

# Appropriations Recommendations for Fiscal Year 2006

for the



Center for Mental Health Services and Related Agencies

National Institute of Mental Health

National Institute on Drug Abuse

National Institute on Alcohol Abuse and Alcoholism

*“[A]nother consequence of our tattered ‘safety net’ for children with mental illness—the inappropriate use of juvenile detention centers as ‘holding areas’ for young people who are waiting for mental health services. Like custody relinquishment [of children with mental illness], these inappropriate detentions are a regrettable symptom of a much larger problem, the lack of available, affordable, and appropriate mental health services and support systems.”*

*— Sen. Susan Collins (R-ME), July 7, 2004*

**MENTAL HEALTH LIAISON GROUP**

National Organizations Representing  
Consumers, Family Members, Advocates, Professionals and Providers

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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.

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**MENTAL HEALTH LIAISON GROUP**

## **Endorsing Organizations**

### **Mental Health Liaison Group Member Organizations**

**Alliance for Children and Families**  
**American Academy of Child and Adolescent Psychiatry**  
**American Association of Children's Residential Centers**  
**American Association for Geriatric Psychiatry**  
**American Association for Marriage and Family Therapy**  
**American Association of Children's Residential Centers**  
**American Board of Examiners in Clinical Social Work**  
**American Counseling Association**  
**American Group Psychotherapy Association**  
**American Mental Health Counselors Association**  
**American Orthopsychiatric Association**  
**American Association of Pastoral Counselors**  
**American Psychiatric Association**  
**American Psychiatric Nurses Association**  
**American Psychological Association**  
**American Psychotherapy Association**  
**Anxiety Disorders Association of America**  
**Association for Ambulatory Behavioral Healthcare**  
**Association for the Advancement of Psychology**  
**Bazelon Center for Mental Health Law**  
**Child Welfare League of America**  
**Children and Adults with Attention-Deficit/Hyperactivity Disorder**  
**Clinical Social Work Federation**  
**Clinical Social Work Guild 49**  
**Depression and Bipolar Support Alliance**  
**Eating Disorders Coalition for Research, Policy & Action**  
**Federation of Families for Children's Mental Health**  
**International Society of Psychiatric-Mental Health Nurses**  
**National Alliance for the Mentally Ill**  
**National Association for Children's Behavioral Health**  
**National Association for Rural Mental Health**  
**National Association of Anorexia Nervosa and Associated Disorders**  
**National Association of County Behavioral Health Directors**  
**National Association of Mental Health Planning and Advisory Councils**  
**National Association of Protection and Advocacy Systems**  
**National Association of Psychiatric Health Systems**  
**National Association of School Psychologists**  
**National Association of Social Workers**  
**National Association of State Mental Health Program Directors**  
**National Coalition of Mental Health Professionals and Consumers**  
**National Council for Community Behavioral Healthcare**  
**National Mental Health Association**  
**Suicide Prevention Action Network USA**  
**Tourette Syndrome Association**  
**Volunteers of America**

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## Mental Health Liaison Group (MHLG) FY 2006

### Appropriation Recommendations for the Center for Mental Health Services

(Dollars in Millions)				
PROGRAMS	FY 04 FINAL	FY 05 FINAL	FY 06 ADMIN REQUEST	FY06 MHLG REQUEST
<b>CMHS</b>				
CMHS TOTAL	\$862.4m	\$901.3m (+\$38.9m)	\$837.3m (-\$64.1m)	\$982.4m (+\$81.1m)
Community Mental Health Performance Partnership Block Grant	\$434.7m	\$432.8m (-\$1.9m)	\$432.8m (+\$0m)	\$471.5m (+\$38.7m)
Children's Mental Health Services Program	\$102.4m	\$105.2m (+\$2.8m)	\$105.2m (+\$0m)	\$114.7m (+\$9.5m)
PATH Homelessness Program	\$49.8m	\$54.8m (+\$5.0m)	\$54.8m (+\$0m)	\$59.8m (+\$5.0m)
Protection and Advocacy (PAIMI)	\$34.6m	\$34.3m (-\$0.3m)	\$34.3m (+\$0m)	\$37.4m (+\$3.1m)
Programs of Regional and National Significance	\$240.9m	\$274.3m (+\$33.4m)	\$210.2m (-\$64.1m)	\$299.1m (+\$24.8m)
Youth Violence Prevention	\$94.4m	\$94.2m (-\$0.2m)	\$66.8m (-\$27.4m)	\$102.7m (+\$8.5m)
State Infrastructure Grants	n/a	\$19.8m <i>New Funding</i>	\$26.0m (+\$6.2m)	\$26.0m (+\$6.2m)
Post Traumatic Stress Disorder	\$29.8m	\$29.8m (+\$0m)	\$29.8m (+\$0m)	\$32.5m (+\$2.7m)
Jail Diversion Grants	\$7.0m	\$6.94m (-\$0.06m)	\$3.91m (-\$3.03m)	\$7.54m (+\$0.6m)
Seniors	\$5.0m	\$4.96m (-\$0.04m)	\$4.96m (+\$0m)	\$5.41m (+\$0.45m)
Community TA Centers	\$2.0m	\$1.98m (-\$0.02m)	\$1.98m (+\$0m)	\$2.16m (+\$0.18m)
Community Action Grants	\$0m	n/a	n/a	\$5.5m (+\$5.5)
Suicide	n/a	\$16.5m (n/a)	\$16.5m (+\$0m)	\$18.0m (+\$1.5m)
<b>NIH</b>				
NIMH	\$1,382.5m	\$1,412.2m (+\$29.7m)	\$1,418.0m (+\$6.0m)	\$1,496.9m (+\$84.7)
NIDA	\$991.5m	\$1006.7m (+\$15.2m)	\$1,010.0m (+\$4.0m)	\$1,067.1m (+\$60.4m)
NIAAA	\$428.9m	\$438.5m (+\$9.6m)	\$440.0m (+\$2.0m)	\$464.8m (+\$26.3m)

## Programs At A Glance

**In keeping with the Mental Health Liaison Group's mission to educate and disseminate critical information concerning pivotal programs important to the 54 million Americans with mental illness and 23 million Americans with substance abuse disorders, the following are short summaries of programs detailed in this report.**

**Addressing Child and Adolescent Post-Traumatic Stress** — These grants would fund the design and implementation of model programs to treat mental disorders in young people who are victims or witnesses of violence, and research, and development of evidence-based practices, on treating and preventing trauma-related mental disorders.

**Aftercare for Youth Offenders** — Provides grants targeted to help youth overcome the serious emotional problems, which have led or contributed to their involvement with the juvenile justice system.

**Children's Mental Health Services Program** — Provides six-year awards to public entities for developing intensive, comprehensive community-based mental health services for children with serious emotional disturbances (SED).

**Community Action Grants** — Enable citizens at the local level to come together in support of evidence based practices, including family education, jail diversion, police training, cultural competence and assertive community treatment. Communities use these grants to gain consensus for implementation of effective programs and services for people with severe mental illnesses. To gain community collaboration for evidence-based outcomes funding should be provided to continue the successful Community Action Grant Program.

**Community Mental Health Performance Partnership Block Grant** — The principal federal discretionary program for community-based mental health services for adults and children. (Formerly known as the Mental Health Block Grant).

**Consumer and Consumer/Supporter Technical Assistance Centers** — The goal of consumer and consumer-supported National technical assistance center grants is to provide technical assistance to consumers, families, and supporters of persons with mental illness.

**Emergency Mental Health Centers** — Provides grants to states and localities that would benefit from enhanced mental health emergency services. Grants may be used to establish mobile crisis intervention teams capable of responding to emergencies in the community. These grants are to establish new services in areas where existing service coverage is inadequate.

**Jail Diversion Grants** — Provides 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 service.

**Juvenile Justice: Interagency Research, Training and Technical Assistance** — Assists 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.

**Mental Health and Child Welfare Services Integration** — Addresses the serious needs of children and adolescents in the child welfare system and the needs of youths at risk for placement in the system.

**Mental Health Outreach and Treatment to the Elderly** — This program provides for implementation of evidence-based practices to reach older adults who require assistance for mental disorders, only a small percentage of whom currently receive needed treatment and services. This program is a necessary step to begin to address the discrepancy between the growing numbers of older Americans who require mental health services and the lack of evidence-based treatment available to them.

**Mental Health Transformation State Incentive Grant (SIG)** — The goal of this new program is to create comprehensive State mental health plans that will enhance the use of existing resources to serve persons with mental illnesses and children and youth with emotional and behavioral disorders. These plans will increase the flexibility of resources at the State and local levels, hold State and local level of government more accountable, and expand the option and array of available services and supports.

**PATH Homeless Program** — Helps localities and nonprofits provide flexible, community-based services to people who are homeless (or at risk of homelessness) and have serious mental illnesses or who have a serious mental illness along with a substance abuse disorder.

**Programs of Regional and National Significance (PRNS)** — These programs allow state and local mental health authorities to access information about the most promising methods for improving the performance of programs.

**Protection and Advocacy (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.

**Statewide Family Network Grants** — Provide peer-to-peer support, accurate information about mental health services, and training so that families can effectively participate in planning, designing, implementing and evaluating services for children with emotional, behavioral, or mental disorders. They are a key vehicle for disseminating information about evidence-based and effective practice to the individuals who can most benefit from the application of research in real world setting.

**Suicide Prevention for Children and Adolescents** — Support service and training programs in states and communities, with a focus on the needs of communities and groups experiencing high or rising rates of suicide.

**Treatment for Co-occurring Mental Illness and Addiction Disorders** — Innovative programs directed to the special needs of people with co-occurring serious mental illnesses and addictions disorders.

**Youth Violence Prevention** — Safe Schools/Healthy Students initiative (one example of Youth Violence Prevention) 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.

## MENTAL HEALTH — IN A STATE OF EMERGENCY

### National Snapshot

An estimated \$100 million of taxpayers' money is spent on detention of youth awaiting community mental health services. (House Government Reform Committee Report, July 7, 2004)

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**"I have a very strong sense that the mental health consequences are going to be the medical story of this war," said Dr. Stephen C. Joseph, an assistant secretary of defense for health affairs from 1994 to 1997.**

(NYT, 12/16/04)

**"I'd rather treat the mentally ill in the community than in jails," said Los Angeles County Sheriff Lee Baca.**

(Associated Press, 11/17/04)

Mental illnesses are "common and under-treated" in many countries, with the highest rate found in the United States, according to a study in June 2, 2004's Journal of the American Medical Association.

Through the end of September 2004, nearly 900 troops had been evacuated from Iraq by the Army for psychiatric reasons, included attempts or threatened attempts at suicide. (NYT, 12/16/04)

Every day, about 2,000 youth are incarcerated simply because community mental health services are unavailable. (House Government Reform Committee Report, July 7, 2004)

But the community-based mental health system that was supposed to replace the mental hospitals never materialized. As a result, prisons have become de facto mental hospitals, but without the treatment that would allow mentally ill patients to control their symptoms and organize their lives. (NYT, 12/13/04)

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*Nebraska:* The state's mental health system is in crisis. (Associated Press, 2/13/04)

*Nevada County Declares State of Emergency After Mentally Ill Overcrowd Hospitals.* (AP/Las Vegas Sun, 7/10)

*Virginia:* One out of every four children in the state's foster care system is there because their parents relinquished custody of them so that the kids can receive mental health treatment that their parents couldn't afford, indicates a state General Assembly study. (The Washington Post, 11/29/04)

*West Virginia:* The fifth-highest suicide rate in the nation led the newspaper, the Sunday Gazette-Mail, to conclude that the state is in the midst of a "mental health crisis." (Associated Press, 1/2/05)

### Administration's FY 2006 Budget

In creating the Commission on Mental Health, President Bush emphatically declared that "Our country must make a commitment: Americans with mental illness deserve our understanding, and they deserve excellent care. I look forward to...fixing the [mental health] system, so that Americans do not fall through the cracks."

### Mental Health Services Funding

Despite this pledge, the administration proposes a 7 percent cut (from \$901 to \$837 million) to mental health services at the Center for Mental Health Services (CMHS). Overall, the administration would cut funding for the Substance Abuse and Mental Health Services Administration (SAMHSA) by 2 percent including a proposal:

- To cut funding for a successful youth-violence prevention program by nearly a third, from \$94 to \$67 million;
- To cut funding for jail diversion program by nearly 50 percent, from \$7 to \$4 million;
- To cut funding for substance abuse prevention by 7 percent, from \$198 to \$184 million;
- To fund at last year's funding levels (in ostensibly a cut given inflation) services to deal with our suicide crisis — almost twice as many individuals die from suicide than homicide;
- To level fund the children's systems-of-care, the homelessness (PATH), PAIMI and elderly programs, the mental health and substance abuse block grants, as well as the Consumer TA Centers; and
- To provide an increase of \$6 million (from \$20 to \$26 million) for the relatively new Mental Health Transformation State Incentive Grant.



### ***Mental Health Research Funding***

The administration's budget proposes an increase of 0.4%, on average, for research activities at the National Institutes of Mental Health, Drug Abuse, and Alcohol Abuse and Alcoholism.

### **The President's New Freedom Commission on Mental Health**

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**"For too many Americans with mental illnesses, mental health services and supports they need are disconnected and often inadequate. The commission has found that the time has come for a fundamental transformation of the Nation's approach to mental health care."**

Dr. Michael F. Hogan, Chairman  
President's New Freedom Commission on Mental Health,  
July 2003

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The President's New Freedom Commission on Mental Health, the first such commission in over 25 years, found that **our nation's failure to prioritize mental health is a national tragedy**. One measure of the scope of that tragedy is the over 30,000 lives lost annually to suicide — a loss, the Commission states, that is largely preventable.

The Commission also found America's mental health system to be "in shambles," resulting in millions of people with mental illnesses not receiving the care they need. The report calls for transforming fragmented public mental health services into a system focused on early intervention and recovery. Such a system would provide people with mental health needs the treatment and supports necessary to live, work, learn and participate fully in their communities.

Consequently, Congress and the Administration should focus on funding community-based services, like those identified as model programs in the Commission's report, and ensure that the federal Center for Mental Health Services (CMHS) at the Substance Abuse and Mental Health Services Administration (SAMHSA) has a budget sufficient to put proven prevention and treatment programs in place in every community across the country.

The President's New Freedom Commission on Mental Health was established in April 2002 as part of the President's agenda to ensure that Americans with mental illnesses not fall through the cracks, that lives not are lost, and that recovery is a realistic goal of treatment.

The Commission was comprised of 15 members, including providers, payers, administrators, and consumers of mental health services and family members of consumers, that were appointed by the President, as well as ex-officio members representing several federal agencies.

**The Commission's report stated decisively that mental illness is shockingly common, affecting almost every American family — directly or indirectly. No community is unaffected, no school or workplace untouched.**

### **Just the Facts**

- Mental illness, compared with all other diseases, ranks **first** in terms of causing disability in the U.S. (chronic disease of the young).
- Approximately 54 million Americans have a mental illness.
- 20 percent of the population experiences a mental illness in a given year.
- For about 5 percent of the population, the mental disorder is a severe and persistent mental illness such as schizophrenia, bipolar disorder, or major depression.
- 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.

