants to local school districts to fund programs addressing school violence prevention through a wide range of early childhood development, early intervention and prevention, suicide prevention, and mental health treatment services. The SSHS program is administered jointly with the Department of Education (Safe and Drug Free Schools Office) and the Department of Justice (Office of Juvenile Justice and Delinquency Prevention).

The primary objective of this grant program is to promote healthy development, foster resilience in the face of adversity, and prevent violence. To participate in the program, a partnership must be established between a local education authority, a local mental health authority, a local law enforcement agency, and family members and students. These partnerships must demonstrate evidence of an integrated, comprehensive community-wide strategy that addresses:

- keeping guns out of school;
- alcohol and other drug and violence prevention, and early intervention programs;
- school and community mental health preventive and treatment intervention services;
- early childhood development and psychosocial development programs;
- educational reform; and
- safe school policies.

Other Youth Violence Prevention Initiatives

Youth violence prevention funding is also used by CMHS to support a variety of activities including the following:

- **School and Community Action Grants** to build community consensus and collaboration as well as pilot an evidence based program to promote healthy childhood development and prevent youth violence.
- **A Technical Assistance Partnership** with a nonprofit organization linked with a network of local community affiliates, government agencies, businesses, and communities in support of school-based violence prevention interventions.
- **A Public Awareness/ Communications Campaign** to fulfill the needs of grantee partnerships and enhance awareness to and ensure sustainability of the violence prevention grant programs.
- **Interactive Technology** to develop a portfolio of interactive multimedia violence prevention materials for students, parents, and teachers that will assist in the development of positive attitudes, adequate knowledge, and effective skills for preventing violence.

The Children’s Health Act (P.L. 106-310), enacted in October 2000, provides specific authority for current CMHS youth violence prevention initiatives and also authorizes new funding for research and training on the subject of psychological trauma to assist witnesses and survivors of community or domestic violence.

Why Is Additional Federal Funding Justified?

Violence continues to plague our schools as demonstrated by the most recent school shooting in Santee, California and the series of violent school incidents that are reported in the news on an almost weekly basis. Students, teachers, parents, and other caregivers experience daily anxiety due to threats, bullying, and assaults in their schools. To help prevent these violent outbursts and to improve our understanding of why so many children are turning to violence to express their frustrations, Congress, since FY 1999, has provided appropriations to CMHS for youth violence prevention initiatives.

While Congress has increased funding for CMHS youth violence prevention activities in FY 2000 and 2001, the need for funding continues to greatly exceed the levels provided. In FY 1999, in response to the first request for proposals for the Safe Schools/Healthy Students Initiative, CMHS received greater than 450 applications

from school districts across the country. Although CMHS used most of its initial \$40 million youth violence prevention appropriation for this grant program, only 54 school-districts could be funded. For FY 2000, CMHS received an additional \$40 million for youth violence prevention activities and as a result, 23 more school districts received funding for the development of programs to address youth violence in schools through mental health and substance abuse prevention and treatment services and other reforms. With the \$10 million in additional appropriated funds provided for FY 2000, CMHS plans to issue another request for proposals for the Safe Schools/Healthy Students Initiative and expects to receive even more applications than in FY 1999.

With additional funds in FY 2002, CMHS could reach more unserved communities through the **Safe Schools/Healthy Students Initiative** and the **School and Community Action Grants**.

Statewide Family Network Grants

(DOLLARS IN MILLIONS)	
AWARD (DISCRETIONARY) FY 2001	MHLG AWARD RECOMMENDATION
\$2.08	\$12.0

What Do the Statewide Family Networks Do?

The Statewide Family Network Grant Program: 1) fosters collaboration among families and others (such as mental health agencies and schools, legislators, and researchers) key to providing effective services for children with mental health needs; 2) promotes leadership and management skills development for boards and staff of the grantees; and 3) provides technical assistance for the grantees. Several of the grantees in the Statewide Family Network Program specifically focus on the needs of ethnic minorities and rural families' issues. Statewide Family Networks are engaged in a number of activities:

- developing and conducting peer support groups
- disseminating information and technical assistance;
- maintaining toll-free telephone numbers, information and referral networks, and newsletters;
- sponsoring conferences and workshops;
- providing outreach to families;
- serving as a liaison with various human service agencies;
- educating states and communities about effective ways to improve children's services;
- developing skills in organizational management, and financial independence.

