

Appropriations Recommendations for Fiscal Year 2007

“[The National Comorbidity Survey Replication Studies] confirm a growing understanding about the nature of mental illness across the lifespan. There are many important messages from this study, but perhaps none as important as the recognition **that mental disorders are the chronic disorders of young people in the U.S.** *(emphasis added)*”

Thomas Insel, Director of the National Institute of Mental Health

MENTAL HEALTH LIAISON GROUP

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

MENTAL HEALTH LIAISON GROUP

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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**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.”**

Endorsing Organizations

Mental Health Liaison Group Member Organizations

Alliance for Children and Families
American Academy of Child and Adolescent Psychiatry
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association of Children's Residential Centers
American Association of Pastoral Counselors
American Counseling Association
American Group Psychotherapy Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Psychotherapy Association
Association for Ambulatory Behavioral Healthcare
Association for the Advancement of Psychology
Bazon 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
Depression and Bipolar Support Alliance
Eating Disorders Coalition for Research, Policy & Action
Federation of Families for Children's Mental Health
National Alliance for the Mentally Ill
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 Psychiatric Health Systems
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Disability Rights Network
National Mental Health Association
Suicide Prevention Action Network US
Therapeutic Communities of America
Tourette Syndrome Association
Volunteers of America



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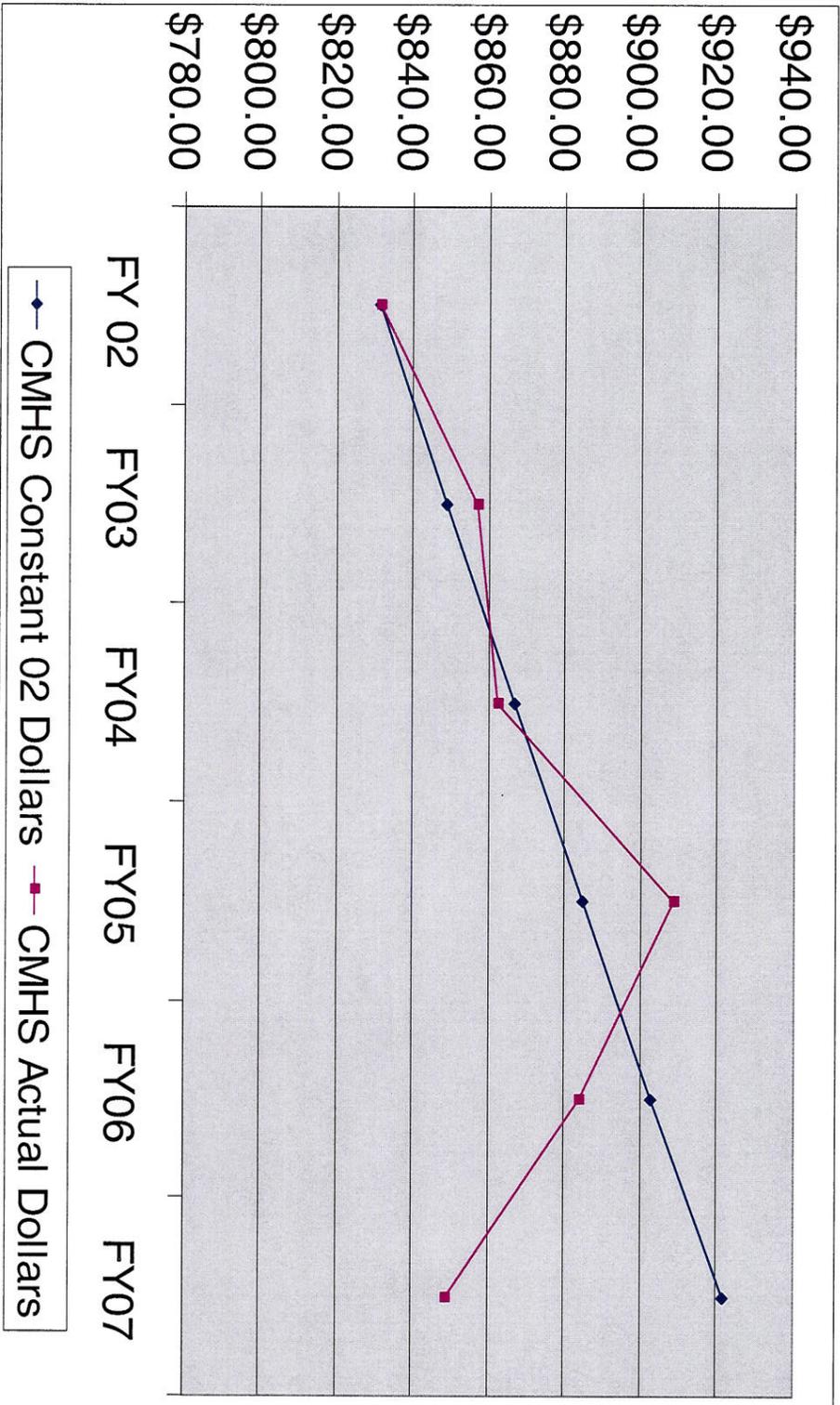
**Mental Health Liaison Group (MHLG) FY 2007
Appropriations Recommendations for the
Center for Mental Health Services and Key NIH Institutes**

(Dollars in Million)

PROGRAMS	FY 05 FINAL	FY06 FINAL	FY07 ADMIN REQUEST	FY07 MHLG REQUEST
CMHS				
CMHS TOTAL	\$901.3m	\$884.0m <i>(-\$17.3m)</i>	\$848.9m <i>(-\$35.1m)</i>	\$939.6m <i>(+\$55.6m)</i>
Community Mental Health Services Performance Partnership Block Grant	\$432.8m	\$428.6m <i>(-\$4.3m)</i>	\$428.5m <i>(-\$0.1m)</i>	\$451.2m <i>(+\$22.7m)</i>
Children's Mental Health Services Program	\$105.2m	\$104.1m <i>(-\$1.1m)</i>	\$104.1m <i>(+\$0.0m)</i>	\$109.7m <i>(+\$5.6m)</i>
PATH Homelessness Program	\$54.8m	\$54.3m <i>(-\$0.5m)</i>	\$54.3m <i>(+\$0.0m)</i>	\$57.1m <i>(+\$2.8m)</i>
Protection and Advocacy (PAIMI)	\$34.3m	\$34.0m <i>(-\$0.3m)</i>	\$34.0m <i>(+\$0.0m)</i>	\$35.8m <i>(+\$1.8m)</i>
Programs of Regional and National Significance	\$274.3m	\$263.2m <i>(-\$11.1m)</i>	\$228.1m <i>(-\$35.1m)</i>	\$285.9m <i>(+\$22.7m)</i>
Youth Violence Prevention	\$94.2m	\$93.3m <i>(-\$0.9m)</i>	\$75.7m <i>(-\$17.6m)</i>	\$98.2m <i>(+\$4.9m)</i>
Suicide Prevention	\$16.5m	\$31.7m <i>(+\$15.2m)</i>	\$34.7m <i>(+\$3.0m)</i>	\$34.7m <i>(+\$3.0m)</i>
Post Traumatic Stress Disorder	\$29.8m	\$29.5m <i>(-\$0.3m)</i>	\$29.5m <i>(+\$0.0m)</i>	\$31.1m <i>(+\$1.6m)</i>
State Incentive Grant	\$19.8m	\$25.7m <i>(+\$5.9m)</i>	\$19.8m <i>(-\$5.9m)</i>	\$26.8m <i>(+\$1.1m)</i>
Jail Diversion Grants	\$6.94m	\$6.93m <i>(-\$0.01m)</i>	\$6.93m <i>(+\$0.0m)</i>	\$7.2m <i>(+\$0.3m)</i>
Seniors	\$4.96m	\$4.95m <i>(-\$0.01m)</i>	\$4.95m <i>(+\$0.0m)</i>	\$5.2m <i>(+\$0.2m)</i>
Community Technical Assistance Centers	\$1.98m	\$1.98m <i>(+\$0.0m)</i>	\$1.98m <i>(+\$0.0m)</i>	\$2.1m <i>(+\$0.1m)</i>
Community Action Grants	\$0.0m	n/a	n/a	\$1.5m <i>(+\$1.5m)</i>
NIH				
NIMH	\$1,412.2m	\$1,403.8m <i>(-\$8.4m)</i>	\$1,395.0m <i>(-\$9.2m)</i>	\$1,472.1m <i>(+\$68.3m)</i>
NIDA	\$1,006.7m	\$1,000.0m <i>(-\$6.7m)</i>	\$995.0m <i>(-\$5.0m)</i>	\$1,049.4m <i>(+\$49.4m)</i>
NIAAA	\$438.5m	\$435.9m <i>(-\$2.6m)</i>	\$433.0m <i>(-\$2.9m)</i>	\$457.1m <i>(+\$21.2m)</i>

CMHS Funding vs. FY 02 Plus Inflation (2.1%/yr)

	FY02	FY03	FY04	FY05	FY06
CMHS Constant FY 02 Dollars	\$831.30	\$848.80	\$866.70	\$884.80	\$902.80
CMHS Actual Dollars	\$831.30	\$857.00	\$862.40	\$908.60	\$884.00



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, the following are short summaries of programs detailed in this report.