### **The Cost of Not Providing Meaningful Funding Increases for Mental Health Programs**

- The rate of teen suicide has tripled since the 1950's; overall, there are 30,000 suicides in America every year.
- Mental illness plays a role in the over 650,000 attempted suicides every year.
- An astounding 80 percent of children entering the juvenile justice system have mental disorders. Many juvenile detention facilities are not equipped to treat them.
- The gap between science discovery to service delivery is an astounding 15 years.
- In a recent award announcement, SAMHSA was only able to fund two applicants in a field of 70 meritorious prospective grantees to expand mental health services in local communities.
- The total yearly cost for mental illness in both the private and public sector in the U.S. is over \$200 billion. Only \$92 billion comes from direct treatment costs, with \$105 billion due to lost productivity and \$8 billion resulting from crime and welfare costs. **The cost of untreated and mistreated mental illness to American businesses, the government and families has grown to \$113 billion annually.**
- When the mental health system fails to deliver the right types and combination of care, the results can be disastrous for our entire nation: school failure, substance abuse, homelessness, minor crime, and incarceration.
- While there are 50,000 beds in state psychiatric hospitals today, there are hundreds of thousands of people with serious mental illness in other settings not tailored to meet their needs — in nursing homes, jails, and homeless shelters.

### **History of Chronic Neglect And Underfunding**

- Mental illness is the leading cause of disability in the U.S., but only 7 percent of all healthcare expenditures are designated for mental health disorders.
- Funding for mental health services has averaged an increase of only **2.5%** a year over the last four years (FY2001-4). In ostensibly, this flat funding is occurring in a landscape of spiraling health care costs/inflation that, according to recent data published in Health Affairs, had skyrocketed **9.3 percent** in 2002 alone.
- The Administration's FY 2006 budget proposes cuts for several vital CMHS programs for the *fifth* consecutive year.
- More than 67 percent of adults and nearly 80 percent of children who need mental health services **do not** receive treatment.
- The reasons for this treatment gap include: (1) financial barriers, including discriminatory provisions in both private and public health insurance plans that limit access to mental health treatment and (2) the historical stigma surrounding mental illness and treatment.

### **Shift from Institutional Care to Community-Based Care**

- Over the last several decades, the public mental health system has shifted its emphasis from institution-based care to community-based care — a more cost-efficient and effective way to promote recovery among many people with mental illnesses who can go on to live productive lives in the community.
- Approximately two-thirds of state funding for mental health currently goes to provide community services. Similarly, most alcohol and drug treatment services are community-based.
- The mission of the Commission was to conduct a comprehensive study of the U.S. mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system. In July 2003, the Commission issued its report with recommendations on how to transform the public mental health system.
- The 1999 U.S. Supreme Court decision in *Olmstead v. LC* mandates that states develop adequate community services to move people with disabilities out of institutions — a blueprint for the President's New Freedom Initiative.
- Without adequate funding, however, efforts to transition people out of institutions and better serve those currently living in our communities will continue to fail.

### **Mental Health Disparities**

- Private insurers typically pay for mental health and substance abuse services at a level far lower than that paid for other healthcare services. That has led to a two-tiered system: a set of privately-funded services for people who have insurance or can pay for their treatment as a result of their disorder; and a public safety net for individuals who have used up all of their benefits or are uninsured.
- For ethnic and racial minorities, the rate of treatment and quality of care is even lower than that for the general population.

### **Vanishing Safety Net**

- Medicaid, the public health safety net, which is in a fiscal crisis, does not meet the mental health needs in many states, forcing state legislatures convening around the country to look for ways to cut benefits.
- In the course of the next year, almost 750,000 people with psychiatric illnesses will find themselves in jails or prisons. There are ten times more people with psychiatric illnesses in jails or prisons than in state psychiatric hospitals.
- The strain of a stressed mental health infrastructure is evident at the local/county level across the country. In the majority of the country, local jurisdictions have the ultimate responsibility to provide care and services in their communities to those most in need.

### **Mental Health and Substance Abuse Services**

- SAMHSA's CMHS, CSAT and Center for Substance Abuse Prevention (CSAP) are the primary federal agencies to mobilize and improve mental health and addiction services in the United States.
- CMHS promotes improvements in mental health services that enhance the lives of adults who experience mental illnesses and children with serious emotional disorders; fills unmet and emerging needs; bridges the gap between research and practice; and strengthens data collection to improve quality and enhance accountability.

### **Mental Health and Substance Abuse Research**

- The National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) - three institutes at the NIH - are the leading federal agencies supporting basic biomedical and behavioral research related to mental illness and substance abuse and addiction disorders.
- An overwhelming body of science demonstrates that: (1) mental illnesses are diseases with clear biological and social components; (2) treatment is effective; and (3) the nation has realized immense dividends from five decades of investment in research focused on mental illness and mental health.

### **Move to National Priority**

- We must address the significant unmet need for mental health and substance abuse treatment, early intervention, and prevention, and further the research that fuels new and more effective treatments.
- Congress and the Administration have singled out mental health services as a critical component of our public health infrastructure.
- Our advocacy for mental health funding increases is compatible with the President's new national priority for FY 2003 of addressing domestic security, including aid for local police and fire departments, and assistance for the public health system.
- With shrinking Medicaid benefits, discretionary federal funding for mental health services will be pivotal to ensure the American people's access to mental health care.
- The transition from institutionalized care to community-based care has never been adequately funded; even though we know that community based care is less expensive than institutional care.
- Criminal justice and corrections officials have called for stronger community mental health service systems in order to prevent unnecessary and costly "criminalization" of people with mental illnesses.
- In the words of the Surgeon General's Report on Mental Health, we must "overcome the gaps in what is known and remove the barriers that keep people from ...obtaining...treatments."

## **Mental Health Services**

### **Fiscal Year 2006 Funding Recommendations**

for the

**Substance Abuse and  
Mental Health Services Administration**

**Center for Mental Health Services**

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#### **Substance Abuse and Mental Health Services Administration (SAMHSA)**

“The role of the 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.” (P.L. 106-310)

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. The authorization of SAMHSA expired at the end of FY 2003. This document addresses appropriations recommendations for the Center for Mental Health Services (CMHS) within SAMHSA. These recommendations are derived from consultations with state and local mental health services authorities, providers, researchers, and consumers.

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#### **Substance Abuse and Mental Health Services Administration (SAMHSA)**

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#### **Center for Mental Health Services (CMHS)**

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

Our nation's public mental health system is undergoing 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. 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 — state and local contributions to community-based services have increased significantly. 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 have left states scrambling to make up for lost federal resources. Finally, 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.

As a result of these trends, the federal investment in community-based care is growing in importance. For example, the nearly \$433 million in FY05 federal funds flowing through the Community Mental Health Services Performance Partnership 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 Performance Partnership Grant Program constitutes as much as 39.5 percent 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 mental 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.

**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.

**Homelessness** — The PATH program is the only federal program that provides mental health care and evaluate the implementation of innovative outreach services to homeless Americans, a third of whom have mental illnesses.

**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 (PRNS)** — As our knowledge of mental illness has steadily increased, Americans' access to care has paradoxically shrunk. Programs of Regional and National Significance are a catalyst for local communities to improve mental-health service delivery by implementing proven, evidenced-based practices for adults with serious mental illnesses and children with serious emotional disorders. These programs allow state and local mental health authorities to access information and "best practices." Without these programs, we expand the gulf of time it takes for research to be applied to the field which the Institutes of Medicine estimates to be 15 years.

These programs 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 the criminal justice system, state welfare agencies; increasing support for community-based services through the Mental Health Services Performance Partnership Block Grants; increasing support for programs to treat mental disorders in young people who are victims or witnesses of violence; helping to support new services for persons with co-occurring mental illnesses and addictions disorders; prevention of suicide particularly for children and adolescents, and preventing school violence.

**Terrorism** — Terrorism is a psychological assault that aims to destabilize society by spreading fear, panic, and chaos. The sustained threat of terrorism leads to significant mental health problems, including post-traumatic stress disorder, depression, suicide and substance abuse. Psychological defenses are integral to Homeland Security — enabling first responders, communities and individuals to cope effectively and maintain stability and productivity. Today, clinicians, public health providers and first responders lack many of the skills necessary to address immediate or long-term psychological needs.

Federal and state public health, mental health and substance abuse agencies rarely have the expertise, personnel or financial resources to respond adequately. Formal and informal community leaders are not prepared to actively stabilize their communities. In fact, people (including many first responders) may misunderstand the difference between psychological distress and mental illness, and may not seek or know how to access supportive services due to fear or stigma.

Current Homeland Security funding does not adequately address these concerns. Generally, the plans and resources have been focused broadly on public health agencies. However, our public health system does not encompass psychological and mental health problems in its epidemiological or service systems. For historical reasons, the existing public mental health system often operates in isolation from the health and public health systems. The Nation cannot afford to let this traditional split undermine our ability to respond to the terrorist threat.

Therefore the Mental Health Liaison Group strongly urges Congress to supplement existing federal Homeland Security funding for states to fully incorporate mental health into current plans and programs.

## Community Mental Health Services Performance Partnership Block Grant

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$434.7m	\$432.8m	\$432.8m	\$471.5m

### What is the Community Mental Health Services Performance Partnership Block Grant?

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

The Community Mental Health Services Performance Partnership 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 Performance Partnership 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 Community Mental Health Services Performance Partnership Block Grant Important?

Over the last three decades, the number of people in state psychiatric hospitals has declined significantly, from about 700,000 in the late 1960s to about 60,000 today. As a result, 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 Performance Partnership Block Grant is vital because 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.

The President's FY 2006 budget proposes to level-fund the block grant. Due to recalculations under the block grant formula for FY 2006, level-funding will result in funding reductions to 36 states.

The budget also proposes significant changes to funding in the \$21.8 million block grant set-aside. Specifically, it proposes to move the State Data Infrastructure Grant program into the set-aside. Doing so will displace approximately \$10 million in funding for state technical assistance programs.

### What Justifies Federal Spending for the Community Mental Health Services Performance Partnership 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, the federal government's financial support is limited. Medicaid provides optional coverage for some services under separate Medicaid options, but technical barriers exist to states that want to use Medicaid waivers

to provide these services. In addition, many essential elements of effective community-based care — such as housing, employment services, and peer support — are non-medical in nature and generally are not reimbursable under Medicaid. **Therefore, Performance Partnership Block Grant funding is the principal vehicle for federal financial support for evidence-based comprehensive community-based services for people with serious mental illnesses.**

The Mental Health Liaison Group has prioritized efforts to increase Performance Partnership Block Grant funding and to ensure that the Performance Partnership 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;
- have a history of interactions with the criminal justice system; including arrests for vagrancy and other misdemeanors; or
- are currently homeless.

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, legal involvement, behavior dangerous to themselves or others, running away, being homeless, or school failure.

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### Community-Based Services Work

*Rhonda recently spent about one month at a local hospital psychiatric unit due to decompensating. She presented with psychotic symptoms of paranoia, auditory hallucinations, agitation, depression, threatening and aggressive behavior and suicidal thoughts. She was evicted from her apartment and in debt due to several bounced checks and unpaid bills.*

*Rhonda refused to take oral medication due to thoughts that someone had tampered with them. The local hospital began injection of psychiatric medication and she began to make progress. She was more alert and no longer contemplated suicide or threatened staff. Therefore, Rhonda did not have to be transferred to Central State Hospital. After her discharge, case management services were increased to daily contacts for one month then changed to weekly face-to-face contacts for two months. The community psychiatrist increased the number of sessions to once every three weeks and continued her medications.*

*Rhonda now has a payee to assist with managing finances and is being assisted with housing in order to return to independent living. Without these additional community supports, she would have decompensated off her medications again and would surely have ended up at the State hospital with her recovery efforts set back.*

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## Comprehensive Community Mental Health Services for Children and Their Families Program

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$102.4m	\$105.2m	\$105.2m	\$114.7m

### Caring for Children with Behavioral or Emotional Needs and Their Families is Essential

An estimated 20%, or 13.7 million American children, have a diagnosable mental or emotional disorder. Between 5-9% have a serious emotional disturbance (SED), which means they have significant problems functioning at home, at school and in their community. Children with serious emotional disturbances (SED) and their families need appropriate and extensive interventions to adequately address their many challenges. **This program creates “systems-of-care” that focus on community based services that are coordinated and uniquely tailored for each child and family.**

Studies have shown that systems-of-care improve the functioning of children and youth with SED, and significantly reduce unnecessary and expensive hospitalizations. Community based services provided through these systems-of-care initiatives include: diagnostic and evaluation services; outpatient services provided in a clinic, school or office; emergency services; intensive home-based services; intensive day-treatment; respite care; therapeutic foster care; 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.

Prior to the development of a system-of-care-approach, these children were typically underserved or served inappropriately by fragmented service systems. In a 1990 survey, several states reported that thousands of children were placed in out-of-state mental health facilities, 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. In response to these findings, Federal leadership, along with a growing family movement promoted a new paradigm for serving children with SED and their families. Since first articulated by Stroul and Friedman in 1986, this system-of-care-approach has evolved into the principal organizing framework shaping the development and delivery of community-based children’s mental health services in the United States.

### What Does the Children’s Program Do?

Established in 1993, the Children’s Mental Health Services Program provides six-year cooperative agreements to public entities for developing comprehensive home and community-based mental health services for children with serious emotional disturbances (SED) and their families. The program assists states, political subdivisions of states, American Indian and Alaska Native tribes, territories, and the District of Columbia implement systems of care that are child-centered, family-driven, and culturally competent.

Hallmarks of this approach include the following:

- The mental health service system is driven by the **needs** and **preferences** of the child and family using a strengths-based, rather than deficit-based, perspective.
- Family involvement is **integrated** into all aspects of system and service policy development, planning, implementation, and evaluation.
- The locus and management of services are built upon multi-agency collaboration and grounded in a strong community base.
- A broad array of services and supports is provided in an **individualized**, flexible, coordinated manner, and emphasizes treatment in the least restrictive, most appropriate setting.
- The services offered, the agencies participating, and the programs generated are responsive to the **cultural** context and characteristics of the populations that are served.

The Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) has the primary responsibility managing this program.

### **Why Is The Children's Program Important?**

Although an estimated 13.7 million American children have a diagnosable mental or emotional disorder, and nearly half of these children have severe disorders, **only one-fifth of these youth receive appropriate services** (NIMH, 1994). In the past ten years, the Children's Mental Health Services Program has provided services to over 60,000 children and youth, who are diagnosed with serious mental and emotional disturbances, however much more needs to be done.

As stated in the Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda published in 2000, "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 developmental 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 outpatient therapy, medication, or hospitalization. Frequently there are long waits for these services because they are operating at capacity, making them inaccessible for new clients, even in crisis situations.

There is a tremendous need to address children's mental health in this country and this program has demonstrated successful outcomes.