Why Are Statewide Family Network Grants Important?

Families raising children with emotional, behavioral, or mental disorders face many obstacles in getting appropriate and effective services and supports. They need emotional support, accurate information about mental health services, and help protecting the rights of their children.

Statewide Family Networks are critical to achieving full participation of families in planning, designing, implementing and evaluating services for children with emotional, behavioral, or mental disorders. Over

the past 15 years, there has been increasing evidence to suggest the engagement of trained and empowered family members is an essential ingredient of systems of care, and can result in increased family satisfaction for themselves as a family unit and better outcomes for their children.

Evidence of Effectiveness

A study of the impact of the Statewide Family Network Grants conducted by the Research and Training Center on Family Support at Portland State University describes the benefits families receive in three categories. One is information on legal rights, specific disorders, and resources. The second is emotional support consisting of parent-to-parent sharing, understanding and friendship, staff as advocates, and training for advocacy. The third is practical services including workshops, financial support and respite care. (*Benefits of Statewide Family Networks for Children's Mental Health: Voices of Family Members*, 1998)

Family members interviewed for the study felt that they were better able to advocate for their children, were more in control of their lives, and were able to make lasting changes both in their lives and in the lives of their children and families because of the help and support that they received through the statewide family networks. They attribute changes in their children's services directly to their involvement with the statewide family networks.

Statewide Family Networks have also contributed to the overall improvement of state and community children's mental health policies and services. For example:

- Mississippi Families As Allies, in collaboration with the business community and state legislators, developed policy support for community based service delivery for children and adolescents with mental health needs.
- Keys for Networking in Kansas worked cooperatively with the state mental health authority to provide information to legislators leading to the development of the state's home and community based waiver which allows families to be authorized service providers in Kansas.
- Georgia Parent Support Network has become a state contracted service provider developing a network of specialized foster homes and working with sex-offending adolescents.

Juvenile Justice: Aftercare Services for Youth Offenders

(DOLLARS IN MILLIONS)		
APPROPRIATION FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
N/A	\$40.0	\$20.0

What Would the Aftercare Services for Youth Offenders Program Do?

As authorized by Congress in the Children’s Health Act (P.L. 106-310), the Services for Youth Offenders program would provide grants targeted to help youth overcome the serious emotional problems which have led or contributed to their involvement with the juvenile justice system. Grants would be awarded to state or local juvenile justice agencies to provide comprehensive services to young people with serious emotional disturbances (SED) (or at risk of developing a SED), who have been discharged from juvenile or criminal justice system facilities. Agencies could use up to 20 percent of the grant funds to implement planning and transition services for incarcerated youth with SED.

Grant recipients would:

- develop a “mental health plan” describing how the agency will provide required services;
- provide comprehensive aftercare services, including: diagnostic and evaluation services, substance abuse treatment, outpatient mental health care, medication management, intensive home-based therapy, intensive treatment services, respite care, and therapeutic foster care; and
- establish a community-based system of services in coordination with other state and local agencies providing recreational, social, educational, vocational, or operational services for youth offenders.

Why Is the Program Important?

Each year more than one million youth come in contact with the juvenile justice system, and more than 100,000 are placed in some type of correctional facility. Studies have consistently found high rates of mental and emotional disorders among the juvenile justice population. The rate of mental disorders among adolescents in detention has been projected to be as high as 60 percent, and over 60 percent are estimated to have substance abuse problems. Many youth offenders have committed minor, non-violent offenses or status offenses, and their incarceration is often the result of systemic problems, including lack of access to mental health services.

Juvenile justice systems are seldom equipped to recognize youth in need of mental health or substance abuse disorders. Even when treatment is initiated, the fragmentation and lack of coordination among systems of medical, mental health, and social services for incarcerated youth virtually assure that these youngsters will not receive the array of services they need after discharge. The failure to provide needed treatment or to provide for continuity in treatment often results in youngsters returning to the justice system, sometimes for more egregious crimes.

What Justifies Federal Spending for the Program?