Addressing Child and Adolescent Post-Traumatic Stress — Funds 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 and behavioral 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 constructively 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 — Represents the principal federal discretionary program for community-based mental health services for adults and children.

Consumer and Consumer/Supporter Technical Assistance Centers — Provide technical assistance to consumers, families, and those giving support to persons with mental illness.

Emergency Mental Health Centers — Provide grants to states and localities so that they may 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 were created to offer new services in areas where existing service coverage is inadequate.

Jail Diversion Grants — Provide up to 125 grants to states or localities to develop and implement programs to divert individuals with a mental illness from the criminal justice system to community-based service.

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 – Provides grants to facilitate the implementation of evidence-based mental health practices to reach older adults, 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 need mental health services and the lack of evidence-based treatment available to them.

Projects for Assistance in Transition from Homelessness (PATH) 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) — 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 in nursing homes, state mental hospitals, residential settings and in the community.



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. These grants serve as a key vehicle for disseminating information about evidence-based and effective practice.

Mental Health Transformation State Incentive Grants (SIG) — Provide the resources to develop plans for enhancing the use of existing resources to serve persons with mental illnesses and children and youth with emotional and behavioral disorders. These plans help increase the flexibility of resources at the state and local levels, hold state and local governments more accountable, and expand the option and array of available services and supports.

Suicide Prevention for Children and Adolescents — Funds 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 – CRISIS after CRISIS

National Snapshot – Exposing The Need For Mental Health Services And Supports

About 2.2 million adolescents ages 12 to 17 (9 percent) experienced at least one major depressive episode in the past year. These adolescents were more than twice as likely to have used illicit drugs in the past month than their peers who had not experienced a major depressive episode (21.2 percent compared with 9.6 percent). These findings were released by the Substance Abuse and Mental Health Services Administration (SAMHSA) from continued analysis of the 2004 National Survey on Drug Use and Health. (SAMHSA 12/29/05)

The Substance Abuse and Mental Health Services Administration (SAMHSA) today released data showing that approximately 900,000 youth had made a plan to commit suicide during their worst or most recent episode of major depression, and 712,000 attempted suicide during such an episode of depression.

(SAMHSA, 9/9/05)

The Department of Veterans Affairs “is committed to treating the ‘whole’ veteran, and an important part of the care we provide our heroes is to ensure that they get the best treatment available to help them recover from any mental health issues – in addition to any physical medical treatment they may require.”

Secretary R. James Nicholson
December 8, 2005

According to a new national survey released by SAMHSA, one-fifth of students receive some type of school-supported mental health services during the school year. Elementary, middle, and high schools all cite social, interpersonal, or family problems as students' most frequent mental health problems. Mental health problems are broadly defined in the new publication, “School Mental Health Services in the U.S., 2002-2003.” (SAMHSA, 11/22/05)

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)

According to SAMHSA, an estimated 17 million adults ages 18 and older (8.0 percent) reported experiencing at least one major depressive episode during the past year. (SAMHSA Advisory, 11/18/05)

Depression Treatment Found to Be **Cost-Effective** Among Older Adults With Diabetes: A study published in the journal Diabetes Care shows that depression in older adults who have diabetes can be effectively treated and, if treated, can be cost-effective. The study's researchers concluded that by treating the older adults' depression, the older adults were better able to "manage their self-care regimens for diabetes." They also noted that because depression can have an adverse physiological effect, treating the disorder among people who have diabetes can reduce any complications from diabetes can produce additional savings. (Reuters, 2/10/06)



Unmet Need

One measure of the lack of investment in resources to provide mental health services is the number of prospective grantees received by SAMHSA and the number that are funded. Given that funding for mental health services is lower in FY 2006 than in FY 2003, SAMHSA has consistently been unable to fund **meritorious** grantees (i.e., grantees that received a score high enough to warrant funding). For example, in FY 2005, SAMHSA:

- Funded only 8 percent of grantees received (6 out of 75) for Jail Diversion activities at a time when 80 percent of young people in the juvenile justice system has a mental illness and the cost of care is much higher in a corrections system than in the community;
- Funded only 7 percent of grantees received (11 out of 160) for programs serving Older Adults at a time when our population is aging and this cohort of individuals has one of the highest rates of suicide, as well as the missed opportunity of treating their mental illnesses as a way to improve their physical health; and
- Funded only 16 percent of grantees received (7 out of 45) for the Children’s System of Care despite data documenting the program’s effectiveness in increased graduation rates and reductions in law enforcement contact.

Hurricane Katrina

Mental health professionals say this city [New Orleans] appears to be experiencing a sharp increase in suicides in the wake of Hurricane Katrina, and interviews and statistics suggest that the rate is now double or more the national and local averages. (NYT, 12/28/05)

Suicide calls have almost doubled – SAMHSA’s suicide hotline was receiving, on average, 900 calls per week pre-Katrina, and skyrocketed to 1,400 calls post-Katrina (a 55 percent increase). (National Suicide Prevention Lifeline, 1/20/06)

According to an estimate by the U.S. Dept. of Health and Human Services, relief workers and nearly 500,000 survivors of Hurricane Katrina may need mental health services. With the lack of medical services available in the region and the slow pace of rebuilding, some experts believe the psychological toll will continue to grow. (HHS, 12/7/05)

A clinical survey of the Centers for Disease Control and Prevention found that 45 percent of residents in Orleans and Jefferson Parishes were experiencing "significant distress or dysfunction" and that 25 percent had even "higher degree(s) of dysfunction." HHS launched a public service campaign encouraging people with psychological issues to seek help. As part of that campaign, public service announcements advertising help-lines will be distributed to 11,000 media outlets. (Kaisernet.org, 12/7/05)

Data on the psychological impact of Katrina's destruction is not yet available, but a small survey by the Centers for Disease Control and Prevention last fall showed that more than 40 percent of survivors had signs of post-traumatic stress disorder, in which sufferers have recurring experiences of traumatic events or "significant distress or dysfunction." That is a higher rate than the 25 percent to 33 percent who suffered post-traumatic stress after Hurricane Andrew struck Florida in 1992. The survey also notes that about 50 percent of residents responding to the survey felt isolated and 25 percent thought at least one family member needed counseling. (CDC, October 2005)

Anthony H. Speier, director of Disaster Mental Health Operations for the Louisiana Office of Mental Health, said Katrina-weariness is setting in, making the survivors vulnerable to depression and other problems. He said psychological counselors for the state have had 425,000 requests for help, a number that is sure to grow. "A lot of people are having trouble reconciling the extreme breadth of their loss," said Speier, "People's homes are gone. Their sense of tradition is gone. Their sense of community is gone. . . A lot of people need to talk about their situations."

Requests for mental health services at community mental health clinics in Baton Rouge have increased by 40 percent in 4 months, and the rate is similar in other parts of the state. In New Orleans, there is a one-month wait for persons seeking outpatient clinic services at local hospitals; a 2 to 3-month wait for a private psychiatrist; and a wait of 2 to 4 days for an inpatient bed in an emergency room, even for those who are at great risk for suicide. (National Public Radio, January 24, 2006)

Administration's FY 2007 Budget

Mental Health Services Funding

Despite the release of last July's federal "Action Agenda" to ensure that people with mental illness have every opportunity for recovery, the administration proposes a 4 percent cut (from \$884 to \$849 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 proposals to:

- cut funding for the second straight year for a successful youth-violence prevention program by nearly 20 percent, from \$94 to \$76 million;
- cut funding for the Mental Health Transformation State Incentive Grants (SIG) program by \$6 million (from \$26 to \$20 million);
- cut funding for substance abuse prevention by 7 percent, from \$193 to \$181 million;
- level-fund (ostensibly a cut given inflation) the children's systems-of-care, funding to prevent homelessness (PATH), PAIMI, jail diversion, and elderly programs, the mental health and substance abuse block grants, as well as the Consumer TA Centers; and
- provide an increase of \$3 million for suicide prevention – almost twice as many individuals die from suicide than homicide.

Mental Health Research Funding

The Administration's budget proposes to level fund research activities at the National Institutes of Health, and also cuts funding for the National Institutes of Mental Health, Drug Abuse, and Alcohol Abuse and Alcoholism.

The President's New Freedom Commission on Mental Health (www.mentalhealthcommission.gov)

“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.”

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

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 CMHS has a budget sufficient to put proven prevention and treatment programs in place in every community across the country.

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.
- Approximately 54 million Americans have a mental illness.
- 20 percent of the population experiences a mental illness in a given year.
- About 5 percent of the population suffers from 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

“[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)

- The rate of teen suicide has tripled since the 1950s; overall, there are 30,000 suicides in America every year.
- Mental illness plays a major 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.
- 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, 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.
- 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.
- The Administration’s FY 2006 budget included significant changes to the \$21.8 million Mental Health Block Grant set-aside, including the transfer of CMHS’ State Data Infrastructure Grant (DIG) program to the set-aside. This change displaced approximately \$10 million in funding for state technical assistance and research and evaluation programs.

History of Chronic Neglect and Underfunding

- The Administration’s FY2007 budget proposes cuts for several vital CMHS programs for the *fifth* year in the last six. SAMHSA’s budget has grown only \$50 million TOTAL in the last five years.
- 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 **1 percent** a year over the last five years (FY 2002 - 2006). 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.
- 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.
- 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.”