### **Justifying the Costs**

Since 1993, CMHS has awarded a total of 96 awards in 48 States (including California, Kentucky, Pennsylvania and Ohio), which demonstrate the benefits of integrated, coordinated community-based services for children with serious emotional disturbance. The program has served children in 256 or 8% of the 3,142 counties in the U.S, representing a small proportion of the country being exposed to these highly successful systems-of-care services (President's 2005 Budget). Examples of the outcome data for all of the funded sites include the following:

1. 44 percent reduction in the number of children who were convicted of a crime.
2. 31 percent reduction in the number of children in a detention center or jail.
3. 25 percent reduction in the number of children attending school infrequently.
4. 20 percent or greater reduction in the level at which children's mental health or substance abuse problems are disruptive to their functioning at school, at home, or in the community. Children continued to improve to 2 years.
5. At intake, 58 percent of children had grade averages of C or above. By one year into the program, that percentage had risen to 71 percent.
6. 92.5 percent of children improved or remained stable in their program behaviors and emotions after six months.

**The national evaluation data provide evidence that children and youth enrolled in systems-of-care experience noticeable improvements on both emotional and behavioral measures.**

The President's New Freedom Commission on Mental Health reported that the Children's Mental Health Services Program is a model approach in the delivery of mental health services and concluded that "the services provided to children not only produce better clinical results, reduce delinquency, and result in fewer hospitalizations, but are cost-effective." Indeed, the program scored well in a review by OMB using their Program Assessment Rating Tool (PART), one of the SAMHSA programs selected for evaluation.

**Many communities and states have experienced positive changes in outcomes based on the successful work of the grantee communities. For instance:**

- In the North Carolina FACES system-of-care communities of Blue Ridge, Cleveland, Guilford and Sandhills, there was a significant reduction in behavioral and emotional problems for children.
- A larger percentage of children enrolled into Nebraska's Region III system-of-care services (funded by SAMHSA's Children's Program) demonstrated clinical improvement in their overall

internalizing and externalizing problems from intake to 12 months when compared to children enrolled in Region IV services (not funded by SAMHSA's Children's Program).

- Decreases in per child costs over time were apparent in the four FACES system-of-care communities in North Carolina.
- Caregivers in the system of care of Birmingham, Alabama (funded by SAMHSA's Children's Program) were much more likely to report that family goals and family strengths had been discussed and used to tailor the treatment plan, than were caregivers in Montgomery, Alabama (not funded by SAMHSA's Children's Program).

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### Child and Family Profile

*The following is a true story that provides a typical example of how mental health challenges impact families, and place children at risk, particularly when services are unavailable and uncoordinated.*

*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, Seth 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 and 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 support person to help him stay on task. These intensive interventions 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 enters adolescence, the family's major goals - to stay together at home and to keep Seth at school - have been realized. The system-of-care services were not only successful, they avoided the emotional and financial cost of having to place Seth in a hospital or institution.*

Stroul, B. A. & Friedman, R. M. (1986 rev.) A system of care for children and youth with severe emotional disturbances. Washington, DC: National Technical Assistance Center for Children's Mental Health

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## Projects for Assistance in Transition from Homelessness (PATH) and Samaritan Initiative to End Chronic Homlessness

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECCOMENDATION FY 2006
<b>\$49.8m</b>	<b>\$54.8m</b>	<b>\$54.8m</b>	<b>\$59.8m</b>

### What Does PATH Do?

The Projects for Assistance in Transition from Homelessness (PATH) formula grant program provides funding to states, localities and non-profits to support individuals who are homeless (or are at risk of homelessness) and have a serious mental illness and/or a co-occurring substance abuse disorder. PATH is designed to encourage the development of local solutions to the problem of homelessness and mental illness through strategies such as aggressive community outreach, case management and housing assistance. Other important core services include referral for primary care, job training and education. PATH requires states and localities to leverage funds through \$1 match for every \$3 in federal funds. Nearly 500 local and county agencies currently use federal PATH funds. Surveys indicate that PATH-funded agencies reached individuals with the most disabling mental illness with a wide range of racial and ethnic diversity. The most common diagnoses were schizophrenia and psychotic disorders and affective disorders. More than half of homeless consumers at first contact had been homeless for more than 30 days.

### Why is PATH Important?

Federal PATH funds, when combined with state and local matching funds are the only resources available in many communities to support the range of services needed to effectively reach and engage individuals with severe mental illness and co-occurring substance abuse disorders. This includes street outreach, engagement in treatment services and transition of consumers to mainstream mental illness treatment, transition and permanent housing and support services. PATH is also a key component in the Bush Administration's interagency strategy to end chronic homelessness over the next decade – the "Samaritan Initiative."

### What Justifies Federal Spending for PATH?

For FY 2006, the President is requesting \$55 million for the PATH program, a freeze at current levels. Services funded by the PATH program provide a critical bridge for individuals with severe mental illness who are experiencing chronic homelessness. An increase for

PATH for FY 2006 would afford Congress the opportunity to adjust the inequitable interstate funding formula that has left 20 rural and frontier states at the \$300,000 minimum allocation since the program's inception. Despite steady increases for PATH funding (funding has more than doubled since FY 1998), these minimum allocation states are still receiving the same amount they did in FY 1993. Legislation increasing the minimum state allocation level (S 319) – without adversely impacting large states – was introduced on February 8 by Senators Pete Domenici (R-NM) and Edward M. Kennedy (D-MA).

## SAMARITAN INITIATIVE

### What will the Samaritan Initiative Do?

The President's FY 2006 budget proposes to expand the Samaritan Initiative to help end chronic homelessness. Specifically, the Administration is requesting an increase of \$200 million for homeless assistance under the McKinney-Vento Homeless Assistance Act. This includes a substantial increase for the Samaritan Initiative to develop permanent housing and provide case management for individuals with disabilities (including mental illness and co-occurring substance abuse) exiting long-term homelessness. Unfortunately, the President's budget proposes to end a successful \$3.4 million chronic homeless demonstration at SAMHSA that had been coordinated with HUD's efforts on the Samaritan Initiative.

### What Justifies Federal Spending for this Program?

This focus on ending chronic homelessness is critically important to addressing the enormous economic and social costs associated with individuals who stay homeless for long periods and impose enormous financial burdens on communities as they cycle through hospital emergency rooms, jails, shelters and the streets. Through Samaritan Initiative the Administration hopes to make resources available to states and localities to fund the some of the services needed by people experiencing chronic homelessness - including permanent housing and case management. Separate legislation designed to complement

the Samaritan Initiative is being planned for the 109th Congress. This bill, known as the Services for Ending Long-Term Homelessness Act (SELHA), authorizes funding for services in permanent supportive housing, such as outreach, mental illness abuse treatment, and primary care.. The bill (HR 4866/S 2937 in the 108th Congress) provides a critical link in the effort to reaching the goal of ending chronic homelessness.

## Protection and Advocacy for Individuals with Mental Illness (PAIMI)

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$34.6m	\$34.3m	\$34.3m	\$37.4m

### What Does PAIMI Do?

The Protection and Advocacy System for Individuals with Mental Illness (PAIMI) provides advocacy services, including legal services for persons with a significant mental illness or emotional impairment who are inpatients or residents of a facility rendering care or treatment, as well as people with serious mental illness who reside in the community. 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 2003, PAIMI programs nationwide addressed 20,3000 abuse, neglect, and rights violation complaints. PAIMI staff also provided information and referral services to approximately 44,656 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?

In the past few years, the PAIMI program has been substantially expanded and the eligible population dramatically increased. For example, it is estimated that

1 in 5 adults in the United States will receive treatment for a mental health condition at some point in their lives. At the same time that it expanded PAIMI's coverage to all individuals with significant mental illness, Congress also asked PAIMI programs to continue to prioritize the original PAIMI-eligible facility-based population in before serving people in the community. Congress also included language giving PAIMI the authority to investigate incidents of death and serious injury from the inappropriate use of restraint and seclusion techniques in both institutional and community settings. The Children's Health Act of 2000 added even more responsibilities to the PAIMI program, including the specific authority to monitor all public and private residential care and treatment facilities for children and youth to ensure they are not at risk for inappropriate use of seclusion and restraint, and to investigate all incidents involving serious injuries and deaths related to seclusion and restraint abuse at those facilities. PAIMI advocates are also playing an increasingly critical role in correctional facilities such as jails and prisons, where many individuals with mental illness are incarcerated. PAIMI advocates work to ensure that needed mental health treatment services and medications are provided, and that inmates are protected from physical and sexual abuse by corrections staff and other inmates.

Finally, the Senate Labor-Health and Human Services-Education (L-HHS-ED) Appropriations Subcommittee included language in its FY 2003 and 2004 Senate LHHS Committee report that State P&A systems have a significant role in addressing the community integration needs of individuals identified in the Supreme Court *Olmstead* decision.

All the directives provided by Congress to PAIMI are welcomed because they reflect the growing awareness of the need for reliable advocacy services to persons with mental illness in a variety of settings, and as a sign of congressional trust in our system. However, in order to accomplish all the directives, additional funding is essential.

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### PAIMI Success Story

*Jay was involuntarily committed to a hospital several counties away from his home. Days later, the hospital discharged him by simply walking him across the street. No follow-up services were arranged and he was not even given access to the medication that had assisted him in the hospital. Jay attempted suicide outside the hospital and was promptly readmitted. With assistance from the California P&A, Jay was given the support of a case manager who arranged for community mental health services near his home, help with medication management, identification of appropriate housing in his home county and transportation to his new home.*

*The California P&A continues to train hospital personnel and people with disabilities across the state about laws requiring this type of comprehensive discharge planning. California, West Virginia, and Alaska are among several P&As that have worked with hospitals to develop a standardized assessment form to be completed on every individual being discharged.*

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## Programs of Regional and National Significance (PRNS)

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECCOMENDATION FY 2006
<b>\$240.9m</b>	<b>\$274.3m</b>	<b>\$210.2m</b>	<b>\$299.1m</b>

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 SAMHSA budget proposal would cut funding for the Programs of Regional and National Significance (PRNS) by roughly \$64 million or nearly 25 percent. The proposed PRNS budget would cut funding for the Youth Violence Prevention program by almost a third or \$27 million, and eliminates the State Data Infrastructure program.

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 21-40, we describe the salient importance of the following PRNS programs:

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## Youth Violence Prevention Initiatives

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$94.4m	\$94.2m	\$66.8m	\$102.7m

### What are the Youth Violence Prevention Initiatives?

Safe School/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 youth violence prevention and intervention funds to a program entitled the **Safe Schools/Healthy Students (SS/HS)** Initiative. This unique collaboration recognizes that violence among young people can have many causes, including roots in early childhood, family life, mental health issues, and substance abuse. No single activity can be counted on to prevent violence. Thus, SS/HS takes a broad approach, drawing on the best practices and the latest thinking in education, justice, social services, and mental health to help communities take action.

Through grants made to local education agencies, the SS/HS Initiative provides schools and communities in urban, suburban, rural, and tribal areas across the United States with the funds and resources to build or enhance the infrastructure to strengthen healthy child development, thus reducing violence behavior and substance use. These three-year grants to local school districts 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 SS/HS 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). With financial and technical support from the three Federal partners, 190 communities are creatively linking new and current services to reflect their own specific needs, all with a vision to prevent violence among youth. While grantees work to correct problems as they arise, they also strive to prevent violence before it starts. Science-based approaches are being used to achieve aims such as promoting students' cooperation with their peers, setting standards of behavior, developing healthy student/family relationships, increasing parental involvement in

schools, building emotional resiliency and strengthening communication and problem solving skills.

As CMHS' major school violence prevention program, the initiative was started in 1999. Between FY 1999 and FY 2004, this program has funded a total of 190 communities and approximately 5.6 million students. In FY 2005 we anticipate funding approximately 35 new sites.

### Why are Youth Violence Prevention Initiatives Important?

Each year fundable applications exceed the availability of funds. With additional funds in FY 2006, CMHS could reach more communities with this comprehensive program designed to foster the healthy development of children and prevent youth violence.

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:

Grantees focus on 6 core areas. Statutory restrictions limit how funding from each federal partner can be applied to these elements:

- Safe school environment. (This element may only be funded by the Department of Education and the Department of Justice);
- Alcohol and other drugs and violence prevention and early intervention programs. (This element may only be funded by the Department of Education and SAMHSA);
- School and community mental health preventive and treatment intervention services. (This element may only be funded by SAMHSA);



- Early childhood psychosocial and emotional development programs. (This element may only be funded by SAMHSA);
- Supporting and connecting schools and communities. (This element may only be funded by the Department of Education); and
- Safe school policies. (This element may only be funded by the Department of Education and Department of Justice).

A National Cross-Site Evaluation is underway, which will include case study reports and documentation of improvement in school safety using key indicators such as school climate, perceptions of safety, and incidents of violent and disruptive behavior. Additionally, local grantee evaluation reports are being reviewed and results summarized for further dissemination.

Technical Assistance is provided to all SS/HS grantees in order to help them attain their goals of interagency collaboration and adoption of evidence-based on practices to reduce school violence and substance abuse and promote the healthy development and resiliency of children and youth.

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.

### **Why Is Additional Federal Funding Justified?**

Despite the perception of a deepening crisis, epidemiological data indicates that juvenile violent crimes, as measured by arrests, has actually declined significantly since the early to mid 1990's. However student reports paint a different picture. For example, the U.S. Surgeon General's Report on Youth Violence notes that violent acts among high school seniors increased nearly 50 percent over the past two decades. Youth violence remains one of the nation's leading public health problems. Students, teachers, parents, and other caregivers experience daily anxiety due to threats, bullying, and assaults in their schools. To help prevent youth violence, Congress, since FY 1999, has provided appropriations to CMHS for youth violence prevention initiatives.

## Mental Health Transformation State Incentive Grant Program

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
n/a	\$19.8m	\$26.0m	\$26.0m

### What is the State Incentive Grants for Transformation Program?

The Mental Health Transformation State Incentive Grant program was proposed in President Bush's FY 2005 budget request. Federal funding for State Incentive Grants will enable governors' offices to create comprehensive mental health plans that will enhance the use of existing resources to serve persons with mental illnesses. SAMHSA will award 8 Transformation State Incentive Grants in FY 2005 and 3 new grants in FY 2006, for a total of 11. New grantees will engage in State planning and coordination activities, with involvement from agencies, such as criminal justice, housing, child welfare, labor and education. In the second year of funding, States will be able to use 85 percent of funds to support programs at the community level as proposed in their State Plan. The remaining 15 percent will continue to support planning activities.

### Why are the State Incentive Grants Important?

Tasked by President Bush to "conduct a comprehensive study of the United States mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system," the New Freedom Commission on Mental Health called for a "fundamental transformation" of the mental health system in America and observed that programs that serve persons with mental illnesses are fragmented across many levels of government and among many agencies. Consequently, the Commission recommends that states develop comprehensive mental health plans outlining responsibility for coordinating and integrating services provided for persons with mental illnesses.

The State Incentive Grants will give states the resources to develop such plans, and will enable them to create new partnerships among the federal, state, and local governments to expand the option and array of available services and supports that mental health consumers and families need, such as: housing, vocational rehabilitation and education services.