Mental health and juvenile justice experts agree on federal strategies to break the cycle of incarceration of juveniles with mental health substance abuse problems:

- providing services to children before they become involved with the juvenile justice system;
- conducting systematic mental health screening and assessment when juveniles enter the juvenile system;
- developing and implementing policies for linking released youth to community-based services when they leave the justice system.

Model programs have demonstrated that providing appropriate services can prevent children from committing delinquent offenses and from re-offending. The Bridge Program in South Carolina, for example, a six-county comprehensive family-centered aftercare program, has had success in providing a full year of wraparound services to youth leaving juvenile facilities. That program provides a model for the kind of initiative envisioned by the congressional authors of the Services For Youth Offenders program.

The CMHS Services for Youth Offenders program offers a vision for reversing the lives of young people with serious emotional and behavioral problems who are at risk of re-offending. This grant will assist local communities to establish or expand much-needed intensive, integrated services for vulnerable youth.

**Juvenile Justice: Youth Interagency
Research, Training and Technical Assistance Centers**

(DOLLARS IN MILLIONS)		
APPROPRIATION FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
N/A	Such Sums as Necessary	\$4.0

What Would the Youth Interagency Research, Training and Technical Assistance Centers Do?

In the Children’s Health Act (P.L. 106-310), Congress authorized funding to establish Youth Interagency Research, Training and Technical Assistance Centers to assist state and local juvenile justice authorities in providing state-of-the-art mental health and justice-related services and collaborative programs that focus on children and adolescents.

This new grant program could support up to four regional centers which would:

- provide training on mental health and substance abuse service delivery and collaborative programming for law enforcement, juvenile and criminal justice system personnel; mental health and substance abuse providers; and policy-makers;
- conduct research and evaluations on state and local justice and mental health systems (and system redesign); and
- provide technical assistance on mental health or substance abuse treatment approaches that are effective within the judicial system, and on improving the effectiveness of community-based services.

SAMHSA would award grants in consultation with the Office of Juvenile Justice and Delinquency Prevention, the Director of the Bureau of Justice Assistance and the Director of the National Institutes of Health on the initiative.

Why is the Program Important?

Among the greatest unmet needs in communities is the need for accessible, high-quality mental health services for children and their families. The dearth of such resources has meant that behaviors which might have been successfully treated are instead addressed through juvenile justice systems. Those systems are ill-equipped to meet or even recognize the human service needs of children who become housed in juvenile justice facilities. Yet studies have found that the juvenile offender population has an acute need for mental health and substance abuse treatment. The rate of mental disorders among adolescents in detention has been projected to be as high as 60 percent, and over 60 percent are estimated to have substance abuse problems.

Juvenile justice systems rarely have sufficient staff trained to recognize youth in need of mental health or substance abuse disorders. Staff, in fact, often punish such children for behaviors which are symptoms of unrecognized mental and emotional problems. And collaboration between juvenile justice and other service agencies has been difficult and often ineffective.

Federally-supported regional centers offer a promising mechanism for filling the gaps in knowledge which juvenile justice system authorities themselves acknowledge, and for fostering needed collaboration with mental health professionals, other public agencies, families, and advocates to design programs that produce better outcomes for children.

What Justifies Federal Spending for the Program?

Providing the modest funding required to establish Youth Interagency Centers represents a modest investment toward reversing a pattern of neglect in responding to the treatment needs of juveniles.

Improving Mental Health and Child Welfare Services Integration

(DOLLARS IN MILLIONS)		
APPROPRIATION FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
N/A	Such Sums as Necessary	\$10.0

What is the Program?

In establishing a new grant program targeted at providing integrated child welfare and mental health services, the Children’s Health Act of 2000 laid the foundation for addressing the serious needs of children and adolescents in the child welfare system and the needs of youths at risk for placement in this system. Under this program, grantees would improve the health, developmental, social, and educational outcomes of youths by providing coordinated child welfare and mental health services. The integration of child welfare and mental health services would provide a single point of access, comprehensive assessments, coordinated service and treatment plans, integrated mental health and substance abuse treatment when both types of treatment are needed, and cooperative efforts with other community agencies such as education, social services, juvenile justice and primary health care agencies.

Why is it Important to Integrate Child Welfare and Mental Health Services?