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 lead 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 1999 U.S. Supreme Court decision in *Olmstead v. LC* and *E.W* 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.
- The transition from institutional care to community-based care has never been adequately funded; even though we know that community-based care is less expensive than institutional care.

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; 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, provides mental health services to low income persons. However, due to current fiscal crisis, many state legislatures are looking for ways to cut benefits.
- There are ten times more people with psychiatric illnesses in jails or prisons than in state psychiatric hospitals. In the course of the next year, almost 750,000 people with psychiatric illnesses will find themselves in jails or prisons.
- 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.
- 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.
- Our advocacy for mental health funding increases is compatible with the President’s national priority of addressing domestic security, including aid for local police and fire departments, and assistance for the public health system.

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 scientific research 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.



Mental Health Services
Fiscal Year 2007
Funding Recommendations

for the

Substance Abuse and
Mental Health Services Administration
Center for Mental Health Services

**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.”

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 new programs to address emerging national priorities. The authorization of SAMHSA expired at the end of FY 2004. This document addresses appropriations recommendations for the Center for Mental Health Services within SAMHSA. These recommendations are derived from consultations with state and local mental health authorities, providers, researchers and consumers.

Substance Abuse and Mental Health Services Administration (SAMHSA)

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SAMHSA Legislative Contact: Joe Faha (240) 276-2000

Center for Mental Health Services (CMHS)

Director: A. Kathryn Power, M.Ed. (240) 276-1310

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. 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 decision in *Olmstead v. L.C. and E.W.* — 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, **but federal investments to community care remain stagnant.**

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.

As a result of these trends, the federal investment in community-based care is growing in importance. For example, the nearly \$428 million in FY 2006 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 Block Grant program constitutes as much as 39.5 percent of all non-institutional services spending in some states. Moreover, these federal dollars are 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 hotlines 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 services, 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 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 funds the organization of 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 Projects for Assistance in Transition from Homelessness (PATH) program is the only federal program that provides mental health care and evaluates the implementation of innovative outreach services to homeless Americans, a third of whom have mental illnesses.



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. The Programs of Regional and National Significance are a catalyst for local communities to improve mental-health service delivery by implementing proven, evidence-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.

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, 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 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$432.8m	\$428.6m	\$428.5m	\$451.2m

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 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, it 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 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 1960's to about 60,000 today. As a result, state mental health agencies have 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 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 2007 budget proposes to reduce funding to the Block Grant by \$174,000. Due to recalculations under the Block Grant formula for FY 2007, there will be a reduction in Block Grant allocations in 29 states.

What Justifies Federal Spending for the 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, 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 block grant funding and to ensure that the Block Grant provides evidence-based community services for populations most in need of services. These populations include adults with severe mental illness who:

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

Mental Health Technical Assistance and Research and Evaluation Programs at Risk

For over a decade, CMHS has used a significant portion of the 5 percent Block Grant administrative set-aside to fund technical assistance and research and evaluation programs that support and enhance community-based mental health services for adults and children. These programs assist a wide range of stakeholders – providers, researchers, consumers, and family members – in providing critical community-based mental health services and supports, such as housing, employment and peer support, to adults and children.

The Block Grant set-aside has also been crucial in supporting CMHS in its unprecedented leadership in carrying out the recommendations of the President’s New Freedom Commission on Mental Health and “transforming” the way mental health services are delivered. The Targeted Technical Assistance project, for instance, has made tremendous strides in helping to reduce systems fragmentation and duplication of effort while promoting policy changes that will result in the recovery-oriented, consumer

and family driven service system envisioned in the Commission report.

Unfortunately, the FY 2006 budget contained significant changes to the Block Grant set-aside, including an earmark for the State Data Infrastructure Grant (DIG) program. Previously, the DIG was funded at approximately \$11 million as a separate line item under the Programs of Regional and National Significance (PRNS). Since the Block Grant was level-funded at \$433 million in FY 2006, the Block Grant set-aside for FY 2006 is fixed at \$21 million. CMHS is therefore forced to cut by more than one-half the programs funded by the set-aside.

The transfer of the DIG to the Block Grant set-aside essentially eviscerates CMHS’ capacity to support technical assistance and research and evaluation activities in the states and communities and severely undermines its capacity to carry out the recommendations of the President’s Commission. It is imperative that the DIG once again be funded out of the PRNS if CMHS is going to continue its success in supporting community-based services and leading the transformation of the mental health system as called for by the President’s New Freedom Commission on Mental Health.

Community-Based Services Work

Rhonda recently spent about one month at a local hospital psychiatric unit. 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 it. The local hospital began an 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 live independently. Without these additional community supports she would have decompensated once again while off her medications. Rhonda would surely have ended up at the State hospital and her recovery efforts set back.

Comprehensive Community Mental Health Services for Children and Their Families Program

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$105.2m	\$104.1m	\$104.1m	\$109.7m

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

An estimated 20 percent, or 13.7 million American children, have a diagnosable mental or emotional disorder. Between 5 and 9 percent have a serious emotional disturbance (SED), which means they have significant problems functioning at home, at school and in their community. Children with 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, away from family and other sources of support — 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 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 focus 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; and
- 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 of 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 and treatment* (NIMH, 1994). In the past twelve years, the Children’s Mental Health Services Program has provided services to nearly 70,000 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. These statements were echoed in the final report of the President’s New Freedom Commission on Mental Health.

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

Justifying the Costs

The program has served children in 473 or 15 percent 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 (the 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 up to 2 years later;

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; and
6. 92.5 percent of children improved or remained stable in their problem behaviors and emotions after six months.

The national evaluation data prove that children and youth enrolled in systems-of-care experience significant 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. Additionally, in a recent study it was demonstrated that costs in other child serving agencies (e.g., child welfare, juvenile justice) were actually reduced as a result of this program (Foster & Connor, 2005).

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 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; and
- 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).

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 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 were faded out over time as Seth's self-control improved. Mentors have also helped Seth develop positive social skills. Although they continue to struggle with Seth's mental illness as he 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.



Projects for Assistance in Transition from Homelessness (PATH)

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$54.8m	\$54.3m	\$54.3m	\$57.1m

What Does PATH Do?

The Projects for Assistance in Transition from Homelessness (PATH) formula grant program provides funding to states, localities and non-profit organizations 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. In 2005, 438 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 outreach on the streets and in shelters, 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 ongoing strategies at the federal, state and local level to end chronic homelessness over the next decade – including the Bush Administration's "Samaritan

A 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 the Samaritan Initiative, the Administration hopes to make resources available to states and localities to fund some of the services needed by people experiencing chronic homelessness – including permanent housing and case management.

What Justifies Federal Spending for PATH?

For FY 2007, the President is requesting \$54.3 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 2007 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 increases for PATH funding since the 1990s, 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 in 2005 by Senators Pete Domenici (R-NM) and Edward M. Kennedy (D-MA).

PATH and State and Local Plans to End Chronic Homelessness

In recent years, federal, state and local policy has shifted toward greater investment in strategies to address chronic homelessness, i.e. the needs of individuals who stay homeless for extended periods of time. Chronic homelessness is extremely costly to local communities in terms of increased utilization of emergency rooms, acute care and the criminal justice system. A recent University of Pennsylvania study found that placement in permanent supportive housing was (on average) only slightly more expensive than the cost of maintaining someone in chronic homelessness. The Bush Administration has developed its federal proposal, the Samaritan Initiative, to support burgeoning efforts at the state

and local level to end chronic homelessness over the next decade. More than 205 Mayors and County Executives have created 10-Year Plans to End Chronic Homelessness, and 53 Governors of states and territories have committed to state Interagency Councils on Homelessness.

PATH is a critical resource for states and localities in reaching people with mental illness who experience chronic homelessness. In addition to the outreach and engagement services funded by PATH, local communities also need assistance in funding ongoing services in permanent supportive housing targeted to individuals who are exiting chronic homelessness, including permanent housing financed through HUD's McKinney-Vento Homeless Assistance Act. Bipartisan legislation introduced by Senators Mike DeWine (R-OH) and Jack Reed (D-RI), and Representatives Deborah Pryce (R-OH) and Anna Eshoo (D-CA) would authorize a new program at SAMHSA to such supportive services tied directly to permanent housing. The Services for Ending Long-Term Homelessness Act (SELHA, S. 2937/H.R. 4866), coupled with PATH, provide critical links in reaching the goal of ending chronic homelessness.



Protection and Advocacy for Individuals with Mental Illness (PAIMI)

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$34.3m	\$34.0m	\$34.0m	\$35.8m

What Does PAIMI Do?

In 1986, Congress authorized the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act. PAIMI is funded through the Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA). The program originally was established to provide protection and advocacy services to individuals with mental illness, who were or had recently resided in institutional settings. In 2000, Congress greatly expanded the PAIMI mandate to include all individuals with significant mental illness, including people living in the community in all settings. In FY 2005 Congress funded the PAIMI program at \$34.3 million, a decrease from 2004 due to an across-the board cut in the omnibus bill. Last year another round of across-the-board cuts resulted in an FY 2006 budget of \$34 million. Given the expanded mission of this critical program and increasing numbers of individuals with mental illness moving from institutions to community settings as a result of the Supreme Court’s Olmstead decision and the President’s New Freedom Initiative, these cuts have had a detrimental effect on Protection & Advocacy organizations’ ability to serve all those who need protection and advocacy services.