The success of the State Incentive Grant program will be measured in terms of the implementation of evidence-based practices, particularly those implemented statewide; better use of technology in the keeping of health records and the dissemination of mental health information and services; increased flexibility for the funding of services; increased accountability by states for helping consumers to achieve positive outcomes; and a reduction in gender, ethnic and geographic disparities. These measures of success are consistent with the values set out in the final report of the President's New Freedom Commission on Mental Health.

### What Justifies Federal Spending for the Transformation State Incentive Grants?

Federal funding for the State Incentive Grants will enable states to develop more comprehensive state mental health plans. These plans will facilitate the coordination of federal, state and local resources to support effective and dynamic state infrastructure to best serve persons with mental illnesses.

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

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$29.8m	\$29.8m	\$29.8m	\$32.5m

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

The Surgeon General's landmark 1999 "Report on Mental Health" explored the roots of mental disorders in childhood, and documented the well-established relationship between childhood exposure to traumatic events and risk for child mental disorders. This report stated that in any given year, about 20% of children have a mental disorder requiring the attention of a mental health professional. In 2002, SAMHSA's National Survey on Drug Use and Health reported that an estimated 5-9% of children and youth have a serious emotional disturbance in any one year. And yet, a 1995 RAND study notes that only 8% of children who need mental health care actually receive services – this leaves 92% of our children who need care without any services. A good portion of them are children and adolescents exposed to trauma or community violence.

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, adolescents exposed to violence are more likely to engage in violent acts themselves. Children are exposed to many kinds of trauma and violence, including physical and sexual abuse, accidental or violent deaths of loved ones, domestic and community violence, natural disasters and terrorism, and severe accidents or life-threatening illnesses. Any of these exposures can have severe and long-term effects. A 2002 GAO Report (GAO-02-813) on child trauma documented that large numbers of children experience trauma-related mental health problems, while at the same time facing barriers to receiving appropriate mental health care. For example, a 2003 report in the Journal of the American Medical Association reported that of the 4,000 children in the Los Angeles Unified School District included in this study, 90% of students in some neighborhoods had been exposed to multiple incidents of violence, as witnesses and victims, and that 27% of them had clinical levels of PTSD and 16% of them had clinical levels of depression.

### 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 community service programs to provide services to children and families who are victims or witnesses of violence. The grants also foster the development of evidence-based practices and research on the treatment and prevention of trauma-related mental disorders through treatment development centers.

### 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 in children's physical health and cognitive development, its record of support for healthy mental development has fallen far short.

With the alarming rise in the numbers of children and adolescents 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 long-term developmental problems that can lead to mental and emotional disorders, including debilitating illnesses such as post-traumatic stress disorder and depression. But despite widespread exposure to trauma and violence and serious consequences for children and youth, we have failed to provide the resources necessary to strengthen research and services for these children. Expanding funding of this program would support and strengthen a broad network of centers of excellence on children, trauma, and violence and would yield improved evaluation tools and evidence-based treatment methods for vulnerable children exposed to violence. This program will support the development of techniques to prevent the onset of mental health problems among children and youth who have experienced such trauma.

In FY02, an additional \$20 million was provided to this program; of this, \$10 million came from the Emergency Supplemental Appropriation (PL 107-38) in the wake of the September 11th tragedies. In FY04, with funding at \$30 million, the innovative National Child Traumatic Stress Initiative has established 54 treatment development and community service centers that work together through a national network to treat children who have experienced trauma. Recent yearly estimates indicate that more than 50,000 individuals -- children, adolescents and their families -- will directly benefit from services through this network, and over 60,000 professionals will be trained in trauma-informed interventions. Many thousands more will benefit from the improvements in treatment, the proliferation of educational opportunities, the development of community and national collaborative partnerships, the ongoing internal and national program evaluations, and the widespread dissemination of public awareness programs and materials that will be made available through the Initiative's resource center. But many hundreds of thousands of children are still in need and will benefit from the strengthening and expansion of this program.

The 2003 JAMA study noted above reported that with the application of evidence-based treatments, children affected by trauma and violence can recover. After 10 sessions of a cognitive-based therapy, the majority of children in this Los Angeles study significantly decreased their symptoms of PTSD and depression. Students who received the intervention experienced a significant increase in grade point average compared not only to students who had not yet received the intervention, but also in comparison to students who had not been diagnosed with either disorders. Children who experience trauma or violence, but who also receive appropriate support through their families, communities, and trained treatment providers can access their own resilience and strength to recover and maintain a healthy developmental course.

## Suicide Prevention for Children and Adolescents

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
n/a	\$16.5m	\$16.5m	\$18.0m

### What will the Suicide Prevention Program Do?

Congress authorized a program for Youth Suicide Early Intervention and Prevention Strategies, the Garrett Lee Smith Memorial Act (P.L. 108-355), to: a) support the planning, implementation, and evaluation of organized activities involving statewide youth suicide intervention and prevention strategies, b) authorize grants to institutions of higher education to reduce student mental and behavioral health problems, and c) authorize funding for the national suicide prevention resource center. The program will provide early intervention and assessment services, including screening programs, to youth who are at risk for mental or emotional disorders that may lead to a suicide attempt, and that are integrated with school systems, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems, and other child and youth support organizations.

### What Justifies Federal Funding for these Programs?

In 2002, official data reported that 31,655 individuals died by suicide in the U.S. and that more than 4,000 of these deaths were young people between the ages of 10-24. The Youth Risk Behavior Surveillance report, a survey of students across the nation which is administered by the Centers for Disease Control and Prevention (CDC), highlighted in 2003 that 8.5% of youth attempt suicide, 16.9% seriously consider attempting suicide, and 2.9% make an a suicide attempt that requires treatment by a doctor or nurse.

Repeatedly over the last several years, the Federal Government has identified suicide as a serious and preventable public health problem. During the 105th Congress, both chambers unanimously passed resolutions recognizing suicide as a national problem and declaring suicide prevention to be a national priority (House Resolution 212 & Senate Resolution 84). Since that time, several of authoritative reports have provided comprehensive information about the problem of suicide and set forth recommendations for effective prevention.

In 1999, the Surgeon General issued a *Call to Action to Prevent Suicide*, followed in 2001 by the National Strategy for Suicide Prevention: Goals and Objectives for Action (NSSP). The NSSP was developed by a broad public/private partnership and founded on research conducted over four decades. It lays out 11 goals and 68 objectives as a blueprint for coordinating the efforts and resources of government and the private sector to reduce deaths by suicide.

In 2002, the Institute of Medicine released *Reducing Suicide: A National Imperative*, which provides an authoritative examination of the available data and knowledge about suicide prevention. The IOM report strongly endorsed the Surgeon General's designation of suicide prevention as a national priority and recommended that "programs for suicide prevention be developed, tested, expanded, and implemented through funding from appropriate agencies including NIMH, DVA, CDC, and SAMHSA."

According to the final report of President Bush's New Freedom Commission on Mental Health (2003), "our Nation's failure to prioritize mental health is a national tragedy...No loss is more devastating than suicide. Over 30,000 lives are lost annually to this largely preventable public health problem...Many have not had the care in the months before their death that would help them to affirm life. The families left behind live with shame and guilt..."

Suicide is the third leading cause of death among children aged 10-14 and among adolescents and young adults aged 15-24. The NSSP sets numerous objectives aimed at preventing suicide among children and adolescents. These include increasing evidence-based suicide prevention programs in schools, colleges, universities, youth programs, and juvenile justice facilities; promoting training to identify and respond to children and adolescents at risk for suicide; and establishing guidelines for screening and referral (Objectives 4.2, 6.5, 8.3-8.6). Continued funding for the Garrett Lee Smith Memorial Act (P.L. 108-355), as authorized by Congress, will provide essential support for States and communities seeking to implement the NSSP's objectives.

**Relationship to Other  
Suicide Prevention Initiatives**

CMHS is the lead agency within SAMHSA for the NSSP. Congress has earmarked CMHS funds for two specific suicide prevention programs. One project, which promotes a national hotline response network, certifies networks and evaluates suicide prevention hotlines. This initiative is important to the NSSP, as it responds to Objective 10.4, which calls for performing scientific evaluation studies of new or existing suicide prevention interventions. The second is the national suicide prevention technical resource center, a specific recommendation of the NSSP set forth in Objective 4.8, which received authorization in P.L. 108-355.

These programs have helped put in place the essential building blocks to guide activities at the state and local level that will help reduce the tragic toll of suicide, particularly among our young people. The immediate need is for resources that will enable States and communities to provide the services that can save lives. Additionally, a public/private partnership, called for in Objective 2.2 of the NSSP to advance and coordinate its implementation, should be developed by the Administration, through SAMHSA. Such a partnership would do much to address objective 1.1 of the President's New Freedom Commission on Mental Health which specifically recommends the advancement and implementation of "a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention."

## Jail Diversion Program Grants

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$7.0m	\$6.94m	\$3.91m	\$7.54m

### Why are Jail Diversion Program Grants Important?

Each year, 11.4 million people are booked into U.S. jails (Stephan, 2001). An estimated seven percent of jail inmates have current symptoms of serious mental illness (Teplin, 1990; Teplin, Abram, and McClelland, 1996). Of these 800,000 people approximately three quarters have co-occurring substance use disorders (Abram and Teplin, 1991; Abram, Teplin, and McClelland, 2001). Women, who represent 11 percent of all jail inmates, have nearly twice the rate of serious mental illness as men (12% vs. 6.4%) (GAINS Center, 2002). Another study, by the U.S. Department of Justice, reported that 16 percent of the population in prison or jail has a mental illness. Across the country, communities are struggling with the alarming increase of people with mental illness in jails and prisons (Consensus Project, 2004):

- The Los Angeles County Jail, the Cook County (Chicago) Jail, and Riker's Island (New York City) each hold more people with mental illness on any given day than any psychiatric facility in the United States;
- Male pretrial detainees charged with misdemeanors and identified as psychotic in the Fairfax County, VA Jail stayed in jail 6.5 times as long as average jail inmates; and
- Inmates with mental illness in Pennsylvania in 2000 were twice as likely as other inmates to serve their maximum sentence; those with a serious mental illness were three times as likely to "max out."

### What are Jail Diversion Program Grants?

Mental health providers, criminal justice professionals, and judges believe that nearly all these arrests and incarcerations are unnecessary and could be avoided if more community mental health services were available. The President's New Freedom Commission recently recommended "widely adopting adult criminal justice and juvenile justice diversion...strategies to avoid the unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illnesses." (New Freedom Commission on Mental Health, 2003). Jail diversion programs provide an alternative to incarceration by diverting individuals with serious mental

illness and co-occurring substance use disorders from jail to community-based treatment and support services. Currently, the Substance Abuse and Mental Health Services Administration (SAMHSA)-funded Technical Assistance and Policy Analysis Center for Jail Diversion (TAPA) lists over 300 operating jail diversion programs nationally (TAPA Center, 2004). These programs include a variety of pre-booking programs, which divert individuals at initial contact with law enforcement officers before formal charges are brought, and post-booking programs, which identify individuals in jail or in court for diversion at some point after arrest and booking. Jail diversion programs link individuals to community-based mental health and substance abuse services, housing, medical care, income supports, employment and other necessary services.

### What Justifies Federal Spending on this Program?

The SAMHSA-funded Knowledge Development and Application (KDA) study found that (TAPA Center, 2004):

- Jail Diversion "works" in terms of reducing time spent in jail, as evidenced by diverted participants spending an average of two months more in the community;
- Jail diversion does not increase public safety risk; and
- Jail diversion programs successfully link divertees to community-based services.

Taken together with the findings from previous studies on jail diversion, these findings provide evidence that jail diversion results in positive outcomes for individuals, systems, and communities. Substantial new knowledge about the effectiveness of jail diversion will soon result from the ongoing multisite evaluation of 20 SAMHSA-funded jail diversion programs being coordinated by the TAPA Center. These Targeted Capacity Expansion Jail Diversion Program grants, awarded by CMHS in 2002, 2003 and 2004, are currently allowing communities across the country to identify for diversion and link individuals to the evidence-based services and supports they need. The Jail Diversion Program should continue based not only on its efficacy, but also because, for people inappropriately warehoused in jails, appropriate and effective community-based treatment is needed now.



## State Data Infrastructure

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$10.9m	\$10.9m	\$0m	\$11.9m

### What is the Data Infrastructure Development Program?

The Data Infrastructure Development Program was established in the Children's Health Act of 2000 (P.L. 106-310) as part of SAMHSA reauthorization. The legislation authorizes grants to states to develop and operate mental health and substance abuse data collection, analysis, and reporting systems for performance measures. With these funds, states develop information systems needed to collect and analyze data related to mental health programs and outcomes.

In FY 2004, the Senate specifically directed SAMHSA to improve its assistance to states strengthening and expanding their data infrastructure (S.Report 108-81). Calling data "an essential part of need identification and service delivery." The MHLG wholehearted supports additional federal funding to assist states in this endeavor.

### 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. Mental health performance measures provide states with the tools needed to more effectively award and monitor contracts with managed care and other providers, ensure quality while containing costs, improve accountability and allocate resources most efficiently.

### What Justifies Federal Spending for the Data Infrastructure Development Program?

Congress has recognized the importance of tying federal funding to performance and, therefore, directed SAMHSA to convert the Community Mental Health Services Block Grant into a "performance partnership." To succeed, state mental health systems will need to develop the capacity to report data that are reliable and uniform across states. Reporting performance measures in this manner will help the states and the federal government achieve the shared goals of quality improvement, expanding access to community-based mental health services, and increased accountability.

Many states lack the capacity to adequately collect and analyze the data HHS would require under a performance partnership effective. To the extent the federal government requires enhanced data reporting of the new performance partnership relationship, it is appropriate for the federal government to contribute funds to help the states meet this burden. So doing will facilitate the success and effectiveness of the performance partnership goals of the Block Grant without diverting scarce resources from service delivery.

## Mental Health Outreach and Treatment to the Elderly

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$5.0m	\$4.96m	\$4.96m	\$5.41m

### What is the Program

Within the total provided in last year's Labor, Health and Human Services Appropriations bill (P.L. 108-447), \$4,960,000 was allocated for evidence-based mental health outreach and treatment to the elderly. By the year 2010, there will be approximately 40 million people in the U.S. over the age of 65 and more than 20 percent of them will experience mental disorders.

This program provides for implementation of evidence-based practices to reach older adults who require assistance for mental disorders, only a small percentage of whom currently receive needed treatment and services. This program is a necessary step to begin to address the discrepancy between the growing numbers of older Americans who require mental health services and the lack of evidence-based treatment available to them.

### Why is it Important to Reach Out and Treat the Elderly?

1. Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes. In particular, dementia, depression, and schizophrenia, among other conditions, will all present special problems in this age group:

- Dementia produces significant dependency and is a leading contributor to the need for costly longterm care in the last years of life;
- Depression contributes to the high rates of suicide among males in this population; and
- Schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.

2. Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for mental disorders enjoyed by younger adults, when these interventions are modified for age and health status.

3. Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults. Opportunities are missed to improve mental health and general medical outcomes when mental illness is under recognized and under treated in primary care settings.