The circumstances that place children in the child welfare system are themselves indicators of a great need for mental health services. Some children enter the system as a result of neglect or abuse and are at high risk for emotional, behavioral, and psychiatric problems. Some enter with already diagnosed serious mental illness as a last resort after a family’s insurance benefits have been exhausted.

All children entering the child welfare system should receive comprehensive assessments to be sure that, first, placements are appropriate and, second, service and treatment planning is fully informed and can begin immediately. Child welfare and mental health agencies need to develop a coordinated process to assess and serve each child in this way. Most children in the child welfare system are eligible for Medicaid services. Medicaid’s EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) program mandates comprehensive health, mental health, and developmental assessments as well as the treatment services identified as necessary.

What Justifies Federal Spending on this Initiative?

The need to better integrate and coordinate these two safety net systems for our most vulnerable children justifies federal funding of these demonstration projects. Improved outcomes for children are the clear result of coordination of care across systems. For years, the Children’s Mental Health Services Program has provided a good example of the benefits of coordination. Cost-savings are also likely, both directly as a result of better service and treatment planning, and through indirect savings as mental health costs are not shifted to other systems such as education or juvenile justice.

Addressing the Needs of Children and Adolescents With Post-Traumatic Stress

(DOLLARS IN MILLIONS)		
EARMARK FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
\$10.0	Such Sums as Necessary	\$10.0

How Does Exposure to Violence Affect the Mental Health of Children and Adolescents?

The Surgeon General’s landmark 1999 Report on Mental Health shed great light on the roots of mental disorders in childhood, and highlighted a well-established relationship between childhood exposure to traumatic events and risk for child mental disorders. The Surgeon General’s 2001 Report on Youth Violence noted that exposure to violence can disrupt normal development of both children and adolescents, with profound effects on mental, physical and emotional health. As the Surgeon General reported, studies have found that adolescents exposed to violence are more likely to engage in violent acts themselves. Too often, children witness traumatic events, ranging from violence in the home in witnessing or experiencing physical or sexual abuse or incidents of domestic violence, to violence in school or in the community associated with weapons, gangs, and drugs. Any of these exposures can have deleterious effects.

How Can We Address This Problem?

Congress, in the Children’s Health Act, Public Law 106-310, established an important new grant program to help address the growing problems arising from children and adolescents witnessing or experiencing violence. These grants would fund the design and implementation of model programs to treat psychiatric disorders in young people who are victims or witnesses of violence, and, importantly, foster the conduct of research, and development of evidence-based practices, on treating and preventing trauma-related mental disorders.

What Justifies Federal Spending on Post-Traumatic Stress in Children?

The Surgeon General, as the nation’s chief public health official, has helped the country understand the importance of mental health, and particularly the importance of mental health in children. However, while this country has appropriately invested extensively in children’s physical health and cognitive development, its record of support for healthy mental development has fallen far short. With the alarming phenomenon of children witnessing or experiencing violence in schools, their communities, and even in their homes, we must develop tools to help young people deal with the effects of such trauma, and prevent such exposures from festering into lifelong mental illness. But despite its importance in terms of the likely impact of trauma on youth, we know considerably less about this subject and how best to treat and prevent chronicity than many other areas of children’s mental health. The Center for Mental Health Services is applying the modest funding it received this fiscal year to initiate the first steps toward developing knowledge of best practices and supporting specialized treatment programs. Expanding that funding to support a broad network of centers of excellence in post-traumatic stress in children can yield improved evaluation tools and treatment methods for vulnerable children who have been subjected to or have witnessed violence, and offers the prospect of developing techniques to prevent the onset of mental health problems among youth who have experienced such trauma.

Jail Diversion Program Grants

(DOLLARS IN MILLIONS)		
APPROPRIATION FY 2001	AUTHORIZATION CEILING	MHLG RECOMMENDATION
N/A	Such Sums as Necessary	\$40.0

What is the Grants for Jail Diversion Program?

The Grants for Jail Diversion Program was newly authorized through the Children’s Health Act of 2000, and it will enable services to be provided to adults as well as children. With the appropriation of funds, this program will provide up to 125 grants to states or localities to develop and implement programs to divert individuals with a mental illness from the criminal justice system to community-based services. Diversion will be based on effective, evidence-based strategies, such as crisis intervention teams and pre-booking or post-booking diversion. These community programs will be integrated within an existing system of care and will be a collaborative effort between systems—including the criminal justice, mental health, and addictions treatment systems.