Why is PAIMI Important?

Under the PAIMI Program, Protection and Advocacy organizations (P&As) are authorized to investigate abuse and neglect in all public and private facilities and community settings, including hospitals, nursing facilities and group homes – and to oversee the effectiveness of state agencies that license and regulate these programs. PAIMI advocates also play an important role in ensuring that people with mental illness have access to needed supports and services in the community so they can live as independently as possible. This includes helping solve problems related to employment and housing discrimination. Unfortunately, PAIMI advocates are playing an increasingly critical role in correctional facilities where people with mental illness, who are not receiving the supports and services they need in the community, often end up incarcerated. In 2004, the PAIMA program:

- Successfully closed 21,495 cases of which 28 percent were related to abuse, 21 percent to neglect, and 51 percent to a violation of individual rights;
- Consistent with the sophisticated and comprehensive approach of the P&A system, utilized a broad range of strategies to resolve issues, including short-term and technical assistance, investigations, and administrative remedies; only 2 percent of cases resulted in legal action being taken;
- Served individuals with mental illness living in all settings, including public and private institutions and hospitals, prisons, foster care, provider-operated housing, and family’s and individual’s homes;
- Served over 7000 children and young adults and nearly 14,000 adults and elderly individuals with mental illness; and
- Provided information and referral services to almost 50,000 individuals.

What Justifies Increased Federal Spending for PAIMI?

Numbers alone clearly demonstrate the need for mental health protection and advocacy services. In recent years, the PAIMI program mandate has been substantially expanded, increasing the eligible population. At the same time that Congress expanded PAIMI’s coverage to all individuals with significant mental illness, it also directed PAIMI programs to give priority to serving people in institutions before serving people in the community. Several years ago, HHS mandated that P&As receive investigation reports of deaths and serious injuries related to abusive restraint and seclusion practices in hospitals and psychiatric facilities for children. Finally, in 2002 and 2003, Congress affirmed that State P&A programs have a significant role in addressing the community integration needs of individuals identified in the 1999 Supreme Court Decision in *Olmstead v. L.C. and E.W.*

The Congressional and administrative directives to the PAIMI Program are welcome for two reasons. First, they reflect the growing awareness of the need

for reliable protection and advocacy services to persons with mental illness in a variety of settings. Second, they are a strong sign of Congressional trust in the P&A system. However, in order to meet the requirements of these directives, additional funding is critical.

PAIMI Success Stories

In addition to the critical oversight and investigation work done by P&As, some examples of the critical work done by PAIMI advocates include:

- The **Louisiana P&A**, despite losing its offices in New Orleans, assisted hundreds of individuals with mental illness who were without supports, services, and medication in the aftermath of Hurricane Katrina;
- The **Wisconsin P&A** worked with state administrators to design and implement a Medicaid benefit to provide individualized, flexible, recovery-oriented community mental health services;
- The **Utah P&A** developed an Inmate Guide to provide information about how to use the medical and mental health systems, which was distributed by the Department of Corrections and presented as a model at a national meeting of correctional executive directors;
- Investigations by the **Iowa P&A** convinced the Governor to establish a task force investigate deaths of individuals with mental illness in correctional facilities which made 15 recommendations to reduce such deaths; and
- The **Native American P&A** trained nearly 500 individuals on housing issues and the rights of individuals with mental illness.



Programs of Regional and National Significance (PRNS)

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$274.3m	\$263.2m	\$228.1m	\$285.9m

The Center for Mental Health Services (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’ system-improvement activities, and it authorized new programs, many of which are included in CMHS’ Programs of Regional and National Significance.

The SAMHSA budget proposal would cut funding for the Programs of Regional and National Significance (PRNS) by roughly \$35 million or nearly 13 percent. The proposed PRNS budget would cut funding for the Youth Violence Prevention program by almost 20 percent or \$18 million.

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 25-38 we describe the salient importance of the following PRNS programs:

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Youth Violence Prevention Initiatives

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$94.2m	\$93.3m	\$75.7m	\$98.2m

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 violent 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, 40 new grantees were funded.

Why Are Youth Violence Prevention Initiatives Important?

Each year qualified applications for the SS/HS Initiative 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:

- 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);
- Safe school policies. (This element may only be funded by the Department of Education and Department of Justice); and
- Grantees focus on 6 core areas. Statutory restrictions limit how funding from each federal partner can be applied to these elements.

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 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.

Suicide Prevention for Children and Adolescents

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$16.5m	\$31.7m	\$34.7m	\$34.7m

What Do the Suicide Prevention Programs Do?

In 2004, 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 provides 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.

Nationally, suicide is the third leading cause of death among children aged 10-14 and among adolescents and young adults aged 15-24.

According to the Youth Risk Behavior Surveillance System, a survey of students across the nation administered by the Centers for Disease Control and Prevention (CDC), in 2003, 8 percent of youth committed suicide, 16.9 percent seriously considered attempting suicide, and 2.9 percent made a suicide attempt that required medical treatment. The National Survey on Drug Use and Health, a separate survey administered by the Substance Abuse and Mental Health Services Administration, found that in 2004, fourteen percent of youth between the ages of 12 and 17 (approximately 3.5 million youth) experienced at least one Major Depressive Episode (MDE) and that

approximately 712,000 attempted suicide during their worst or most recent episode.

Repeatedly over the last several years, the Federal Government has identified suicide as a serious and preventable public health problem. 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. Many of its 11 goals and 68 objectives are aimed at preventing suicide among children and adolescents, and 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. Funding for the Garrett Lee Smith Memorial Act, as authorized by Congress, provides essential support for States and communities seeking to implement the NSSP's objectives.

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 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..."



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, which calls for performing scientific evaluation studies of new or existing suicide prevention interventions. The second is the national suicide prevention technical resource center.

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 should be developed by the Administration through SAMHSA. Such a partnership would do much to address the advancement and implementation of “a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.”

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

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$29.8m	\$29.5m	\$29.5m	\$31.1m

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 20percent 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 to 9 percent of children and youth have a serious emotional disturbance in any one year. And yet, a 1995 RAND study notes that only 8percent of children who need mental health care actually receive services – this leaves 92 percent of children who need care without any services. Many of these children and adolescents have been exposed to trauma or violence. The trauma exposure for children in the community has been well documented, with rates of exposure to at least one traumatic event for 25 percent of the children in the Great Smoky Mountain study. Higher rates have been found among institutionalized children; an NIMH/OJJDP study showed rates of 92 percent for trauma exposure and up to 18 percent experiencing PTSD.

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. The 2003 President’s New Freedom Commission Report, “Achieving the Promise: Transforming Mental Health Care in America,” identifies trauma as one of four crucial areas where the knowledge base must be expanded as part of mental health system transformation and the improvement of care.

The U.S. DHHS Child Maltreatment Report from the National Child Abuse and Neglect Data Systems, which annually aggregates state child protection reports, estimated that 906,000 children were confirmed victims of child abuse and neglect in 2003. Exposure to violence and trauma is a daily experience for many children. 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 percent of students in some neighborhoods had been exposed to multiple incidents of violence, as witnesses and victims, and that 27 percent of them had clinical levels of PTSD and 16 percent of them had clinical levels of depression. Without treatment, long-term consequences can result. A 1996 study of severely maltreated children showed that 40 percent were diagnosed with PTSD at the time of the removal from their abusers, with 33 percent still suffering from the disorder two years later. Without early intervention with children exposed to trauma, the symptoms may re-emerge following a subsequent trauma, and can affect development, physical health, ability to function, and relationships in adulthood. The ACEs (Adverse Childhood Experiences) study showed that as the number of adverse childhood experiences increases, there is a related increase in the number of serious health problems such as alcoholism, drug abuse, suicide attempts, smoking, and poor general health.

How Can We Address this Problem?

Congress, in the Children’s Health Act (Public Law 106-310), established the National Child Traumatic Stress Initiative (NCTSI) to help address the growing problems arising from children and adolescents witnessing or experiencing violence and trauma.



These grants fund a national network of child trauma centers, including community service programs to provide services to children and families who are victims or witnesses of violence and trauma, treatment development centers that collaborate closely with community providers in the development of evidence-based practices and research on the treatment and prevention of trauma-related mental disorders, and a national coordinating and resource center to guide the network's efforts.

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

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 further development of treatment and services that will prevent the onset of mental health problems among children and youth who have experienced such trauma.

The Children's Health Act originally authorized the NCTSI program at \$50 million. In its first year, \$10 million was appropriated, shortly before the September 11 attacks. In FY02, an additional \$20 million was provided to this program; of this, \$10 million came from the Emergency Supplemental Appropriation (PL 107-38) for the recovery efforts after 9/11. The NCTSI grew rapidly from 17 to 54 centers from 2000-2004, with funding at \$30 million. In 2005, funding remained at \$30 million, but the level funding (and the loss of the supplemental funds) led to a reduction in the total number of funded centers, from 54 to 45 centers, and the inability to

renew funding for the many experienced trauma professionals in the Network.

The innovative program has developed a strong, collaborative network of committed community and treatment development centers that work together to help children who have experienced trauma and develop new and more effective interventions. The program has developed training programs, resource materials, new interventions, and has a strong internal and external evaluation program in place. 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 200,000 professionals will be trained in trauma-informed interventions. Over 700 external partnerships have been established by Network members in their work to integrate trauma-informed services into all child-serving systems (such as schools, foster care, correctional facilities, residential care, shelters, and more).