4. Treating older adults with mental disorders accrues other benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider's directions and advice, particularly about taking medications.

5. Stressful life events, such as declining health and/or the loss of mates, family members, or friends often increase with age. However, persistent bereavement or serious depression is not "normal" and should be treated.

6. Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to the society, in spite of physiologic changes due to aging and increasing health problems.

7. Continued intellectual, social, and physical activity throughout the life cycle are important for the maintenance of mental health in late life.

8. Normal aging is not characterized by mental or cognitive disorders. Mental or substance use disorders that present alone or co-occur should be recognized and treated as illnesses.

9. There are effective interventions for most mental disorders experienced by older persons (for example, depression and anxiety), and many mental health problems, such as bereavement.

10. Barriers to access exist in the organization and financing of services for aging citizens. There are specific problems with Medicare, Medicaid, nursing homes, and managed care.

**What Justifies Federal Spending on this Initiative?**

As the life expectancy of Americans continues to extend, the sheer number-although not necessarily the proportion-of persons experiencing mental disorders of late life will expand confronting our society with unprecedented challenges in organizing, financing, and delivering effective mental health services for this population. An essential part of the needed societal response will include recognizing and devising innovative ways of supporting the increasingly more prominent role that families are assuming in caring for older, mentally impaired and mentally ill family members.

The greatest challenge for the future of mental health care for older Americans is to bridge the gap between scientific knowledge and clinical practice in the community, and to translate research into patient care. Adequate funding for this geriatric mental health service initiative is essential to disseminate and implement evidence-based practices in routine clinical settings across the country.

## Statewide Family Network Grants

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$3.3m	\$3.3m	\$3.3m	\$3.6m

### What Do the Statewide Family Networks Do?

The purpose of the Statewide Family Networks program is to enhance State capacity and infrastructure to be more oriented to the needs of children and adolescents with serious emotional disturbances and their families. Recognizing that family members are the best and most effective change agents, the program is designed to ensure that families are the catalysts for transforming the mental health and related systems in their State. The grantees accomplish this by strengthening coalitions with policymakers, program administrators, and service providers; promoting leadership and management skills development for boards and staff of the grantees; and providing technical assistance to improve the quality of life for children with mental health needs and their families. Several of the grantees in the Statewide Family Network Program specifically focus on the needs of ethnic minorities and rural families' issues. Examples of Statewide Family Network activities are:

- Developing and conducting peer support groups;
- Disseminating information and technical assistance through clearinghouses, websites, newsletters, sponsoring conferences and conducting workshops;
- Providing outreach to families through toll-free telephone numbers and through information and referral networks;
- Serving as a liaison with various human service agencies and educating states and communities about effective ways to improve children's services; and
- Training on advocacy for children's services and developing skills in organizational management and financial independence.

### Why Are Statewide Family Network Grants Important?

Families raising children with emotional, behavioral, or mental disorders need emotional support, accurate information about mental health services, and help protecting the rights of their children. Research on systems of care has indicated that strengthening families enhances resilience in children<sup>1</sup>.

The Goal 2 of the final report of the President's New

Freedom Commission on Mental Health envisions a transformed mental health system that is "consumer and family driven<sup>2</sup>" and states that, "Local, State, and Federal authorities must encourage consumers and families to participate in planning and evaluating treatment and support services.<sup>3</sup>" The Surgeon General<sup>4</sup> recognized that families have become essential partners in the delivery of mental health services to children and adolescents. Family-run organizations linked to a national network are the means by which families can fulfill this important role.

Growing evidence suggest that engagement of trained and empowered family members is an essential ingredient of systems of care and can result in increased family satisfaction and better outcomes for children<sup>5</sup>. 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.

### Evidence Of Effectiveness

A study of the impact of the Statewide Family Network Grants<sup>6</sup> groups the benefits received into three categories:

1. Information on legal rights, specific disorders, and resources;
2. Emotional support consisting of parent-to-parent sharing, understanding and friendship, staff as advocates to support families, and training for advocacy at a higher policy level; and
3. Practical services including workshops, financial support and respite care.

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 because of the help and support that they received through the statewide family networks.

The Statewide Family Networks Government and Performance and Results Act Report (GPRA) shows that forty Statewide Family Network grantees reported providing at least one services to 194,988 family members and youth in 2002-2003. In the same period, over 2000 family members reported holding a seat on a mental health policy board or commission in their community or state.

## **Accomplishments of Statewide Family Network Grants**

Statewide Family Networks have contributed to the overall improvement of state and community children's mental health policies and services in many ways. Some examples are:

- Keys for Networking in Kansas worked cooperatively with the state mental health authority and the state legislature to develop a home- and community-based waiver that allows families to be authorized service providers in Kansas.
- The Georgia Parent Support Network contracts with the state to operate a network of specialized foster homes. They also facilitate a team planning process to safely and successfully maintain juvenile sex offenders in the community.
- A study by the Maryland Coalition of Families for Children's Mental Health stimulated the Governor to appoint a commission which made policy recommendations to eliminate the practice requiring families to relinquish custody of their child in order to get mental health services.
- Mississippi Families As Allies, in collaboration with the business community and state legislators, developed policy support for community based services delivery for children and adolescents with serious emotional disturbance.
- The executive director of Families Together in New York State chairs the state's Coordinated Children's Services Initiative, a top level governing entity that establishes policies, practices, and funding for this multiple state agency initiative. Families Together hires and supervises the statewide Coordinated Children Services Initiative director and trains families to serve on local county councils.

## Grants to Provide Integrated Treatment for Co-occurring Serious Mental Illnesses and Substance Abuse Disorders

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$9.2m	\$14.2m	\$12.2m	\$13.3m

### 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 that clearly demonstrates that mental and addictions disorders are often inter-related and that integrated treatment is more effective than parallel and sequential treatment to treat co-occurring disorders. 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, program 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., 1993a; 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.

In 2000, 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. Unfortunately, the Children's Health Act of 2000 specifically bars states from blending dollars from the Mental Health and Substance Abuse Block Grants to fund integrated treatment programs. It is therefore critically important that Congress direct funding toward integrated treatment to make up for funding that the states cannot provide through their SAMHSA block grant programs.

The Center for Mental Health Services (CMHS) held two conferences in 2004 to disseminate new treatment techniques which have proved efficacious in treating co-occurring disorders.

## Consumer and Consumer/ Supporter Technical Assistance Centers

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$2.0m	\$1.98m	\$1.98m	\$2.16m

### What are the Consumer And Consumer/ Supporter Technical Assistance Centers?

Consumer and consumer-supporter National Technical Assistance Center grants provide technical assistance to consumers, families, and supporters of consumers with the aim of helping people with severe mental illnesses decrease their dependence on social services and avoid psychiatric hospitalization. This technical assistance is directed both to individuals and to community-based organizations run by people recovering from psychiatric disabilities and/or their supporters:

- Individuals are taught skills to help them use community resources, recover from the disabling effects of mental illness, and enhance self-determination; and
- Organizations receive assistance that enhances their capacity to meet operational and programmatic needs. Program support focuses on enhancing peer-support approaches, recovery models, and employment programs.

### Why are Consumer and Consumer/Supporter Technical Assistance Centers important?

The importance of supporting and promoting consumer-run mental health services was recognized by the President's New Freedom Commission Report and the Surgeon General's 1999 report, *Mental Health: A Report of the Surgeon General*. The 2003 report of the President's Commission declared recovery from mental illnesses the goal of the nation's mental health system, and it pointed to evidence of the important role played by consumer-run organizations in achieving this goal. In addition, the Surgeon General's report found that consumers in the role of peer-specialists provide services that improve patient outcomes.

Furthermore, a recently published report by CMHS, entitled *Consumer/Survivor- Operated Self-Help Programs*, noted that consumer/survivor-operated programs have provided such benefits as coping strategies, role modeling, peer-support, and education in a non-stigmatizing setting. In assessing the experience of consumer service programs, the CMHS report found that consumer-run program sites had technical assistance needs:

- more training and technical assistance would contribute to increased successes; and
- respondents felt that coordinated, comprehensive approaches to meeting technical assistance needs would be beneficial.

### What Justifies Federal Spending on this Program?

A CMHS-funded evaluation in 2001 found that the centers serve an impressive number of consumers, consumer-supporters, and organizations, and it found that these recipients of technical assistance have high levels of satisfaction with the quality of services provided. According to the study conducted by the Kentucky Center for Mental Health Studies, in a single month, staff at the centers provided assistance to 2,202 individuals and organizations. Among the technical assistance recipients, 96 percent "liked the quality of services they received" and 97 percent "would contact [a center] again for additional information and assistance." More recent evaluation data, expected in the near future, are expected to find similar levels of satisfaction. Funding national technical assistance centers to advance recovery and self-help goals puts mental health care dollars to use where they have significant impact and proven effectiveness.

## Juvenile Justice: Aftercare Services for Youth Offenders

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$0m	\$0m	\$0m	\$2.0m

### 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 provides 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 can 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?

Data revealed a rapidly emerging national crisis in juvenile detention. From 1985 to 1995, the number of youth held in secure detention nationwide increased by 72 percent. This increase might be understandable if the youth in custody were primarily violent offenders for who no reasonable alternative could be found. But other data reveal that less than one-third of the youth in secure custody (in a one day snapshot in 1995) were charged with violent acts. In fact, far more kids in this one day count were held for status offenses (and related court order violations) and failures to comply with conditions of supervision than for dangerous delinquent behavior.

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:

1. providing services to children before they become involved with the juvenile justice system;
2. conducting systematic mental health screening and assessment when juveniles enter the juvenile system; and
3. 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 Aftercare 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.



## Community Action Grants

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$0m	\$0m	\$0m	\$5.0m

### What are Community Action Grants?

The Community Action Grant Program, started in FY1999, provides one year awards that support communities to implement evidence-based exemplary practices that serve adults with serious mental illness and children and adolescents with serious emotional disorders. Phase I is directed at achieving consensus among stakeholders to implement the practice in their community or state. Phase II supports the actual implementation of the practice with funds for training and other non-direct services.

### Why are Community Action Grants Important?

As our knowledge of mental illness has steadily increased, Americans' access to care has paradoxically shrunk. Community Action Grants are a catalyst for local communities to improve mental-health service delivery by implementing proven, evidenced-based practices for adults with serious mental illnesses and children with serious emotional disorders. Discontinuing these grants has the potential to hinder the Olmstead process, since these grants are designed to implement effective community-based services.

### What Justifies Federal Spending on this Program?

The Community Action Grants Program builds community-based consensus for adoption of identified exemplary mental health service delivery practices, and provides technical assistance to spur adoption into practice, and synthesizes and disseminates new knowledge about effective approaches to the provision of comprehensive community-based services to persons with serious mental illnesses. Congress did not fund the Community Action Grants in FY 2005.

## Improving Mental Health and Child Welfare Services Integration

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$0m	\$0m	\$0m	\$10.0m

### What is the Program?

The Improving Mental Health and Child Welfare Services Integration program authorizes demonstration grants to provide coordinated child welfare and mental health services for children in the child welfare system. Coordinating the delivery of child welfare and mental health services will better address the health, developmental, social, and educational needs of children in the child welfare system.

The integration of child welfare and mental health services will provide a single point of access in order to better provide children with appropriate services including comprehensive assessments, coordinated service and treatment plans, integrated mental health and substance abuse treatment when both types of treatment are needed. This integration of services between the child welfare and mental health systems would also extend to cooperative efforts with other community agencies such as education, social services, juvenile justice and primary health care agencies.

This new grant program was authorized in the Children's Health Act of 2000 (P.L. 106-310) to lay the foundation for addressing the serious needs of children in the child welfare system as well as those children who are at risk for placement in out-of-home care.

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

It is estimated that 85 percent of the 588,000 children living in foster care today in the U.S. have a developmental, emotional, or behavioral problem. Most of these children

have experienced abuse and/or neglect and are at high risk of emotional, behavioral, and mental problems. Upon entering foster care some children already have a diagnosed serious emotional disturbance and require significant services. In addition, all children who are separated from their families experience some trauma and may require mental health services.

All children entering the child welfare system should receive comprehensive assessments that are appropriate, accessible, and available to ensure that placements and services are based on the needs of the child and the family. Child welfare and mental health agencies need to develop a coordinated process to assess and provide services, treatment, and support for each child and their family.

### What Justifies Federal Spending on this Initiative?

One in five children and youth have a diagnosable mental, emotional, or behavioral problem. The mental health needs of children that come to the attention of the child welfare system are even greater. Better integration and coordination of services between the child welfare and mental health systems will help to ensure that children in the child welfare system receive the mental health services they need. With improved coordination of services and treatment planning and implementation, mental health services provided to children and youth that come to the attention of the child welfare system can be achieved in a more appropriate, efficient, and cost-effective manner.

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### Need for Collaboration

*Children in state protective custody are likely to have a range of acute and chronic health problems. For many children, the trauma of family separation and placement within the foster care system compounds these problems.*

*Two-year old Crystal was discovered abandoned in a hotel room. No one knew how long she had been left to fend for herself. For weeks she would speak only in a whisper. Crystal's child welfare worker described feeling haunted by her eyes. She described them as "old" revealing a depth of experience way beyond her years — trauma beyond anyone's years.*

*Fortunately for Crystal, the county she lives in has set up a collaboration between its child welfare agency and public mental health service system so that she will receive treatment for her post-traumatic stress disorder and other emotional and developmental disorders she may have as a result of being neglected and then abandoned. But abused and neglected children in a majority of state child welfare systems are not so fortunate and will not receive needed mental health treatment. Untreated childhood mental illness can lead to a cycle of relationship difficulties with foster and adoptive families, and school failure.*

*Despite laws and policies that mandate appropriate care, numerous systemic and direct service barriers prevent many children in state protective custody from receiving mental health care. CMHS's Improving Mental Health and Child Welfare Services Integration program allows states that are unable to fund these system collaborations to do so and provide mental health care for these children who desperately need it.*

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

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$0m	\$0m	\$0m	\$4.0m

### 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 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 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. Studies show about half of all adolescents receiving mental health services have a co-occurring substance use disorder, and as many as 75-80 percent of adolescents receiving inpatient substance abuse treatment have a coexisting mental disorder. Adolescents with emotional and behavioral problems are nearly four times more likely to be dependent on alcohol or illicit substances than are other adolescents, and the severity of a youth's problems increases the likelihood of drug use and dependence.

Among adolescents with co-occurring disorders, conduct disorder and depression are the two most frequently reported disorders that co-occur with substance abuse.

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, but an important step forward, toward reversing a pattern of neglect in responding to the treatment needs of juveniles.

## **Mental Health Research**

### **Fiscal Year 2006 Funding Recommendations**

for the

National Institute of Mental Health  
National Institute on Drug Abuse, and  
National Institute of Alcohol Abuse and Alcoholism

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#### **National Institutes of Health (NIH)**

The National Institutes of Health (NIH) is the world's premier medical and behavioral 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 27 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).