Under the program, individuals with a mental illness will be diverted into state-of-the art mental health services, including case management, assertive community treatment, medication management and access, integrated mental health and co-occurring substance abuse treatment and psychiatric rehabilitation. The primary treatment will be coordinated with social services, including life-skills training, housing placement, vocational training, education, job placement and health care.

The Grants for Jail Diversion Programs can also be used to fund several activities that complement jail diversion programs, including:

- creation or expansion of community-based mental health and co-occurring mental illness and substance abuse services;
- training for professionals involved in the system of care as well as law enforcement officers, attorneys and judges; and
- the provision of community outreach and crisis intervention services.

Why is the Grants for Jail Diversion Programs Important?

Individuals with a severe mental illness are being arrested and jailed at increasing rates, many times for minor, non-violent offenses directly related to lack of services, a result of being homeless or other issues as they struggle to survive on the streets. Today 16% of all individuals incarcerated in state and local jails suffer from mental illness. Once in jail, mental ill offenders remain longer than others with similar convictions. Often their condition deteriorates. On Riker’s Island, New York City’s jail, 15 percent of new inmates have a serious mental illness and their average stay is 215 days—five times as long as other inmates.

Community-based jail diversion programs are important to the effort to reduce recidivism, by addressing the treatment needs of persons with mental illness who come to the attention of law enforcement, but who would be better served by effective community treatment. By addressing the unmet treatment needs, through the provision of an array of mental health and substance abuse services and supports, individuals with mental illness will be able to live successfully in the community, receiving humane care. Additionally, public safety will be enhanced by ensuring that individuals who now cycle in and out of jail and re-offend, will instead receive on-going, effective treatment.

What Justifies Federal Spending for the Grants for Jail Diversion Programs?

The key to stopping the revolving jail door for people with severe mental illness rests with the coordination of services in different systems, and early identification of those who need treatment. Accordingly, these programs—which have been around for several years in cities scattered across the nation—have had positive outcomes, including increased public safety, lower arrest rates, reduced officer injuries and a reduction in future psychiatric hospitalizations.

Cost-Savings in Three Cities

In Galveston, Texas, the Mental Health Deputy Program—a pre-booking jail diversion program serving the sheriff’s office—reported that in 1995 the program reduced psychiatric hospitalizations by 52% and saved an estimated \$2 million in correctional costs. In California, the Los Angeles Police Department has reported that the System wide Mental Assessment Response Team (SMART) has saved approximately \$2,200 per case in reduced jail time and officer time. Furthermore, in the Thresholds program—a nationally recognized psychiatric rehabilitation program in Chicago, Illinois—case workers arrange with judges an early release for mental ill offenders into the program. Since the program began in 1997, the 45 participants with a mental illness have had no re-arrests. The program also reported cost savings, with approximately \$26 a day for the program as compared to \$70 a day in jail and \$400 a day for a psychiatric hospital.

**Grants to Provide Integrated Treatment for
Co-Occurring Serious Mental Illnesses and Substance Abuse Disorders**

APPROPRIATION FY 2001	(DOLLARS IN MILLIONS) AUTHORIZATION CEILING	MHLG RECOMMENDATION
N/A	Such Sums as Necessary	\$40.0

What Will the Integrated Treatment Program Do?

The Children’s Health Act of 2000 authorized Integrated Treatment grants that will support the start-up of innovative programs directed to the special needs of people with co-occurring serious mental illnesses and addictions disorders. These programs stem from a research base which finds that mental and addictions disorders are often inter-related and that it is effective to treat co-occurring disorders by using interventions that address both problems at once. It is necessary to use clinical staff who are cross-trained in the treatment of both kinds of disorder.

In many cases people with co-occurring disorders develop chemical dependencies as a result of efforts to self-medicate their illnesses. Many people resort to self-medication with alcohol or other drugs because of a lack of access to appropriate psychotropic medication or because of the serious side effects (such as severe tremors, nausea, and seizures) that many medications can cause. Studies have shown that it is not uncommon for people with serious mental illness to receive too little, too much, or the wrong medication. In resorting to self-medicating, many with mental illness compound their health problems.