The NCTSI was immediately mobilized in the aftermath of Hurricanes Katrina and Rita, and deployed staff and disseminated resources, training, and materials throughout the country, serving as a major national resource to the interagency federal response. With additional support for the NCTSI, many thousands more will benefit from the improvements in treatment, the expansion 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 are made available through the coordinating center (the National Center for Child Traumatic Stress, based at Duke University and UCLA) and the affiliated National Resource Center. The ongoing federal evaluation of this program has determined that it is "exceeding expectations."

**Mental Health Transformation
State Incentive Grant Program**

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$19.8m	\$25.7m	\$19.8m	\$26.8m

What Is the Mental Health Transformation State Incentive Grant Program?

The Mental Health Transformation State Incentive Grants (SIGs) support states’ efforts to create comprehensive mental health plans and enhance the use of existing resources to serve persons with mental illnesses. SAMHSA awarded 7 Transformation State Incentive Grants in FY 2005. Grantees engage in State planning and coordination activities with involvement from agencies, such as criminal justice, housing, child welfare, Medicaid and education. In the second year of funding, States may use 85 percent of funds to support programs at the community level as proposed in their State Plan. The remaining 15 percent is used 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 give states the resources to develop such

plans, and 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 supports states’ efforts to develop more comprehensive state mental health plans. These plans facilitate the coordination of federal, state and local resources to support effective and dynamic state infrastructure to best serve persons with mental illness.



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

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$13.7m	\$12.0m	\$7.6m	\$12.8m

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 mental 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 some 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 treatment and service needs of people with co-occurring disorders. Although evidence supports integrated treatment for co-occurring disorders, 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 severe levels of co-occurring disorders are more likely to experience a chronic course and to over-utilize health and expensive emergency room 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 co-morbidity and service use — about 15 percent of those with a mental disorder in 1 year.

Adults with co-occurring mental health and substance use disorders represent one of the most challenging populations to serve. They are more likely to be homeless or without stable housing than people with mental illnesses only, and they are more likely to have interactions with the police and the criminal justice system. They are also more likely to be victims of street crime.

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.

Jail Diversion Program Grants

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$6.94m	\$6.93m	\$6.93m	\$7.2m

Why are Jail Diversion Program Grants Important?

Each year, 11.4 million people are booked into U.S. jails. An estimated seven percent of jail inmates have current symptoms of serious mental. Of these 800,000 people approximately three quarters have co-occurring substance use disorders. Women, who represent 11 percent of all jail inmates, have nearly twice the rate of serious mental illness as men (12 percent vs. 6.4 percent). 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:

- 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 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.” 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. 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:

- 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 multi-site 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.



Mental Health Outreach and Treatment to the Elderly

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$4.96m	\$4.95m	\$4.95m	\$5.2m

What is the Program?

The Mental Health Outreach and Treatment to the Elderly 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.

Although \$4,960,000 was allocated for evidence-based mental health outreach and treatment to the elderly last year, this allocation falls short because 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 by the year 2010.

Normal aging is not characterized by mental or cognitive disorders.

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 long-term care in the last years of life; and
 - 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 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.

What Justifies Federal Spending for 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.

In December 2005, the White House Conference on Aging included in its top 10 resolutions a recommendation to “Improve recognition, assessment and treatment of mental illness and depression among older Americans.”

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 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECOMMENDATION FY 2007
\$3.3m	\$3.4m	\$1.7m	\$3.7m

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.

Statewide Family Network activities are all critical to supporting the implementation of "Transforming Mental Health Care in America: the Federal Action Agenda" developed and being promoted by the Substance Abuse and Mental Health Services Administration:

- Developing and conducting peer support groups helps families: address issues of stigma, shame, guilt, and blame; learn how to constructively and successfully manage their own child's disorder; and actively participate in care planning for themselves and their child;
- Disseminating information and technical assistance through clearinghouses, websites, newsletters, sponsoring conferences and conducting workshops changes attitudes, reduces stigma and discrimination, transfers knowledge, and links families to resources;
- Providing outreach to families through toll-free telephone numbers and through information and referral networks prepares youth and family members to request and obtain needed or wanted services;

- Serving as a liaison with various human service agencies and educating states and communities about effective ways to improve children's services and informs providers about emotional disorders and services, including need for care, access to services, and effectiveness of treatments; and
- Training developed skills for effective advocacy for children's services and successful 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.

The Surgeon General 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. 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" and declares that, "Local, State, and Federal authorities must encourage consumers and families to participate in planning and evaluating treatment and support services." The Federal Action Agenda, developed by the Substance Abuse and Mental Health Services Administration to implement the Commission's recommendations, states very clearly that, "A keystone of the transformation process will be the protection and respect of the rights of adults with mental illnesses, children with serious emotional disturbances, and their parents."



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. 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 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 importance of funding from the Center for Mental Health Services to support the infrastructure of family networks needs to be underscored. Most funding sources will only fund specific programs or services – not the administrative cost associated with maintaining an organization and communication network. The 1998 report evaluating this program found that the organizations receiving repeated years of funding were more viable entities, able to raise funds from other sources and able to conduct more extensive and vigorous support and advocacy.

In the Government and Performance and Results Act (GPRA) report for 2003-2004, the Statewide Family Network grantees reported providing at least one services to 158,459 family members and youth. In the same period, 33 grantees reported that 2,905 family members and youth held seats 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 children in order to get mental health services;
- United Advocates for Children of California was a critical partner ensuring that family members participated in the stakeholder group drafting the Mental Health Services Act (Proposition 63) and making sure services consistent with system of care values and principles would be provided to children and youth;
- 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; and
- The Florida Institute for Family Involvement developed a nationally recognized, comprehensive family-to-family response to hurricanes and other disasters including an extensive website and tip sheets in several languages to help families of children with mental health needs be better prepared to respond to and recovery from the trauma caused by natural disasters.

Statewide Consumer Network Grants

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECOMMENDATION FY 2007
\$1.5m	\$1.5m	\$0.70m	\$1.7m

What Do the Statewide Consumer Networks Do?

The Statewide Consumer Network Grants (SCNGs) enhance State capacity and infrastructure by supporting consumer organizations. The SCNGs ensure that consumers are the catalysts for transforming the mental health and related systems in their state and for making recovery and resiliency the expectation and not the exception.

These small, three-year grants provide crucial resources for leadership development and for fostering consumer-driven mental health systems. Grantees use these resources to address stigma, reduce mental health disparities, prevent criminalization, promote self-care and carry out many other activities.

Approximately \$1.5 million is provided to support 19 grantees at \$70,000 each per year. The current 3-year funding cycle ends in August 2007. The President's budget submission reduces funding for this program to \$700,000, which will only support 14 grants (of about \$45,000 each). This reduction will result in a major loss in mental health transformation efforts and will significantly curtail the efforts of grass-roots consumers to promote systems change.

Why are the Statewide Consumer Networks Important?

The goals of the program are to: (1) strengthen organizational relationships; (2) promote skill development with an emphasis on leadership and business management; and (3) identify technical assistance needs of consumers and provide training and support to ensure that they are the catalysts for transforming the mental health and related systems

For example, the SCNGs:

- **Educate the public that mental health care is essential to overall health** by conducting education campaigns that increase knowledge and consciousness about mental health care, and convening Leadership Academies, BRIDGES Programs, Consumer Support Specialists and Peer Support Activity that promote and sustain leadership skills;

- **Promote consumer and family driven care** through the development of position papers and/or impact statements to courts, local mental health councils and state administrators on systems needs and creative funding and providing outcomes based training that strengthens organizational relationships, promotes consumer leadership and develops local consumer councils throughout states;
- **Demonstrate interest in the elimination of disparities in mental health services** by developing regional partnerships that overlap with existing service needs and developing media and training materials that are culturally appropriate to consumers of various ethnic groups;
- **Promote recovery and resilience through self-help models** by incorporating the Wellness Recovery Action Plan (WRAP), leadership academies and self-help models into training programs and partnering with academic institutions to assist on the development and evaluation of self-help models, vocational training and innovative ways to promote mental health recovery; and
- **Promote the use of technology to access mental health care and information** by implementing technological advances to disseminate information statewide and nationally, and creating interactive websites that allow consumers to exchange information, learn about recovery, and sustain recovery through self-help models.



Consumer and Consumer-Supporter Technical Assistance Centers

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$1.98m	\$1.98m	\$1.98m	\$2.1m

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.

Community Action Grants

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$0.0m	\$0.0m	n/a	\$1.5m

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. Since these grants are designed to implement effective community-based services, discontinuing these grants has the potential to hinder the movement of mental health services from institution-based care to community-based care.

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 or in FY 2006.



Mental Health Research

Fiscal Year 2007 Funding Recommendations

for the

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

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).

National Institutes of Health (NIH)

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

**Fiscal Year 2007
Funding Recommendations**

for the

National Institute of Mental Health (NIMH)

National Institute of Mental Health (NIMH)

The mission of the National Institute of Mental Health (NIMH) is to reduce the public health burden of mental and behavioral disorders through research on mind, brain, and behavior. Mental disorders are common, and can be chronic and disabling. They cause more disability than any other class of medical illness in American adults. This public health mandate demands that NIMH harness science to achieve the fundamental understanding of how mental illnesses begin and progress in the brain, to discover new treatments, and eventually to prevent and cure them.