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#### **National Institutes of Health (NIH)**

Director: Elias Zerhouni, MD (301) 496-4000

## **Mental Health Research**

### **Fiscal Year 2006 Funding Recommendations**

for the

National Institute of Mental Health (NIMH)

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#### **National Institute of Mental Health (NIMH)**

The mission of the National Institute of Mental Health (NIMH) is to reduce the burden of mental illness through research on mind, brain, and behavior. This public health mandate demands that NIMH harness powerful scientific tools to achieve better understanding, treatment, and eventually prevention and cure of mental illness.

Through research, NIMH and the scientists it supports seek to gain an understanding of the fundamental mechanisms underlying thought, emotion, and behavior and an understanding of what goes wrong in the brain in mental illness. The Institute strives, at the same time, to hasten the translation of this basic knowledge into clinical research that will lead to better treatments and ultimately be effective in our complex world with its diverse populations and evolving health care systems.

The National Institute of Mental Health faces an enormous challenge: to reduce the burden of mental and behavioral disorders through research. To do so, the current mental health system must be transformed, as called for in the President's New Freedom Commission on Mental Health. The report describes the dire need for improving the delivery of evidence-based treatments that already exist directly to communities, as well as the development of new treatments that more effectively reduce suffering and improve recovery for people with mental illnesses such as schizophrenia, bipolar disorder, depression, anxiety disorders and autism.

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#### **National Institute of Mental Health (NIMH)**

Director: Thomas Insel, MD (301) 443-3675

#### **Constituency Relations and Public Liaison**

Director: Gemma Weiblinger (301) 443-3673

## National Institute for Mental Health (NIMH)

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$1,382.5m	\$1,412.2m	\$1,418.0m	\$1,496.9m

### Mental Health in America

Diseases such as schizophrenia, depression, autism, Alzheimer's disease, bipolar disorder, attention deficit hyperactivity disorder, personality disorders, and a broad array of other mental disorders affect 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 54 million people. In addition, 10-12 percent of children and adolescents have mental and behavioral conditions that need treatment. Many people suffer from more than one mental disorder. The most severe disorders affect nearly 5 million adults, and they can destroy the lives of their victims and devastate those who love them.

Of the 10 leading causes of disability in the U.S. and other developed countries, four are mental disorders: major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. This is an extraordinarily significant burden on health and productivity in the United States and throughout the world. In the landmark Global Burden of Disease Study,<sup>1</sup> which was commissioned by the World Health Organization and the World Bank, the authors found that while mental illnesses are responsible for slightly more than one percent of death, they account for almost 11 percent of disability worldwide. In the developed Nations major depression is second only to heart disease in life-years lost from illness.

In addition to the tragedy of lost lives, mental illnesses come with a devastatingly high financial cost. In the U.S., the annual economic, indirect cost of mental illnesses is estimated to be \$79 billion. Most of that amount - approximately \$63 billion - reflects the loss of productivity as a result of illnesses. But indirect costs also include almost \$12 billion in mortality costs (lost productivity resulting from premature death) and almost \$4 billion in productivity losses for incarcerated individuals and for the time of those who provide family care.

In 1997, the latest year comparable data are available, the United States spent more than \$1 trillion on health care,

including almost \$71 billion on treating mental illnesses. Mental health expenditures are predominantly publicly funded at 57%, compared to 46% of overall health care expenditures. Between 1987 and 1997, mental health spending did not keep pace with general health care because of declines in private health spending under managed care and cutbacks in hospital expenditures.

There is hardly one of us untouched to some degree by the impact of brain-related disorders. Thanks, in part, to research funded and conducted over the last 50 years by NIMH, there are effective treatments for these devastating illnesses. Our rapidly expanding knowledge of how the brain works in health and illness, combined with modern technologies of neuroscience and with progress in behavioral and clinical sciences, will lead to new conceptualizations of how to assess symptoms, based on the underlying brain dysfunctions, and then how to tailor treatments to address specific problems.

### Unbiased Scientific Testing and Analysis

NIMH supports the design of new interventions and the refinement of existing therapeutic approaches through randomized, controlled clinical trials to demonstrate their efficacy. NIMH emphasizes clinical research and human subject protections: To help ensure the success of this research, NIMH assigns high priority to investigating research ethics, including the ongoing process of informed consent and the use of surrogate decision-makers (legally authorized representatives). While rigorously controlled clinical efficacy trials will remain an essential step in bringing new treatments to the public, "real-world" relevant information is vital to the Nation's public health. NIMH has launched a series of community based effectiveness trials of interventions for adolescent depression, treatment-resistant depression in adults, bipolar disorder, and the effectiveness of newer atypical antipsychotic medications in Alzheimer's disease and schizophrenia. During FY 2006, all of these trials will be working to attain the targeted number of research participants.

### **President's Commission on Mental Health**

An NIMH-wide priority in FY 2006 will be the enthusiastic pursuit of research and related activities that will complement and further the efforts of the President's New Freedom Commission on Mental Health. The Commission completed a comprehensive study of the U.S. mental health service delivery system, including the public and private sectors, and will submit its report and recommendations to the President. The Commission's report also encourages the development of more effective bridges between the Institute and the services community. NIMH research has increased our understanding of the mental health consequences of traumatic events, including natural disasters and human-caused events, and efforts are underway to enhance existing epidemiological and clinical research studies by adding questions relevant to the impact of the recent disasters.

### **PTSD**

PTSD is an anxiety disorder that occurs after exposure to an extreme stressor in which a person experiences, witnesses, or is confronted with actual or threatened death or serious injury to self or others. Events most often associated with PTSD are physical or sexual assault, childhood neglect or physical abuse, natural disasters, accidents, combat exposure, and bioterrorism. Given its prevalence, disability impact, chronicity, and treatment resistance, PTSD represents a major public health risk. Building on what we have learned about the psychological aspects of traumatic stress reactions and links to many neurobiologic systems, NIMH intends to accelerate clinical research studies to determine whether chemicals that block abnormal stress responses after a trauma can prevent or reduce development of PTSD. NIMH-funded researchers have now identified a molecular and cellular pathway in the brain that is important in imprinting fear-related experiences to memory and its relationship with a gene that codes for a neurochemical signal called GRP which stimulates a fear response. Other trials will look at the optimal duration, timing, and methods of combining pharmacological and psychosocial intervention.

### **Children**

NIMH has initiated studies to test sequenced treatments for attention deficit hyperactivity disorder in preschool and school-age children. However, there are many other disorders that would benefit from expansion of this research.

NIMH will also expand studies to test the efficacy and safety of interventions for children with autism.

Treatments with promising results in the pilot phase will be directed toward full clinical trials over the next several years. NIMH is particularly committed to expanding the portfolio of psychosocial/behavioral treatment research in autism.

### **Genetics**

NIMH will assign priority in FY 2006 to its Human Genetics Initiative, which is meant to assemble and make available to the scientific community large data sets that contain high statistical power to detect genes producing vulnerability to mental disorders. The institute will intensify efforts to recruit into the study individuals/families with bipolar disorder, major depression, autism, obsessive-compulsive disorder, and attention-deficit hyperactivity disorder. Special emphasis will be placed on fostering large-scale collaborations, by which combined meta-analyses of all available data may occur. Characterization of these vulnerability genes will significantly advance drug discovery and individualized treatment selection.

### **Suicide**

Recognizing that in the United States, deaths by suicide consistently outnumber deaths by homicide, and that suicide is the third leading cause of death for 10-24 year olds, and the eighth leading cause of death for males of all ages, NIMH will encourage a variety of studies focused on the reduction and prevention of suicide. While research on risk factors has identified diverse social, biologic, and genetic factors associated with suicide, the most consistent factors are major mental illnesses, which affect up to 90% of all people who die by suicide. Despite the high correlation between mental illness and suicide, only a small proportion of persons with mental disorders engage in suicidal behavior, making it difficult to test treatments aimed at preventing or reducing suicidality. In FY 2006, NIMH will encourage research to further characterize protective factors against suicide, as well as new treatments to reduce suicide. NIMH plans to encourage research on suicidality by highlighting research gaps and opportunities, including measurement (e.g., risk and protective factors, treatment response), biological bases, and interventions for underserved populations (rural, racial/ethnic minority populations). The invitation for research applications also will note the need for studies of safe approaches to providing public health messages about suicide, its risk factors, and how to obtain treatment.



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## Research Spotlight

### Improving Cognition in Schizophrenia

*Current medications can often effectively manage the “positive” symptoms of schizophrenia, such as delusions and hallucinations. But cognitive problems can remain a significant barrier to a productive life for people with schizophrenia. Cognitive deficits, such as trouble with memory, attention, problem solving, verbal fluency, working memory and social cognition (ability to understand social situations and respond effectively) are core features of schizophrenia, and remain largely unaffected by medications or changes in severity of positive symptoms. There has been a lack of scientific consensus on which cognitive impairments should be targeted and which tools are best for measuring them.*

*As a result, the FDA has not yet been able to recognize cognition in schizophrenia as a valid treatment endpoint for industry-sponsored research and drug registration. To address these issues, NIMH has launched the Measurement and Treatment Research to Improve Cognition in Schizophrenia (MATRICS) program. Through this program, academic, industry and regulatory agencies will convene to develop a comprehensive assessment tool to measure cognitive functioning in people with schizophrenia. MATRICS will also review pre-clinical models of neurocognition to identify potential molecular targets for new compounds, develop models for industry/government/academic collaboration to test compounds for improving cognition, and identify potential lead compounds. Once the new instrument to assess cognition is completed, NIMH will create a network of Treatment Units for Neurocognition in Schizophrenia (TURNS), which will include four to six new research sites nationwide. These sites will further refine experimental methods needed to assess compounds, identify and obtain promising treatments, and conduct clinical trials.*

*A significant goal of these efforts is to help clarify the issues obstructing regulatory acceptance of cognition in schizophrenia as a valid clinical target for drug registration. Drug registration would provide a compelling incentive for academic and industry investment to focus on an important but neglected clinical area which could make a huge difference in the daily lives of people with schizophrenia.*

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## **Mental Health Research**

### **Fiscal Year 2006 Funding Recommendations**

for the

National Institute on Drug Abuse (NIDA)

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#### **National Institute on Drug Abuse (NIDA)**

NIDA's mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction. This charge has two critical components: The first is the strategic support and conduct of research across a broad range of disciplines. The second is to ensure the rapid and effective dissemination and use of the results of that research to significantly improve drug abuse and addiction prevention, treatment, and advise policy.

NIDA-supported scientific advances over the past three decades have revolutionized our understanding and our approaches to drug abuse and addiction. Research has shown that drug addiction is a chronic relapsing disease that results from the prolonged effects of drugs on the brain. Using drugs repeatedly over time changes brain structure and function in fundamental and long-lasting ways that can persist long after the individual stops using them. It is these neuro-adaptive changes that make addiction a brain disease – a disease that is expressed in the form of compulsive behavior. Both developing it and recovering from it depend upon biology, behavior, and social context. The good news is that the research has shown that addiction is both preventable and treatable.

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#### **National Institute on Drug Abuse (NIDA)**

Director: Nora D. Volkow, MD (301) 443-6480

#### **Office of Science Policy**

Deputy Director, Timothy P. Condon, Ph.D. (301) 443-6036

## National Institute On Drug Abuse (NIDA)

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$991.5m	\$1,006.7m	\$1,010.0m	\$1,067.1m

### Background

As the world's largest supporter of research on the health aspects of drug abuse and addiction, NIDA supports a comprehensive research portfolio that continues to bring us new knowledge about addiction and has led to our current understanding of addiction as a disease. Widespread acceptance of the disease model of addiction is a top priority for NIDA, for our patient population, and for the field. NIDA works closely with other stakeholders to bring science to communities across the country and to reduce the stigma of addiction.

The economic burden of drug abuse on our society is estimated to be **\$484 billion per year** (Office of National Drug Control Policy, 2001; Harwood, 2000; Rice, 1999). Drug abuse is inextricably linked with the spread of infectious diseases such as HIV/AIDS, tuberculosis, and Hepatitis C, and is associated with domestic violence, child abuse, and other violent behavior. The overall picture of drug abuse in the United States is constantly changing. NIDA monitors drug use patterns and trends and uses the power of science to prevent emerging drug problems from becoming national epidemics. NIDA's long-standing Monitoring the Future (MTF) survey shows that there has been an approximately 17% decline over the last three years in any illicit drug use in the past month by students in the eighth, tenth, and twelfth grades combined. Despite this good news, drug abuse continues. The National Survey on Drug Use and Health (NSDUH) supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) also tracks drug use in populations aged 12 and older. Both surveys (MTF and NSDUH) indicate that disturbing patterns in overall drug use are still evident.

- An estimated 19.5 million Americans aged 12 or older were current users of an illicit drug in 2003. This estimate represents 8.2 percent of the population;
- Over half (51%) of America's teenagers have tried an illicit drug by the time they finish high school;
- An estimated 71 million Americans reported being current users of a tobacco product in 2003, a prevalence rate of 30% for the population 12 years and older;
- Marijuana is the most widely used illicit substance

in this country. In 2003, 14.6 million people were current users of marijuana;

- For the second year in a row inhalant use has increased in 8th graders with 17.3% reporting use at least once in their lifetime. These drugs are particularly dangerous because they can damage the nervous system even after a single use, and they can be fatal;
- Vicodin is one of the drugs most commonly abused by high school seniors. Nearly one in ten 12th graders reported non-medical use of Vicodin in 2004; one in twenty 12th graders reported non-medical use of OxyContin.

NIDA's research portfolio 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. The ultimate aim of our Nation's investment in drug abuse research is to enable society to prevent drug abuse and addiction and to reduce the adverse individual, social, health and economic consequences associated with drugs.

### NIDA's Research Priorities

Neuroscience research is the foundation for all of NIDA's drug abuse prevention and treatment efforts. New research is revealing that drug addiction is a **"developmental disease;"** that is, it often starts during adolescence and sometimes as early as childhood. This is a time when the human brain is undergoing major changes in both structure and function. We now know that the brain continues to develop throughout childhood and into early adulthood. Exposure to drugs of abuse at an early age may increase a child's vulnerability to the effects of drugs and impact brain development. NIDA has increased its emphasis on adolescent brain development to better understand how developmental processes and developmental outcomes are affected by drug exposure and other factors like the environment and genetics. Indeed, recent advances in genetic research have enabled researchers to start to investigate what genes make a person more vulnerable and what genes protect a person against addiction and how genes and the environment interact. As part of the prevention portfolio

NIDA is also involving pediatricians and other primary care physicians to develop tools, skills and knowledge to be able to screen and treat patients as early as possible, including patients with mental disorders who may be at high risk to develop addiction. If we do not intervene early, drug problems can last a lifetime.

Treatment is another priority area where NIDA is making tremendous efforts to develop, test and ensure the delivery of evidence-based interventions to practitioners and patients across the country. Building upon advances from basic neuroscience and behavior research, NIDA has brought a number of effective medications and behavioral treatments to the world. For example, there are about 60,000 people who are being treated with a new medication that NIDA helped to develop. Buprenorphine, sold under the brand name Suboxone, is the very first medication that can be prescribed by physicians in their offices to treat patients for opiate addiction. NIDA is now testing new compounds for America's most abused illegal substance – marijuana. NIDA is developing new treatments for marijuana abuse and addiction, especially for adolescents and those suffering from co-occurring mental illnesses.

