



APPROPRIATIONS RECOMMENDATIONS FOR FY 2003

FOR THE

National Institute of Mental Health

National Institute on Drug Abuse

National Institute on
Alcohol Abuse and
Alcoholism

AND

Center for Mental
Health Services
and Related
Agencies

M E N T A L H E A L T H L I A I S O N G R O U P

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

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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The Mental Health Liaison Group would like to thank the following individuals — in addition to many others — for their help in producing this booklet.

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M E N T A L H E A L T H L I A I S O N G R O U P

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

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 of Private Practice Psychiatrists
American Counseling Association
American Federation of State, County and Municipal Employees
American Mental Health Counselors Association
American Occupational Therapy Association
American Orthopsychiatric Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association
Anxiety Disorders Association of America
Bazelon Center for Mental Health Law
Child Welfare League of America
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Federation
Corporation for the Advancement of Psychiatry
Federation of Families for Children's Mental Health
International Association of Psychosocial Rehabilitation Services
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 Protection and Advocacy Systems
National Association of Psychiatric Health Systems
National Association of Psychiatric Treatment Centers for Children
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Depressive and Manic-Depressive Association
National Mental Health Association
National Network for Youth
Suicide Prevention Advocacy Network
Tourette Syndrome Association

Mental Health Liaison Group Observer Organizations

American Family Foundation
National Coalition for the Homeless

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Mental Health Liaison Group (MHLG) FY 2003

Appropriation Recommendations for the Center for Mental Health Services

(Dollars in Millions)			
PROGRAMS	FINAL FY 02	FY 03 ADMIN REQUEST	FY03 MHLG REQUEST
CMHS			
CMHS TOTAL	\$832.1m	\$832.1m (0)	\$953.59m (+121.49m)
Mental Health Performance Partnership Block Grant	\$433.0m	\$433.0m (0)	\$495.35m (+\$62.35m)
Children's Mental Health Services Program	\$96.69m	\$96.69m (0)	\$110.61m (+\$13.92m)
PATH Homelessness Program	\$39.9m	\$46.9m (+\$7m)	\$46.9m (+\$7m)
Protection and Advocacy (PAIMI)	\$32.5m	\$32.5m (0)	\$37.18m (+\$4.68m)
Programs of Regional and National Significance	\$230.1m	\$223.1m (-\$7m)	\$263.65m (+\$33.55m)
Youth Violence Prevention	\$95.0m	\$95.0m (0)	\$108.68m (+\$13.68m)
Post Traumatic Stress Disorder	\$20.0m	\$20.0m (0)	\$22.88m (+\$2.88m)
Jail Diversion Grants	\$4.0m	\$5.0m (+1m)	\$5m (+\$1m)
Seniors \$5.0m	\$5.0m (0)	\$5.72m (+\$0.72m)	
Community Technical Assistance Centers	\$2.0m	\$0m (-2m)	\$2.228m (+\$0.288m)
Community Action Grants	\$5.5m	\$0m (-5.5m)	\$6.29m (+\$0.79m)
NIH			
NIMH	\$1,254.0m	\$1,359.0m (+\$111m)	\$1,454.2m (+\$200m)
NIDA	\$890.93m	\$967.90m (+\$80m)	\$1,033.5m (+\$143m)
NIAAA	\$385.9m	\$418.5m (+\$34m)	\$447.7m (+\$62m)

Executive Summary

Mental Health Performance Partnership Block Grant — The principal federal discretionary program for community-based mental health services for adults and children.

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

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

Protection and Advocacy (PAIMI) — Provides services for persons with a significant mental illness or emotional impairment who are inpatients or residents of a facility rendering care or treatment.

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.

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.

Juvenile Justice: Interagency Research, Training and Technical Assistance — Assists state and local juvenile justice authorities in providing state-of-the-art mental health and justice-related services and collaborative programs that focus on children and adolescents.

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

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

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

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.

Training for Teachers and Emergency Services Personnel — Programs provide teachers and emergency personnel with training on mental disorders, as they, in the course of their work often encounter individuals with mental disorders, but lack the training to recognize or respond appropriately.

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

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

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

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.

Assertive Community Treatment — The Center for Mental Health Services should continue investing in dissemination of evidence-based practices, especially assertive community treatment (ACT). ACT is the most well-researched community treatment, rehabilitation, and support model available to people with severe mental illnesses. ACT is particularly effective for people with co-occurring severe mental illness and substance abuse disorders. ACT is effective as diversion from jail and treatment upon release from incarceration. ACT achieves reductions in hospitalization and incarceration because it is an outreach-oriented, treatment team approach that provides services 24 hours a day, 7 days a week. ACT services are comprehensive including direct provision of substance abuse treatment, supported housing and vocational assistance.