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 of Mental Health (NIMH)

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$1,412.2m	\$1,403.8m	\$1,395.0m	\$1,472.1m

Mental Health in America

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 U.S. and throughout the world. Research has shown that while mental illnesses are responsible for slightly more than one percent of deaths, 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 to illness. These studies and other studies make it clear that severe mental illness is often a lifelong problem, one that is more prevalent than generally realized.

A recent study funded by NIMH found that mental illnesses are quite common, and also revealed that an untreated mental disorder can lead to a more severe, more difficult to treat illness, and to the development of co-occurring mental illnesses. The study, the National Co-morbidity Survey Replication (NCS-R), was published in the spring of 2005 and provided clear evidence about the prevalence and severity of specific mental disorders. The study also indicated that half of all lifetime cases of mental illness begin by age 14, making these the chronic diseases of the young. Often, a young person develops these disorders in late adolescence or early adulthood—just as they are entering the most productive period of their lives. Often, these early years of the disease are wasted because even though effective treatments are available, the NCS-R showed that there are often delays of many years between first onset of symptoms and when people seek and receive treatment. The NCS-R also illustrates the severity of the mental health problem in the United States. About 6 percent of the US population is afflicted with a *severely disabling* mental disorder in a given year.

Even those who do get treatment cannot be assured of a straightforward road to health. Evidence from other NIMH studies suggests that many people suffering

from severe mental illness have had traumatic or harmful experiences while being treated in various psychiatric settings and have been victimized while living in community settings. Both findings warrant increased attention by policy-makers, corrections officials, public health officials, and mental health professionals.

Despite this discouraging news, there is also amazing progress that has been made in recent years, including extraordinary new tools and technologies that are offering real hope for the future. Multiple approaches to identifying abnormal functional activity in the brain are emerging. New discoveries in neuroimaging and genomics are establishing certain mental disorders as brain disorders. This is a critical step in the creation of more effective strategies to diagnose, manage, treat, and even prevent these debilitating disorders. A major challenge is to integrate and translate basic and technological advances across these levels of analysis into practical strategies that will help translate this new knowledge and technological capabilities to a broad spectrum of people in communities around the globe, including children, the socio-economically disadvantaged, and those with various other barriers to mental health care.

NIMH supports the design of new interventions and the refinement of existing therapeutic approaches through randomized, controlled clinical trials to demonstrate their efficacy. To ensure the success of this research, NIMH assigns high priority to research ethics including the process of informed consent. To move these findings into the world of practice, NIMH launched large practical-effectiveness trials; results are just beginning to be published. Each of these trials should prove a landmark in the field as they provide results from the largest and longest studies ever designed to answer urgent questions about the treatment of depression, bipolar disorder, and schizophrenia. In addition, these trials advance the NIMH goal of designing individualized treatments for patients with mental illness. These trials are intended to provide unbiased, reliable answers to

questions of patients, families, and community health care providers.

Areas of emphasis:

The Autism Phenome Project

Autism is a developmental brain disorder with a wide range of symptoms that vary in degree of severity. Core deficits include difficulty in communicating, expressing emotion, and relating to others socially. It is one of a broader continuum of five disorders commonly known as autism spectrum disorders (ASD). The Interagency Autism Coordinating Committee (IACC), for which NIMH is the lead Institute, convened a panel of outstanding scientists to assess the field of autism research, and identify roadblocks that may be hindering progress in understanding its causes and best treatment options.

In collaboration with this panel of experts, the IACC developed a matrix (<http://www.nimh.nih.gov/autismiacc/congapprcommrep.pdf>) of short and long term goals toward finding the causes and effective treatments for autism. One goal of the matrix is to develop and launch an autism phenome project. Just as the Human Genome Project identified the sequence and organization of human DNA, the phenome project seeks to identify the various clinical characteristics (phenotype) and subtypes of autism. Identifying specific phenotypic subtypes for autism and autism spectrum disorders will facilitate research on genetic and other potential causes and suggest more specific approaches to treatment.

Re-Adjustment After Military Deployment

American soldiers in Iraq and Afghanistan face unprecedented challenges, not only in theatre but also when returning from deployment. While we have learned much about the risks of post-traumatic stress disorder (PTSD) and other mental disorders from earlier wars, the current engagement involves more women, more National Guard members, more Reservists, and more double deployment than in previous wars. NIMH will be collaborating with the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to study the mental health needs of active duty, National Guard, and Reserve personnel including their transition to VA health services. The goal is to establish representative groups of men and women on active duty or in the

National Guard and Reserves who can be studied longitudinally to assess post-deployment adjustment difficulties, to study the pathophysiology of PTSD and identify biological markers for risk, to determine whether early detection and intervention decreases the occurrence of long-term illness, and to determine what health and economic benefits may result from early intervention. The project will establish a model inter-departmental continuum of care that links administrative and health data for screening, assessment, and referral services that is intended to decrease the risk of developing chronic conditions, including PTSD and depression, as well as disability and death in those with adjustment difficulties.

Antidepressant Use and Pregnancy

A new study funded by NIMH found that pregnant women who discontinue antidepressant medications may significantly increase their risk of relapse during pregnancy. Women in the study who stopped taking antidepressants while pregnant were five times more likely than those who continued use of these medications to experience episodes of depression during pregnancy.

Depression is a disabling disorder that has been estimated to affect approximately 10 percent of pregnant women in the United States. Recently there has been concern about the use of antidepressants during pregnancy; however what has not been addressed is the risk of depression recurrence should someone discontinue antidepressant use. This study sheds light on the risk of relapse associated with discontinuing antidepressant therapy during pregnancy.

Contrary to the belief that hormonal changes shield pregnant women from depression, this study demonstrates that pregnancy itself is not protective. Among the pregnant women who stopped taking antidepressants, 68 percent relapsed during pregnancy compared to 26 percent who relapsed despite continuing their antidepressants. Among the women who discontinued use and relapsed, 50 percent experienced a relapse during the first trimester and 90 percent did so by the end of the second trimester.

This study demonstrates the importance of weighing the risks not only of antidepressant use, but also the risk of relapse should antidepressants be discontinued. It highlights the importance of women



discussing with their physicians their own individual risks versus benefits of continuing antidepressant use during pregnancy.

Research Program on Bipolar Disorder Begin to Build Evidence-Base on Best Treatment Options

Findings from an NIMH research program on bipolar disorder provide much needed long-term data on the chronic, recurrent course of the disorder, and begin the work of building an evidence-base on the best treatments for those with the disorder. Also known as manic-depressive illness because of its recurring episodes of mania and depression, bipolar disorder is a serious, chronic illness which causes shifts in a person's mood, energy, and ability to function.

Today, more than 2 million American adults have bipolar disorder. Its episodic, chronic nature means that in many cases, no single medication or therapy is effective in treating it, making it a complicated puzzle to solve. Typical treatment for bipolar disorder includes both medication and talk therapy. Mood stabilizers are commonly used to even out mood swings, and additional medications are often used to suppress the phases of acute mania and depression and prevent relapse. The newest findings are the first of many analyses which will become available over the coming months as researchers examine the largest dataset ever created on treatment outcomes for those with bipolar disorder.

Little is currently known about the factors that can help predict when a person with bipolar disorder will have a recurrence of manic or depressive episodes. According to the researchers, results indicate that in spite of modern, evidence-based treatment, bipolar disorder remains a highly recurrent, predominantly depressive illness. One strong predictor of recurrence was the presence of residual symptoms (of depression or mania) still present at recovery. This finding may indicate that complete symptomatic remission, i.e., the absence of all symptoms, should be the goal of treatment, as it is in non-bipolar, major depression.

Another important predictor of recurrence in this group of patients was the presence of other psychiatric illnesses. For instance, patients in this group who also suffered from anxiety, eating disorders or substance abuse disorders had a greater risk of depressive symptoms recurring. More research is needed to better understand how these predictors (residual symptoms and other psychiatric illnesses) work to increase the chance of recurrence.

**Fiscal Year 2007
Funding Recommendations**

for the

National Institute on Drug Abuse (NIDA)

National Institute on Drug Abuse (NIDA)

Drug abuse is costly to Americans, tearing at the fabric of our society and taking a huge financial toll on our resources. Beyond its inextricable link to the spread of infectious diseases (e.g., tuberculosis, hepatitis C virus [HCV], and HIV/AIDS), drug abuse is often implicated in family disintegration, loss of employment, failure in school, domestic violence, child abuse, and other crimes. Placing dollar figures on the problem, smoking and illegal drugs cost this country about \$338 billion a year, with illicit drug use alone accounting for about \$180 billion in crime, productivity loss, health care, incarceration, and drug enforcement.

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 these adverse individual, social, health, and economic consequences. As the world’s largest supporter of research on the health aspects of drug abuse and addiction, NIDA brings the force of science to bear in addressing this important national goal. In that regard, a critical component of the Institute’s mission is to strategically support and conduct research across a broad range of disciplines. NIDA then strives to ensure the swift and effective dissemination of the results of that research to significantly improve prevention and treatment efforts. Another part of this mission is to serve as a credible resource for drug abuse and addiction information and to work with both public and private partners to raise awareness and advise policy.