Why are the Integrated Treatment Grants Important?

Our country faces a serious treatment gap in addressing the needs of people with co-occurring disorders. Although evidence supports integrated treatment, it is only available in a limited number of communities, and the 1999 Surgeon General’s *Report on Mental Health* cites an estimate that 10 million Americans have co-occurring disorders. Individuals with co-occurring disorders are more likely to experience a chronic course and to utilize services than are those with either type of disorder alone. Clinicians, pro-

gram developers, and policy makers need to be aware of these high rates of comorbidity—about 15 percent of those with a mental disorder in 1 year (Regier et al., 1993; Kessler et al., 1996).

Adults with co-occurring mental health and substance abuse disorders represent one of the most difficult populations to serve. They are more likely to be homeless or without housing than people with mental illnesses only, and they are more likely to have interactions with the criminal justice system.

What Justifies Federal Spending for Integrated Treatment Grants?

Publicly-funded mental health and addictions treatment programs in the states – such as those that ultimately receive federal funding through Mental Health and Substance Abuse Prevention and Treatment block grants – are often housed in separate “administrative silos.” Providers often work in separate mental health and substance abuse treatment systems within a single state. These separate systems often have different requirements for facility licensure, certification of clinical staff, and the MIS systems and data required to bill for publicly-funded services. As a result, significant bureaucratic hurdles exist for providers who wish to provide both kinds of services. In states like Pennsylvania and Massachusetts, the challenges confronted by pioneering integrated treatment programs established at the community level led state policy makers to address the bureaucratic obstacles to such programs in their systems.

Congress, recognizing the need to reach this difficult to serve population with the best known treatment, authorized funding for integrated treatment for co-occurring mental health and substance abuse disorders. It is important for Congress to follow through with last year’s authorization approval and approve funding for this program.

Training on Mental Disorders for Teachers and Emergency Services Personnel

(DOLLARS IN MILLIONS)		
APPROPRIATION FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
\$0	Such Sums as Necessary	\$5.0

What Would this Program Do?

Certain professionals, notably teachers and emergency services personnel, in the course of their work often encounter individuals with mental disorders but lack the training to recognize or respond appropriately. Those encounters, however, can be critical and can make the difference between detection and treatment of mental health problems, or worsening of disorders through benign neglect. In the case of teachers, it is well understood that childhood is a critical period for preventing mental disorders and promoting healthy development since mental illness often has its roots in childhood problems. If funds are appropriated, new programs would be established to provide teachers and emergency personnel with training on mental disorders.

What Justifies

Federal Funding for this Program?

As the Surgeon General advised in his 1999 Report on Mental Health, "prevention does work," and it is vital to intervene early in children's lives before problems become established. As many as one in five children and adolescents have a mental health problem that

can be identified and treated. Despite such alarming data, however, mental health treatment needs in children too often escape detection. Yet schools can be a critical site for early recognition of incipient problems, with teachers and other school personnel being key to early identification. Despite the important roles that teachers and emergency services personnel such as paramedics and firefighters can play in identifying symptoms of mental disorders, the formal education of these professionals seldom includes such training. Given the critical interventions that can and should take place in classrooms and elsewhere in the community, that knowledge gap should be bridged.

Congress, in authorizing a new program of mental illness awareness grants targeted at training teachers, other school personnel, and emergency services personnel to recognize symptoms of mental disorders and to respond appropriately, provides a mechanism through which communities can meet this need. The program's design recognizes that while there exist very effective treatments for most mental disorders, treatment can be most effective when problems are identified early. Early intervention works, and should be supported.

Additional Programs of Regional And National Significance

Suicide Prevention for Children and Adolescents

(DOLLARS IN MILLIONS)	
APPROPRIATION FY 2001	MHLG RECOMMENDATION
N/A	\$10.0

What Will the Suicide Prevention Program Do?

The Suicide Prevention for Children and Adolescents was newly authorized last year as part of the Children’s Health Act of 2000. The primary goal of this program is to reduce suicide in children and adolescents through interagency collaboration among the Substance Abuse and Mental Health Services Administration, the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Administration on Children and Families.