Recognizing substance abuse as a disorder that can affect the course of other diseases including HIV/AIDS, mental illnesses, trauma, cancer, cardiovascular disease and even obesity, is critical to improving the health of our citizens. NIDA has launched several efforts to reach out to various professions within the medical community, including psychiatrists. NIDA partnered with the American Psychiatric Association at their annual conference to focus on how to better integrate the science of addiction into psychiatric practice.

Another important treatment priority for NIDA is curtailing the spread of HIV/AIDS. Because illicit drug use can impact decision-making and increase the likelihood that an individual will engage in risk-taking behaviors, treatment for drug abuse is, itself, HIV prevention. NIDA is especially interested in reducing HIV/AIDS rates in racial and ethnic minority populations, which are disproportionately affected by this disease. Almost half the HIV/AIDS cases occur among African Americans even though they constitute only about 12% of the population according to the latest Census data.

### **National Drug Abuse Treatment Clinical Trials Network (CTN)**

NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN) established in 1999 has grown to include over 17 research centers across the country. The CTN

provides an infrastructure to test the effectiveness of new and improved interventions in real-life community settings with diverse populations, allowing us to expand treatment options for providers and patients. NIDA plans to expand the mission of the CTN beyond its role as a critical bridge between research and practice. Now, the CTN also will serve as a platform to help NIDA respond to emerging public health needs. Several areas of National importance have already been identified: first, the rising use of prescription drugs for non-medical purposes; second, effectively treating patients who concurrently suffer from Attention Deficit Hyperactivity Disorder and substance abuse disorders; and third, determining the effects that some addiction medications have on liver function.

### **Combating Emerging Drug Problems**

The NIDA-supported MTF data suggest there is a "silent epidemic" lurking. For the second year in a row we see eighth graders abusing inhalants at disturbing rates. Inhalants can damage the nervous system or even be fatal. In response, NIDA launched a new website in January 2005 [www.inhalants.drugabuse.gov](http://www.inhalants.drugabuse.gov), and has formed partnerships with other concerned groups to aggressively combat this problem.

MTF has also alerted NIDA to disturbing news about prescription drugs. In 2002, the MTF survey initiated questions about the prescription pain medications oxycodone (OxyContin) and hydrocodone (Vicodin). In that year and in 2003, about 4 percent and 4.5 percent, respectively, of high school seniors reported nonmedical use of oxycodone in the 12 months preceding the survey. Roughly 10 percent of seniors reported nonmedical use of hydrocodone, making it the third most widely abused illicit substance (after marijuana and amphetamine) in this age group. The abuse of prescription pain medications is increasing among adult Americans as well. NIDA is responding on several fronts. NIDA convened a Consultant Workgroup meeting to develop an outline for a large-scale clinical study of treatment for prescription opiate abuse that will be designed and conducted by NIDA's Clinical Trials Network. NIDA research also is expanding its understanding of the risks posed by prescription medications in different populations—women, adolescents, racial and ethnic groups, health professionals, those with comorbid substance abuse and mental health disorders, and those with HIV/AIDS and other infectious diseases. One group that may be especially at risk is the elderly for whom age-related changes may influence the way in which their bodies metabolize and respond to prescription drugs.

Older adults are also more likely to have undiagnosed psychiatric and medical illnesses, making them more vulnerable to adverse health effects or even addiction.

NIDA also continues to monitor methamphetamine use. Most recently NIDA's Community Epidemiology Work Group (CEWG), which monitors drug abuse problems in selected areas across the Nation, alerted NIDA to increases in methamphetamine abuse in 11 of the 21 CEWG areas, including rural areas. NIDA maintains a comprehensive program that includes basic, epidemiological, prevention and treatment research to combat methamphetamine abuse.

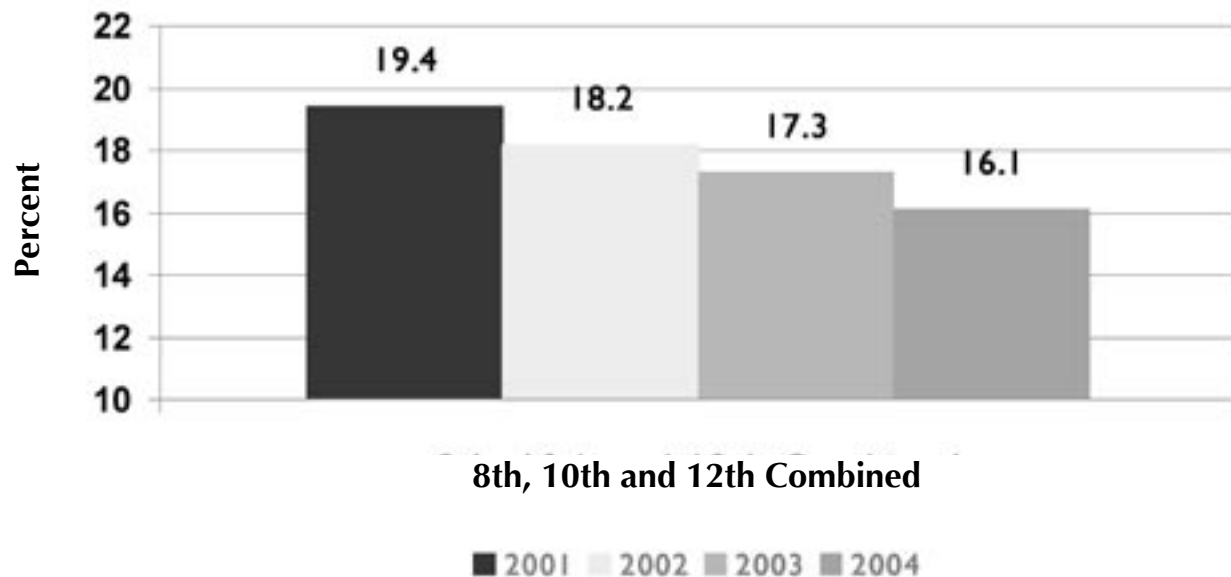
### **Addressing Co-occurring Diseases**

A great number of individuals simultaneously suffer from substance abuse, mental illness, and other medical or physical disorders, including chronic pain, Hepatitis C, AIDS and other diseases. NIDA is working with NIMH and SAMHSA, among others, to develop effective strategies and to ensure timely delivery of evidence-based practices for prevention and treatment of co-occurring disorders. This issue is especially relevant for children and adolescents. NIDA will encourage researchers to develop prevention programs that are geared toward adolescents who may be at high risk for substance use disorders, because of co morbidities such as learning disabilities, trauma, conduct disorders and ADHD.

### **Reaching out to Primary Care Physicians**

Substance abuse in youth and adults is a serious public health problem, with significant morbidity and mortality. The primary care physician can make major inroads into effective prevention and treatment by recognizing and addressing these issues in the outpatient office setting. NIDA has been supporting research to give physicians the tools they need to accomplish this. The response to NIDA's recent call to expand this area of research has been impressive, with about eight new grants funded. Researchers will continue to develop brief interventions for both adolescents and adults that are practical for use in busy office settings where patients receive their routine healthcare. In the coming year, NIDA will test some of these new interventions in primary care settings. NIDA will also continue to co-fund grants with SAMHSA related to this topic. Additionally, NIDA will fund new research that will help develop innovative financing strategies for physicians who do take the time to assist people with substance abuse problems. Primary care physicians need to be reimbursed for treating patients with substance abuse disorders.

## Percent of Students Reporting Past Month Use of Any Illicit Drug Has Decreased 17% Decline 2001 to 2004\*



\* This decline is statistically significant at the  $p < .05$  level.

Source: Monitoring the Future Survey, 2004  
Supported by the National Institute on Drug Abuse, NIH, DHHS

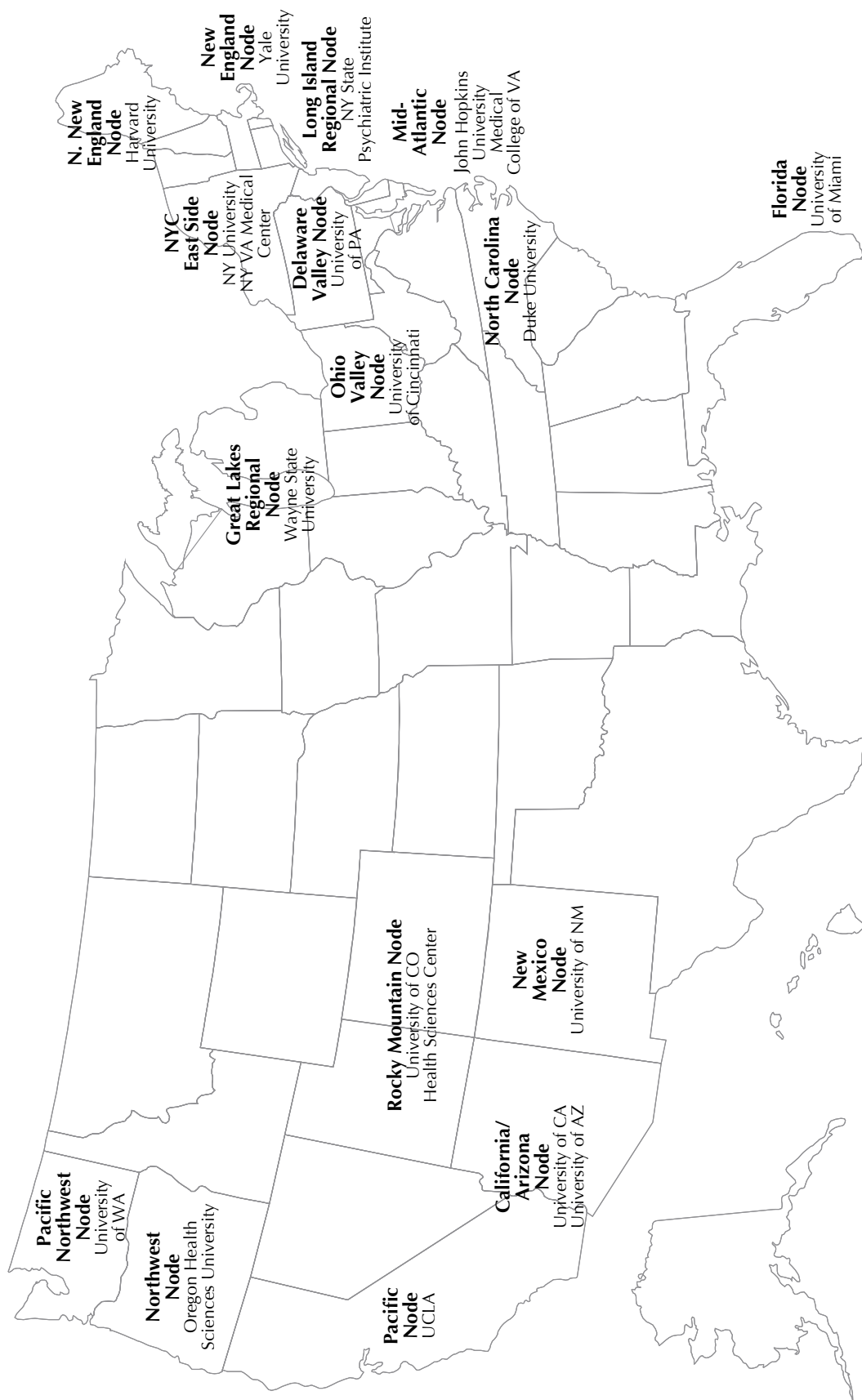
### Research Spotlight Unraveling the Mysteries of Development

New research continues to uncover the mysteries of the human brain. Understanding how the human brain works and develops, particularly the brains of adolescents, is critical to prevention efforts. We now know that the brain continues to develop structurally until about the age of 25. Tools like magnetic resonance imaging are showing us the changes occurring in the adolescent brain. These images are showing how the prefrontal cortex, an area of the brain critical to decision-making, is among the last areas of the brain to fully develop. They are also showing us how and when the brain's gray matter (nerve cells) and white matter (nerve pathways) develop. We now know that the brain's gray matter peaks around age 11 in girls and age 12.5 in boys beyond which other maturational processes that are believed to reflect strengthening and consolidation of connections between brain areas become more prominent. All of these findings have tremendous implications for prevention. As scientists begin to understand how these structural changes affect function, such as thinking, decision-making, sensation and perception, they will be

better able to develop more targeted prevention strategies using a developmental perspective. Understanding adolescent motivational processes and decision-making, especially as they relate to the drive and decision to use drugs, is an important research area for NIDA. Equally critical is understanding the neurobiological consequences of environmental stressors during childhood and adolescence as it pertains to drug use and addiction.

To truly understand the effects that drugs of abuse can have on the adolescent brain, we need to know what the normal brain of an adolescent looks like. That is why NIDA is committed to working collaboratively with other NIH institutes to actively support and participate in the "NIH MRI Study of Normal Brain Development." This study uses noninvasive magnetic resonance imaging (MRI) to map brain changes during development. Along with the information obtained from the MRI studies, data on behavioral development are also being gathered. The study will produce a database of human neurobiological and behavioral development that will be highly useful as we try to discern the effects of drugs of abuse on the human brain and to understand other serious childhood conditions including epilepsy, psychosis and autism.

## National Drug Abuse Treatment Clinical Trials Network



## **Mental Health Research**

### **Fiscal Year 2006 Funding Recommendations**

for the

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

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#### **National Institute on Alcohol Abuse and Alcoholism (NIAAA)**

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems. NIAAA also provides leadership in the national effort to reduce the severe and often fatal consequences of these problems by:

- conducting and supporting research directed at determining the causes of alcoholism, discovering how alcohol damages the organs of the body, and developing prevention and treatment strategies for application in the Nation's health care system;
- supporting and conducting research across a wide range of scientific areas including genetics, neuroscience, medical consequences, medication development, prevention, and treatment through the award of grants and within the NIAAA's intramural research program;
- conducting policy studies that have broad implications for alcohol problem prevention, treatment and rehabilitation activities;
- conducting epidemiological studies such as national and community surveys to assess risks for and magnitude of alcohol-related problems among various population groups;
- collaborating with other research institutes and Federal programs relevant to alcohol abuse and alcoholism, and providing coordination for Federal alcohol abuse and alcoholism research activities; and
- disseminating research findings to health care providers, researchers, policymakers, and the public.

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**National Institute on Alcohol Abuse and Alcoholism (NIAAA)**  
Director: Ting-Kai Li, MD (301) 943-3885



## National Institute On Alcohol Abuse and Alcoholism (NIAAA)

APPROPRIATIONS FY 2004	APPROPRIATIONS FY 2005	ADMINISTRATION REQUEST FY 2006	MHLG RECOMMENDATION FY 2006
\$428.9m	\$438.5m	\$440.0m	\$464.8m

### Background

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 borne 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 is also involved in homicides and suicides, 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 on 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;
- New technologies to advance identification of the genes likely to influence the risk for alcoholism, and advancing discovery of new behavioral treatments and medications development; 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.