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

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$1,006.7m	\$1,000.0m	\$995.0m	\$1,049.4m

Background

NIDA-supported scientific advances over the past three decades have revolutionized our understanding of and approaches to drug abuse and addiction. Committed to the principle that addiction is a preventable and treatable disease, NIDA works closely with other stakeholders to bring this message—backed by science—to communities across the country. These efforts help to educate and inform diverse populations and to diminish the stigma associated with this disease so that more people can seek treatment.

“The inability to stop drug use is the essence of addiction... It’s like riding in a car with no brakes.”

-Nora Volkow, M.D., NIDA Director

NIDA’s comprehensive research portfolio continues to address the most fundamental and essential questions about drug abuse, ranging from understanding how drugs work in the brain to developing and testing new treatment and prevention approaches to detecting and responding to emerging drug use trends. New knowledge about addiction and the amalgam of biological, behavioral, and social factors that influence it continue to emerge. NIDA uses its ever-expanding Clinical Trials Network (CTN) to test promising research-based approaches with real people in community health settings.

Decades of research progress have positioned NIDA to take advantage of accumulated research findings by applying new tools, techniques, and knowledge that could change the course of drug addiction in this country. Innovative use of brain imaging technologies, for example allow us to literally see into the brains of people addicted to drugs and discover the impact on brain function. Advances in genetics are allowing the identification of genes of vulnerability or protection so that interventions can

be tailored for the greatest impact. Growing knowledge about the dynamic interactions of genes with environment confirms addiction as a complex and chronic disease of the brain with many contributors to its expression in individuals.

NIDA monitors drug use patterns and trends and uses the power of science to prevent emerging drug problems from becoming national epidemics. A long-standing tool in this regard is the annual Monitoring the Future (MTF) Survey, supported by NIDA. Results from the 2005 MTF Survey indicate that over the last 4 years, illicit drug use has continued to decline—down 19 percent for past month use of any illicit drug by 8th, 10th, and 12th graders combined (see figure). While these findings are encouraging, disturbing drug use patterns remain. Another survey, the National Survey on Drug Use and Health (NSDUH), supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), bears this out. It tracks drug use in populations aged 12 and older. Findings from both surveys reveal the following trends:

- In 2004, 19.1 million Americans, or 7.9 percent of the population aged 12 or older, were current illicit drug users;
- In 2005, the proportions of young people having ever tried any illicit drug in their lifetimes were 21 percent, 38 percent, and 50 percent in grades 8, 10, and 12, respectively. In other words, half of the students today have tried an illicit drug by the time they finish high school;
- More than 70.3 million Americans were current users of a tobacco product in 2004. This is 29.2 percent of the population aged 12 or older, most of whom smoked cigarettes;
- Marijuana was the most commonly abused illicit drug in 2004, with a rate of 6.1 percent, or 14.6 million current users. Similar to rates in 2003, there were also 2.0 million current cocaine users (467,000 of whom used crack), 929,000 users of hallucinogens, and an estimated 166,000 heroin users;
- Past year use of Vicodin was 9.5 percent among 12th graders in 2005, ranking it among the most

commonly abused drugs for this group, after marijuana. Past year use of OxyContin was 5.5 percent for 12th graders in 2005, a significant increase from 2002.

To influence these trends, NIDA has continued to support a number of research and dissemination activities over the past year on topics covering prescription drugs, marijuana, methamphetamine, and other drugs of abuse, as well as linkages between drug abuse and HIV/AIDS. Corresponding to emerging trends, new initiatives will target prescription opioid abuse and development of alternative pain-relieving drugs. These and other research priorities are described in the narrative that follows.

NIDA'S Research Priorities

Addiction as a developmental disease. We know now that age matters when it comes to drug abuse: exposure to drugs of abuse during adolescence or childhood may adversely affect brain development and increase vulnerability to drug effects and addiction. With new tools and technologies, NIDA's enhanced capacity to investigate the motivational processes at work in the young brain can provide valuable insight into teen decisions about whether to use drugs and can inform prevention messages and intervention strategies that are more likely to succeed with them. Additionally, the application of high-resolution brain-imaging technologies and new genetic databases to existing data sets (e.g., longitudinal studies of cohorts of children prenatally exposed to drugs) will reveal more about the trajectory of addiction and the contribution of social-environmental factors. Such factors include stress experienced in childhood from physical or sexual

abuse, or poverty. These analyses will help to tailor interventions for those at high risk.

“We must continue the important work aimed at advancing the science and erasing the stigma to solve the problem of drug abuse in this country.”

Nora Volkow, M.D., NIDA Director

Translating knowledge into effective treatments for drug abuse. It is a sad fact that most people who need drug abuse treatment in this country do not receive it. In response, NIDA is creating an infrastructure for translating science into real-world treatment settings—to move evidence-based treatments from “bench to bedside to community.” NIDA is taking an aggressive approach, reaching out to physicians, judges, law enforcement, and other pivotal members of society to educate them about substance abuse disorders, promote a more integrated and compassionate system, and translate research findings into effective community-based prevention and treatment programs. The Institute's landmark Blending Initiative uses NIDA's community research infrastructure and extensive collaborations with SAMHSA and State decision makers to identify needed products and disseminate them to providers for use with their patients. In so doing, this initiative is helping to close the gap between the scientific discovery and community practice.

HIV/AIDS and Role of Drug Abuse, Health Disparities. Drug abuse and HIV/AIDS are intertwined epidemics with daunting health and social consequences. And while intravenous drug use is well known in this regard, less recognized is the role that drug abuse plays more generally in the spread of HIV by increasing the likelihood of high-risk sexual activity with infected partners. This is because of the addictive and intoxicating effects of many drugs, which can alter judgment and inhibition and lead people to engage in impulsive and unsafe behaviors. Drug abuse may also weaken the immune system, causing people to be more vulnerable to infection and to experience a more severe progression of the illness and its consequences.

NIDA's multifaceted response to this problem includes support of research to learn more about the pivotal role of drug abuse in the spread of HIV/AIDS and about the differential impact of both drug abuse



and HIV on racial and ethnic minorities, particularly African Americans.

Prescription Opioid Abuse and Pain. Opioid analgesics, the most powerful medications available for the treatment of most pain conditions, enable many of the estimated 90 million Americans suffering from chronic pain to lead relatively normal and productive lives. However, opioid treatment of pain can also result in negative health consequences, such as intoxication and physical dependence and can sometimes lead to opioid abuse and addiction. Moreover, diversion or illicit acquisition of opioid medications is common: nearly three-fourths of the estimated 6 million people aged 12 and older who reported non-medical use of prescription psychoactive drugs said they abused pain relievers in particular, with young adults (18-25) showing the greatest increases in lifetime use from 2002 to 2004. Even younger populations are involved, as revealed by findings from NIDA's 2005 Monitoring the Future Survey.

To combat these trends, NIDA's new Prescription Opioid Use and Abuse in the Treatment of Pain initiative will solicit a broad range of both human and animal studies from across the sciences. Because opioid medications are prescribed for all age groups, NIDA is encouraging research that assesses the effects of chronic use over the lifespan and elucidates those factors (genetic, biological, and environmental) that predispose patients to, or protect them from, opioid abuse and addiction. NIDA is encouraging research on formulations to reduce abuse potential and diminish intoxicating effects, and on screening and diagnostic tools that primary care physicians can use to assess the potential for prescription drug abuse in their patients.

RESEARCH SPOTLIGHT:
Targeting of New Treatments for Addiction

Since the establishment of a Medications Development Program by Congress in 1992, NIDA has advanced a series of research initiatives aimed at finding medications for people addicted to cocaine, opiates, methamphetamine, marijuana, and other drugs of abuse. This push is particularly important to NIDA, as efforts to enlist the private sector to help develop effective medications have been only partially successful, largely because of financial disincentives for the pharmaceutical companies as well as the continuing stigma associated with medications for treating addiction.

Like anyone suffering from a chronic disease, most addicted patients will require some type of continuing therapeutic support. Fortunately, with a better understanding of the molecular and physiological bases of reward, craving, withdrawal, and relapse phases of addiction, multiple medications offering potentially promising treatments for addiction have emerged. Several are already FDA-approved for other indications.

For example, Modafinil, a treatment for narcolepsy (a sleep disorder), promotes wakefulness and has the added advantage of enhancing memory. Thus, it may be particularly useful for ameliorating the cognitive dysfunction associated with long-term use of stimulants, especially methamphetamine. Substantial research efforts have already revealed the positive effects of combining pharmacotherapy with behavioral treatments.

NIDA's medications development program actively pursues promising compounds by conducting research and clinical trials and by working with pharmaceutical companies to help bring new addiction medications to light. One recent success in this regard stems from the discovery of receptors in the brain and body that bind delta-9-tetrahydrocannabinol (THC), the compound accounting for nearly all of marijuana's pharmacological activities. This discovery set off a race to find the body's natural compounds that could recognize these cannabinoid receptors and influence a range of phenomena, including memory, anxiety, pain, obesity, immunity, brain development, pregnancy—and reward, abuse, and addiction pathways. Using NIDA and other NIH-supported research, the pharmaceutical industry eventually developed a promising cannabinoid receptor antagonist called Rimonabant for the treatment of obesity and other ailments (an antagonist interferes with the action of a substance by combining with and blocking its receptor). Growing evidence suggests that compounds like Rimonabant, which modify the cannabinoid system, may also show promise for treating marijuana addiction and relapse to other drugs of abuse.