This program aims at providing services to communities or groups that experience high or rapidly rising rates of suicide. The grants, contracts or cooperative agreements funded will provide assessment, treatment and referral for children and adolescents at risk for suicide and these services will be established on best evidence-based practices that are sensitive to the cultural needs of each community. In addition, the program supports the development of primary prevention programs aimed at educating the community about suicide prevention. Suicide prevention programs will be integrated with other delivery systems in order to provide comprehensive and coordinated treatment. The program also provides for training staff in suicide prevention and requires that mental health professionals who are providing services be trained in identifying children and adolescents at risk for suicide.

Emergency Mental Health Center Grants

(DOLLARS IN MILLIONS)		
APPROPRIATION FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
N/A	Such Sums as Necessary	\$10.0

What are Emergency Mental Health Centers?

The Emergency Mental Health Center program was one of the mental health programs that were newly authorized as part of the Children’s Health Act of 2000. With the appropriation of funds, this program will provide grants to states and localities that would benefit from enhanced psychiatric emergency services. Grant funds may be used to establish mobile crisis intervention teams capable of responding to emergencies in the community. In addition, funds can be used to establish new emergency mental health services in areas where existing service coverage is inadequate. These new centers will be a central receiving point in the community for individuals in psychiatric crisis. They will provide treatment and be capable of making referrals to follow-up treatment providers.

Why are Emergency Mental Health Centers Important?

While mobile crisis teams have proven highly successful in many communities, they are unavailable in most areas of the United States. These mobile services often obviate the need for the involvement of police or other emergency services, providing a more effective intervention when an individual in crisis is not in immediate danger. In addition, access to emergency mental health centers is inadequate in some communities—particularly in rural areas.

Emergency Response Initiatives

Why Is an Emergency Response Capability Important?

Communities across the country are grappling with volatile issues like adolescent suicide and youth violence in the face of lack of access to culturally appropriate, quality care for youth with serious mental, emotional, behavioral, or substance abuse problems. Such problems can create real emergencies for communities. And many such communities and advocates alike recognize that local emergency situations can create a need that the deliberative, methodical competitive grant process cannot meet in a timely way. It is important in what amount to life-or-death circum-

stances to provide avenues to respond relatively quickly with well designed community efforts to cope with local crises. Providing start-up funds for this contingency mechanism will provide critical help to desperate communities, and potentially avert serious jeopardy.

What Are Emergency Response Initiatives?

Through an array of programs, the Substance Abuse and Mental Health Services Administration (SAMHSA) plays an important role in improving access to care for those who need mental health and substance abuse services when local emergencies arise.

Data Collection and Infrastructure Program

What Is the Data Infrastructure Development Program?

The Data Infrastructure Development Program is a new initiative that would facilitate the development of performance indicators and outcome measures for mental health and substance abuse programs and services. This initiative would provide grants to states to develop the infrastructure needed to collect and analyze data related to performance indicators.

Why Is the Data Infrastructure Development Program Important?

The development of performance and outcomes measures is a key component of evaluating and improving service delivery. It is particularly important that public sector services be evaluated to ensure accountability – yet few resources are available to undertake this task. Mental health performance measures would provide states with the tools needed to more effectively award and monitor contracts with managed care and other providers, ensure quality while containing costs, and allocate resources most efficiently. The same measures could be used to develop “report cards” that would empower consumers to make choices among

providers and to compare data and performance across states and providers to improve the overall quality of services. Measuring performance requires that public sector provider organizations be given the resources and technical assistance needed to implement new data collection procedures and technology without reducing service levels.

What Justifies Federal Spending for the Data Infrastructure Development Program?

Congress has recognized the importance of developing performance goals, rather than arbitrary process requirements, as a condition of participation in federal programs. Within the arena of mental health service delivery, the Community Mental Health Services Block Grant is in the process of establishing “performance partnership” goals that require states to demonstrate the effectiveness of programs funded through Block Grant dollars. However, many states lack the capacity to adequately collect and analyze the data needed to make performance partnership Block Grants effective. A federal-state partnership to develop data collection infrastructures for mental health would facilitate the success and effectiveness of the performance partnership goals of the Block Grant without diverting scarce resources from service delivery.

CMHS Direct Operations

(DOLLARS IN MILLIONS)		
APPROPRIATION FY 2001	AUTHORIZAITON CEILING	MHLG RECOMMENDATION
\$13.2	* *	\$20.0

**This is not a separately authorized activity. Funds for CMHS direct operations are appropriated under SAMHSA's Program management budget line.