### NIAAA SCIENTIFIC ADVANCES

#### Shared Pathology Appears to Precede Early Drinking, Alcoholism, and Other Behavioral Disorders

NIAAA researchers recently discovered a striking association between early age at first alcohol use and development of alcoholism at some point in life. This finding raised another question: Is early alcohol use per se a cause of alcoholism, or are both alcoholism and early initiation of drinking reflections of some other childhood vulnerability that underlies a variety of subsequent problems? A new study shows that early age at first drink — 11 to 14 years of age — correlates with a number of signs of psychopathology and behavioral disorders, such as attention-deficit disorder and impulsiveness, that appear in early childhood, before the first drinking experience. In addition, adolescents who began drinking early were more likely than others to have reduced amplitude of a brainwave called "P3," an abnormality that serves as a marker of risk of alcoholism. The latter finding

suggests that the common vulnerability that appears to underlie these various problems may be, at least in part, physically based. A particularly suggestive aspect of the new findings is that the signs of psychopathology and impulsive behaviors researchers measured — signs like nicotine and drug dependence, antisocial personality disorder, and behavioral conduct disorder — predicted which 11-year-olds would try alcohol by age 14. This indicates that these behaviors pre-dated the early drinkers' alcohol use, strengthening the case for a common vulnerability that underlies a range of problems, including both early drinking and alcoholism.

### **Mechanisms and Markers of Alcohol-Induced Organ Damage and Organ Protection**

Heavy alcohol use has toxic effects on tissues and organs, with potentially serious or fatal sequelae, while moderate use appears to protect against cardiovascular disease and, perhaps, dementia. NIAAA is integrating research on a core group of biochemical processes, common to all cells of the body, that are particularly prone to disruption by alcohol. Understanding the mechanisms that underlie these shared processes will contribute to development of (1) genetic and molecular biomarkers of susceptibility and of cellular changes that initiate tissue injury, which can be used in prevention strategies, and (2) pharmacogenomic treatment strategies. Of particular interest is the role of this core group of mechanisms in susceptibility to alcohol-induced liver damage, especially in conjunction with hepatitis C; certain cancers; fetal damage; pancreatitis; cardiomyopathy, hypertension, and stroke associated with heavy alcohol use.

### **Multi-site, Collaborative Initiative on Fetal Alcohol Syndrome**

Children with fetal alcohol syndrome (FAS) and alcohol related neurodevelopmental disorders have serious neurobehavioral deficits and other physical problems that impair daily function and often persist throughout life. In the U.S., these conditions disproportionately affect American Indians, Native Alaskans, and African Americans. The NIAAA Collaborative Initiative on Fetal Alcohol Spectrum Disorders will support a consortium of individual investigators, multi-site collaborations, and collaborations between basic-science investigators and clinical scientists. This initiative will ensure that

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**Research Spotlight**  
**Preventing Underage Drinking in Rural  
 and Small Urban Areas**

*As a recent Congressional hearing on underage drinking attested, alcohol is the primary substance of abuse among the nation's children. Among children who use alcohol, one group is notable for its particularly high risk: rural youth. In a major survey, rural children topped the geographical list of youth who reported drinking within the past year (and almost twice as many used alcohol as used illegal drugs). The percentage of 12- to 17-year-olds who reported binge drinking within the past month was higher among rural children than among children in any other geographic region in the U.S. Research literature that could help us understand this problem and develop effective preventive interventions is unavailable.*

*We need to know why children in this high-risk population drink and how to prevent them from doing so and from harming themselves and others. An initiative in this area could identify risk factors common to youth in rural and small urban communities, another high-risk population, and would develop and implement community-based, longitudinal prevention and intervention programs. Academic health centers would be ideal candidates for this research, since they can add a medical component to the range of disciplines and services (for example, social work and those related to the justice system), usually involved in these kinds of studies.*

*Adolescents have in common unique neurobiological factors that affect risk and resiliency vis-a-vis alcohol use. Few studies have addressed neurobiological mechanisms and consequences of heavy drinking in this group. The utility of rural and urban cohorts could be maximized by including neurobiological studies, whose results would apply to adolescents in general. The Substance Abuse and Mental*

*Health Services Administration, the Department of Education, NIDA, and NCI will collaborate in this initiative.*

**Medication Development For Alcoholism:**

- (1) Bypassing the IND Bottleneck and**
- (2) Human Laboratory Studies and Early Phase II Clinical Trials —**

*Developing more widely effective medications is one of the most pressing needs in alcohol research. NIAAA currently has at least nine compounds that merit preclinical testing. The infrastructure and resources required for Investigational New Drug approval continue to be a bottleneck for this Institute. NIAAA intends to make use of NIDA's medications-development infrastructure for preclinical studies, which largely bypasses roadblocks to progress. Through interagency agreements, NIAAA can avoid the duplication of effort (and expense) that would be involved in creating its own, similar infrastructure to test compounds that show promise as alcoholism treatments.*

*As a separate activity, NIAAA will develop its own contracts for Phase I human laboratory studies and early Phase II clinical trials of compounds with potential to treat alcoholism. The intent of this activity is to discover whether a compound is worth pursuing further before expending resources for Phase III trials. Candidate compounds currently are available.*

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## **Centers for Substance Abuse Treatment and Prevention**

The Substance Abuse and Mental Health Services Administration is comprised of three centers. The Center for Mental Health Services which has been described extensively in the previous pages as well as the Center for Substance Abuse Treatment and Center for Substance Abuse Prevention described below.

### **Center for Substance Abuse Treatment — CSAT**

The Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS), was created in October 1992 with a congressional mandate to expand the availability of effective treatment and recovery services for alcohol and drug problems. CSAT supports a variety of activities aimed at fulfilling its mission: to improve the lives of individuals and families affected by alcohol and drug abuse by ensuring access to clinically sound, cost-effective addiction treatment that reduces the health and social costs to our communities and the nation.

CSAT's initiatives and programs are based on research findings and the general consensus of experts in the addiction field that, for most individuals, treatment and recovery work best in a community-based, coordinated system of comprehensive services. Because no single treatment approach is effective for all persons, CSAT supports the nation's effort to provide multiple treatment modalities, evaluate treatment effectiveness, and use evaluation results to enhance treatment and recovery approaches.

### **Center for Substance Abuse Prevention — CSAP**

The Center for Substance Abuse Prevention (CSAP) provides national leadership in the development of policies, programs, and services to prevent the onset of illegal drug use, to prevent underage alcohol and tobacco use, and to reduce the negative consequences of using substances. CSAP is one of three Centers in the Substance Abuse and Mental Health Services Administration (SAMHSA) in the U.S. Department of Health and Human Services (HHS). The other two are the Center for Substance Abuse Treatment (CSAT) and the Center for Mental Health Services (CMHS).

CSAP carries out its mission through the following strategies:

- Develop and disseminate prevention knowledge;
- Identify and promote effective substance abuse prevention programs;
- Build capacity of States, communities, and other groups to apply such knowledge effectively; and
- Promote norms supportive of prevention of substance abuse at the family, workplace, community, and national levels.

CSAP promotes comprehensive programs, community involvement, and partnership among all sectors of society. Through service capacity expansion and knowledge development, application, and dissemination, CSAP works to strengthen the Nation's ability to reduce substance abuse and its associated problems.

## Mental Health Liaison Group (MHLG) FY 2006

### Appropriation Recommendations for the Center for Mental Health Services

(Dollars in Millions)				
PROGRAMS	FY 04 FINAL	FY 05 FINAL	FY 06 ADMIN REQUEST	FY06 MHLG REQUEST
<b>CMHS</b>				
<b>CMHS TOTAL</b>	<b>\$862.4m</b>	<b>\$901.3m (+\$38.9m)</b>	<b>\$837.3m (-\$64.1m)</b>	<b>\$982.4m (+\$81.1m)</b>
Community Mental Health Performance Partnership Block Grant	\$434.7m	\$432.8m (-\$1.9m)	\$432.8m (+\$0m)	\$471.5m (+\$38.7m)
Children's Mental Health Services Program	\$102.4m	\$105.2m (+\$2.8m)	\$105.2m (+\$0m)	\$114.7m (+\$9.5m)
PATH Homelessness Program	\$49.8m	\$54.8m (+\$5.0m)	\$54.8m (+\$0m)	\$59.8m (+\$5.0m)
Protection and Advocacy (PAIMI)	\$34.6m	\$34.3m (-\$0.3m)	\$34.3m (+\$0m)	\$37.4m (+\$3.1m)
Programs of Regional and National Significance	\$240.9m	\$274.3m (+\$33.4m)	\$210.2m (-\$64.1m)	\$299.1m (+\$24.8m)
Youth Violence Prevention	\$94.4m	\$94.2m (-\$0.2m)	\$66.8m (-\$27.4m)	\$102.7m (+\$8.5m)
State Infrastructure Grants	n/a	\$19.8m <i>New Funding</i>	\$26.0m (+\$6.2m)	\$26.0m (+\$6.2m)
Post Traumatic Stress Disorder	\$29.8m	\$29.8m (+\$0m)	\$29.8m (+\$0m)	\$32.5m (+\$2.7m)
Jail Diversion Grants	\$7.0m	\$6.94m (-\$0.06m)	\$3.91m (-\$3.03m)	\$7.54m (+\$0.6m)
Seniors	\$5.0m	\$4.96m (-\$0.04m)	\$4.96m (+\$0m)	\$5.41m (+\$0.45m)
Community TA Centers	\$2.0m	\$1.98m (-\$0.02m)	\$1.98m (+\$0m)	\$2.16m (+\$0.18m)
Community Action Grants	\$0m	n/a	n/a	\$5.5m (+\$5.5)
Suicide	n/a	\$16.5m (n/a)	\$16.5m (+\$0m)	\$18.0m (+\$1.5m)
<b>CSAT</b>				
<b>Block Grant</b>	<b>\$1,779.1m</b>	<b>\$1,775.6m (-\$3.5m)</b>	<b>\$1,775.6m (+\$0m)</b>	<b>\$1,847.0m (+\$71.4m)</b>
<b>Programs of Regional and National Significance</b>	<b>\$419.2m</b>	<b>\$422.4m (+\$3.1m)</b>	<b>\$447.1m (+\$24.7)</b>	<b>\$456.3m (+\$33.8m)</b>
<b>CSAP</b>				
<b>Programs of Regional and National Significance</b>	<b>\$198.5m</b>	<b>\$198.7m (+\$0.2m)</b>	<b>\$184.3m (-\$14.4m)</b>	<b>\$210.0m (+\$11.3m)</b>
<b>NIH</b>				
<b>NIMH</b>	<b>\$1,382.5m</b>	<b>\$1,412.2m (+\$29.7m)</b>	<b>\$1,418.0m (+\$5.8m)</b>	<b>\$1,496.9m (+\$84.7)</b>
<b>NIDA</b>	<b>\$991.5m</b>	<b>\$1,006.7m (+\$15.2m)</b>	<b>\$1,010.0m (+\$3.3m)</b>	<b>\$1,067.1m (+\$60.4m)</b>
<b>NIAAA</b>	<b>\$428.9m</b>	<b>\$438.5m (+\$9.6m)</b>	<b>\$440.0m (+\$1.5m)</b>	<b>\$464.8m (+\$26.3m)</b>

## Programs At A Glance

**In keeping with the Mental Health Liaison Group's mission to educate and disseminate critical information concerning pivotal programs important to the 54 million Americans with mental illness and 23 million Americans with substance abuse disorders, the following are short summaries of programs detailed in this report.**

**Addressing Child and Adolescent Post-Traumatic Stress** — These grants would fund the design and implementation of model programs to treat mental disorders in young people who are victims or witnesses of violence, and research, and development of evidence-based practices, on treating and preventing trauma-related mental disorders.

**Aftercare for Youth Offenders** — Provides grants targeted to help youth overcome the serious emotional problems, which have led or contributed to their involvement with the juvenile justice system.

**Children's Mental Health Services Program** — Provides six-year awards to public entities for developing intensive, comprehensive community-based mental health services for children with serious emotional disturbances (SED).

**Community Action Grants** — Enable citizens at the local level to come together in support of evidence based practices, including family education, jail diversion, police training, cultural competence and assertive community treatment. Communities use these grants to gain consensus for implementation of effective programs and services for people with severe mental illnesses. To gain community collaboration for evidence-based outcomes funding should be provided to continue the successful Community Action Grant Program.

**Community Mental Health Performance Partnership Block Grant** — The principal federal discretionary program for community-based mental health services for adults and children. (Formerly known as the Mental Health Block Grant).

**Consumer and Consumer/Supporter Technical Assistance Centers** — The goal of consumer and consumer-supported National technical assistance center grants is to provide technical assistance to consumers, families, and supporters of persons with mental illness.

**Emergency Mental Health Centers** — Provides grants to states and localities that would benefit from enhanced mental health emergency services. Grants may be used to establish mobile crisis intervention teams capable of responding to emergencies in the community. These grants are to establish new services in areas where existing service coverage is inadequate.

**Jail Diversion Grants** — Provides 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 service.

**Juvenile Justice: Interagency Research, Training and Technical Assistance** — Assists 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.

**Mental Health and Child Welfare Services Integration** — Addresses the serious needs of children and adolescents in the child welfare system and the needs of youths at risk for placement in the system.

**Mental Health Outreach and Treatment to the Elderly** — This program provides for implementation of evidence-based practices to reach older adults who require assistance for mental disorders, only a small percentage of whom currently receive needed treatment and services. This program is a necessary step to begin to address the discrepancy between the growing numbers of older Americans who require mental health services and the lack of evidence-based treatment available to them.

**Mental Health Transformation State Incentive Grant (SIG)** — The goal of this new program is to create comprehensive State mental health plans that will enhance the use of existing resources to serve persons with mental illnesses and children and youth with emotional and behavioral disorders. These plans will increase the flexibility of resources at the State and local levels, hold State and local level of government more accountable, and expand the option and array of available services and supports.

**PATH Homeless Program** — Helps localities and nonprofits provide flexible, community-based services to people who are homeless (or at risk of homelessness) and have serious mental illnesses or who have a serious mental illness along with a substance abuse disorder.

**Programs of Regional and National Significance (PRNS)** — These programs allow state and local mental health authorities to access information about the most promising methods for improving the performance of programs.

**Protection and Advocacy (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.

**Statewide Family Network Grants** — Provide peer-to-peer support, accurate information about mental health services, and training so that families can effectively participate in planning, designing, implementing and evaluating services for children with emotional, behavioral, or mental disorders. They are a key vehicle for disseminating information about evidence-based and effective practice to the individuals who can most benefit from the application of research in real world setting.

**Suicide Prevention for Children and Adolescents** — Support service and training programs in states and communities, with a focus on the needs of communities and groups experiencing high or rising rates of suicide.

**Treatment for Co-occurring Mental Illness and Addiction Disorders** — Innovative programs directed to the special needs of people with co-occurring serious mental illnesses and addictions disorders.

**Youth Violence Prevention** — Safe Schools/Healthy Students initiative (one example of Youth Violence Prevention) 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.

# MENTAL HEALTH LIAISON GROUP

National Organizations Representing  
Consumers, Family Members, Advocates, Professionals and Providers