NIDA will continue to engage industry and to support development of promising addiction treatments. Ongoing clinical trials to develop and test promising medications will lead to their availability so that people suffering from drug addiction can get the help they need.

**Fiscal Year 2007
Funding Recommendations**

for the

National Institute on
Alcohol Abuse and Alcoholism (NIAAA)

Nation Institute on Alcohol Abuse and Alcoholism (NIAAA)

The National Institution 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.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

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Public Liaison Officer: Fred Donedeo (301) 443-6370

National Institute On Alcohol Abuse and Alcoholism (NIAAA)

APPROPRIATIONS FY 2005	APPROPRIATIONS FY 2006	ADMINISTRATION REQUEST FY 2007	MHLG RECCOMENDATION FY 2007
\$438.5m	\$435.9m	\$433.0m	\$457.1m

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 alcohol abuse. NIAAA funds 90 percent 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. Alcohol 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 ADVANCES

Finding May Explain Link between Alcohol & Certain Cancers

Drinking alcoholic beverages has been linked to an increased risk of upper gastrointestinal cancer and other types of cancer. Researchers looking for the potential biochemical basis for this link have focused on acetaldehyde, a suspected carcinogen formed as the body metabolizes alcohol. Scientists from the NIAAA and the National Institute of Standards and Technology (NIST) report that polyamines - natural compounds essential for cell growth - react with acetaldehyde to trigger a series of reactions that damage DNA, an event that can lead to the formation of cancer. Acetaldehyde's role in the carcinogenicity of alcohol beverage consumption had been suspected,

but this study led to important breakthroughs regarding its involvement. This work provides an important framework for understanding the underlying chemical pathway that could explain the association between drinking and certain types of cancer.

Initiative on Underage Drinking

Underage drinking presents an enormous public health issue. Alcohol is the drug of choice among children and adolescents. Annually, about 5,000 youth under age 21 die from motor vehicle crashes, other unintentional injuries, and homicides and suicides that involve underage drinking. As the lead federal agency for supporting and conducting basic and applied research on alcohol problems, NIAAA is spearheading this initiative to intensify research, evaluation, and outreach efforts regarding underage drinking.

Advances in scientific research have helped to shed light on several important aspects of this problem, and through ongoing and planned studies we will continue to learn about effective prevention and treatment options. At the same time, however, underage drinking rates have remained constant - and unacceptably high - for about a decade. More work remains on all aspects of this problem, a need acknowledged by the Institute of Medicine (IOM) in its recent report on underage drinking.

Anti-Social Syndromes More Common Among People with Substance Abuse Disorders

Data from a recent epidemiologic survey of more than 43,000 U.S. adults show that antisocial syndromes — marked by little concern for the rights of others and violations of age-appropriate societal rules — are more common among people with substance abuse disorders than those without these disorders.

Antisocial personality disorder, conduct disorder, and adult antisocial behavior are characterized by differing degrees or severity of lying, impulsivity, physical aggression, reckless disregard for one's own safety and the safety of others, indifference regarding

pain inflicted on others, destructive behavior, and stealing.

The study by researchers from the National Institute on Drug Abuse (NIDA) and NIAAA, is published in the June 2005 issue of *The Journal of Clinical Psychiatry*.

Helping Patients Who Drink Too Much: A Clinician's Guide

NIAAA released a new guide for health care practitioners to help them identify and care for patients with heavy drinking and alcohol use disorders entitled *Helping Patients Who Drink Too Much: A Clinician's Guide*.

About 3 in 10 U.S. adults drink at levels that increase their risk for physical, mental health, and social problems. Of these heavy drinkers, about 1 in 4 currently has alcohol abuse or dependence. Although relatively common, these alcohol use disorders often go undetected in medical and mental health care settings. When effective methods are used for alcohol screening and brief interventions, however, research shows they can promote significant, lasting reductions in drinking levels and alcohol-related problems.

The 2005 edition of the *Guide* provides a research-based approach to alcohol screening and brief intervention for both primary care and mental health clinicians. It updates earlier NIAAA guidelines, which focused solely on primary care providers and used a lengthier screening process.

In the new *Guide*, alcohol screening is simplified to a single question about heavy drinking days. If a patient drinks heavily (5 or more drinks in a day for men or 4 or more for women), the *Guide* shows how to assess for symptoms of alcohol abuse or dependence. Whether the patient has an alcohol use disorder or is a heavy, at-risk drinker, the *Guide* offers streamlined, step-by-step guidance for conducting brief interventions and managing patient care.



SAMHSA Centers for Substance Abuse Treatment and Prevention

The Substance Abuse and Mental Health Services Administration (SAMHSA) 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, which are described below:

Center for Substance Abuse Treatment — CSAT

The Center for Substance Abuse Treatment (CSAT) 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 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 2007
Appropriations Recommendations for
SAMHSA and Key NIH Institutes

(Dollars in Million)

PROGRAMS	FY 05 FINAL	FY06 FINAL	FY07 ADMIN REQUEST	FY07 MHLG REQUEST
CMHS				
CMHS TOTAL	\$901.3m	\$884.0m <i>(-\$17.3m)</i>	\$848.9m <i>(-\$35.1m)</i>	\$939.6m <i>(+\$55.6m)</i>
Community Mental Health Services Performance Partnership Block Grant	\$432.8m	\$428.5m <i>(-\$4.3m)</i>	\$428.5m <i>(-\$0.1m)</i>	\$451.2m <i>(+\$22.7m)</i>
Children's Mental Health Services Program	\$105.2m	\$104.1m <i>(-\$1.1m)</i>	\$104.1m <i>(+\$0.0m)</i>	\$109.7m <i>(+\$5.6m)</i>
PATH Homelessness Program	\$54.8m	\$54.3m <i>(-\$0.5m)</i>	\$54.3m <i>(+\$0.0m)</i>	\$57.1m <i>(+\$2.8m)</i>
Protection and Advocacy (PAIMI)	\$34.3m	\$34.0m <i>(-\$0.3m)</i>	\$34.0m <i>(+\$0.0m)</i>	\$35.8m <i>(+\$1.8m)</i>
Programs of Regional and National Significance	\$274.3m	\$263.2m <i>(-\$11.1m)</i>	\$228.1m <i>(-\$35.1m)</i>	\$285.9m <i>(+\$22.7m)</i>
Youth Violence Prevention	\$94.2m	\$93.3m <i>(-\$0.9m)</i>	\$75.7m <i>(-\$17.6m)</i>	\$98.2m <i>(+\$4.9m)</i>
Suicide Prevention	\$16.5m	\$31.7m <i>(+\$15.2m)</i>	\$34.7m <i>(+\$3.0m)</i>	\$34.7m <i>(+\$3.0m)</i>
Post Traumatic Stress Disorder	\$29.8m	\$29.5m <i>(-\$0.3m)</i>	\$29.5m <i>(+\$0.0m)</i>	\$31.1m <i>(+\$1.6m)</i>
State Incentive Grant	\$19.8m	\$25.7m <i>(+\$5.9m)</i>	\$19.8m <i>(-\$5.9m)</i>	\$26.8m <i>(+\$1.1m)</i>
Jail Diversion Grants	\$6.94m	\$6.93m <i>(-\$0.01m)</i>	\$6.93m <i>(+\$0.0m)</i>	\$7.2m <i>(+\$0.3m)</i>
Seniors	\$4.96m	\$4.95m <i>(-\$0.01m)</i>	\$4.95m <i>(+\$0.0m)</i>	\$5.2m <i>(+\$0.2m)</i>
Community Technical Assistance Centers	\$1.98m	\$1.98m <i>(+\$0.0m)</i>	\$1.98m <i>(+\$0.0m)</i>	\$2.1m <i>(+\$0.1m)</i>
Community Action Grants	\$0.0m	n/a	n/a	\$1.5m <i>(+\$1.5m)</i>
CSAT				
Block Grant	\$1,775.6m	\$1,757.8m <i>(-\$17.8m)</i>	\$1,758.6m <i>(+\$0.8m)</i>	\$1,851.0m <i>(+\$93.2m)</i>
Programs of Regional and National Significance	\$422.4m	\$398.9m <i>(-\$23.5m)</i>	\$375.4m <i>(-\$23.5m)</i>	\$440.3m <i>(+\$41.4m)</i>
CSAP				
Programs of Regional and National Significance	\$198.7m	\$193.1m <i>(-\$5.6m)</i>	\$180.6m <i>(-\$12.5m)</i>	\$207.1m <i>(+\$14.0m)</i>
NIH				
NIMH	\$1,412.2m	\$1,403.8m <i>(-\$8.4m)</i>	\$1,395.0m <i>(-\$9.2m)</i>	\$1,472.1m <i>(+\$68.3m)</i>
NIDA	\$1,006.7m	\$1,000.0m <i>(-\$6.7m)</i>	\$995.0m <i>(-\$5.0m)</i>	\$1,049.4m <i>(+\$49.4m)</i>
NIAAA	\$438.5m	\$435.9m <i>(-\$2.6m)</i>	\$433.0m <i>(-\$2.9m)</i>	\$457.1m <i>(+\$21.2m)</i>