What Is the CMHS

Direct Operations Program?

CMHS has leadership responsibilities in policy development, data collection and analysis, and stewardship of federal resources. CMHS plays a critical leadership role in the development and dissemination of effective service delivery. The volume of CMHS programs and oversight responsibilities of the states, require, at the very least, an adequate staffing for each statutory function. Regrettably, this has not been the case since CMHS was established in 1992. Adequate staffing for the Center for Mental Health Services (CMHS) should be a priority in FY 2002 appropriations for mental health services.

Considering only the following high profile mandates, CMHS is severely under-funded:

- Administering the Mental Health Services Block Grant, including: compliance reviews and evaluations of the state block grant implementations;
- Administering the Children's Mental Health Services Program competitive grant and the newly authorized children & violence programs that include school-based violence prevention as well as children and trauma grants;

- Conducting Studies and Assisting States on managed care and Medicaid services including capitation rates and outcomes measurements. This is especially important with over 22 Section 1115 waivers to the states;
- Assuring quality services to underserved areas and populations, including: women, minorities, elderly, and those living in rural areas;
- Administering other newly established grant programs.

What Justifies CMHS

Direct Operations Spending?

According to the conference report on the 1992 ADAMHA Reorganization Act (H.Rep.102-546): "The principal purpose of the reorganization is to fully develop the Federal government's ability to target effectively substance abuse and mental health services to the people most in need.—**Sufficient resources and personnel shall be made available to each of the federal agencies affected by the reorganization to enable each to carry out the functions assigned to it.**"

CMHS needs continued funding to effectively administer its program oversight duties, policy development, data collection and analysis and guide rapidly changing service delivery at the state level.

Social Services Block Grant (Not Administered by CMHS)

(DOLLARS IN MILLIONS)	
APPROPRIATION FY 2001	MHLG RECOMMENDATION
\$1.73	\$2.0

What is the Social Services Block Grant?

According to HHS, the Social Service Block Grant is the major source of funding for all social service programs. The program is authorized under Title XX of the Social Security Act, and unlike most of the services-oriented programs in this booklet, it is not administered by the Center for Mental Health Services. Nonetheless, it helps to provide many services that are crucial to people with psychiatric disabilities. States, in partnership with local governments and nonprofit organizations, use the Social Service Block Grant (SSBG) for a range of services directed at increasing self-sufficiency, preventing or remedying neglect and abuse of children or adults, and preserving families. States are allowed to use the block grant for a broad range of mental health-related services including: child and adult counseling; mental health therapy; case management to individuals and families; and personal and family counseling. The block grant can also be used for independent and transitional living services to help adults make the transition from an institution, or from homelessness to independent living.

Why is the Social Services Block Grant Important?

According to preliminary data, over \$146 million dollars of SSBG funds were used to provide such mental health-related services as case management and coun-

seling in FY1998. This does not include portions of independent living and residential service dollars that are also used to support persons with mental illness. Many states contract out their Title XX services but others spend the funds directly. In fact, reports from a survey by the National Association of State Mental Health Program Directors shows that close to \$55 million dollars of SSBG funds were used in FY1997 by state mental health agencies across the country. Seven states actually received more mental health revenues from the Social Services Block Grant than from SAMHSA funds.

What Justifies Federal Spending for the Social Services Block Grant?

As state institutions across the country are closed, persons with mental illness look to the support of the community systems. These systems include community mental health centers, supported living programs with intensive case management, residential treatment programs, and employment and training programs. The SSBG program is a source of funding for all of these services, yet federal funding for the block grant has steadily decreased. Since FY 1997, the SSBG has been cut by \$591 million dollars. In addition, \$2.46 billion dollars of SSBG funds were used as a set aside in the Surface Transportation Reauthorization Law. The bill not only cut the authorization level of Title XX down to \$1.7 billion for FY 2001-2003, it also changed how much states could add to the program. Currently, states have the option of transferring up to 10 percent of their TANF dollars into Title XX. This policy, however, was eroded in the transportation bill which decreased the amount states can transfer to 4.25 percent starting in FY 2001.



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