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

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

Introduction to the Issue

Mental Health: A Disintegrating System Under Siege

Health and Human Services Secretary Tommy Thompson expressed in a November, 2001 address in New York that the country needs additional resources to fund a well-coordinated network of mental health support to battle the anxiety that follows tragedies.

Snapshot

- Mental illness is the second leading cause of disability and premature mortality in the US.
- 20 percent of the population experiences a mental illness in a given year.
- For about 5 percent of the population, the mental disorder is a severe and persistent mental illness such as schizophrenia, bipolar disorder, or major depression.
- Among adolescents aged 15-19, suicide is the second leading cause of death; overall, there are 30,000 suicides in America every year.
- 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.

Mental Health and Substance Abuse Services

- The Centers for Mental Health Services (CMHS), Substance Abuse Treatment (CSAT) & Prevention (CSAP), in the Substance Abuse and Mental Health Services Administration (SAMHSA), are the primary federal agencies to mobilize and improve mental health 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, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism — three institutes at the National Institutes of Health (NIH) — are the leading federal agencies supporting basic biomedical and behavioral research related to mental illness and substance abuse and addiction disorders.
- An overwhelming body of science demonstrates that: (1) mental illnesses are diseases with clear biological and social components; (2) treatment is effective; and (3) the nation has realized immense dividends from five decades of investment in research focused on mental illness and mental health.

History of Chronic Neglect and Underfunding

- Mental illness is the second leading cause of disability in the U.S., but only 7 percent of all healthcare expenditures are designated for mental health disorders.
- Administration FY 2003 budget includes cuts for several vital CMHS programs for the second year in a row.
- Of the more than \$1 trillion of all U.S. healthcare expenditures in 1997, mental health and substance abuse expenditures represented only 7.8 percent, down from 8.8 percent in 1987. Funding for community-based services in real dollars has declined in recent years.

- Fewer than one-third of adults and one-fifth of children who need mental health services 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.
- Between 50 to 75 percent of incarcerated youth have a diagnosable mental health disorder. Many juvenile detention facilities are not equipped to treat them.

Economic Impact

- 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.**

Shift from Institutional Care to Community-Based Care

- Over the last several decades, the public mental health system has shifted its emphasis from institution-based care to community-based care — a more cost-efficient and effective way to promote recovery among many people with mental illnesses who can go on to live productive lives in the community.
- Approximately two-thirds of state funding for mental health currently goes to provide community services. Similarly, most alcohol and drug treatment services are community-based.
- The U.S. Supreme Court in *Olmstead v. LC* mandates that states develop adequate community services to move people with disabilities out of institutions.
- Without adequate funding, however, efforts to transition people out of institutions and better serve those currently living in our communities will continue to fail.

Mental Health Disparities

- Private insurers typically pay for mental health and substance abuse services at a level far lower than that paid for other healthcare services. That has led to a two-tiered system: a set of privately-funded services for people who have insurance or can pay for their treatment as a result of their disorder; and a public safety net for individuals who have used up all of their benefits or are uninsured.
- Nationwide, mental health services receive about 57 percent of their funding from public sources, while all other health care received only 46 percent of its funding from public sources.

Vanishing Safety Net

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

The Tragedy of September 11th

- The nation's mental health infrastructure was strained before the terrorist attacks. It is certainly unable to cope effectively with the anticipated long-term need resulting from the trauma caused by the terrorist attacks or any future events.
- As an example, the New York Police Department ordered all 55,000 employees, including uniformed officers, to attend mental health counseling to relieve the stress and strain imposed by the attack on the World Trade Center and its aftermath.

New Leadership

- The new Administrator of the Substance Abuse and Mental Health Services Administration is Charles Curie. He was unanimously confirmed by the U.S. Senate on October 25, 2001.
- As Deputy Secretary for Mental Health and Substance Abuse Services at the Pennsylvania Department of Public Welfare, Mr. Curie was instrumental in dramatically reducing the incidence of seclusion and restraint in the state's psychiatric hospitals and expanding community-based treatment options. He was the recipient of a 2000 Innovations in American Government Award sponsored by Harvard University's John F. Kennedy School of Government, the Ford Foundation, and the Council on Excellence in Government.

Recommendations

- We must address the significant unmet need for mental health and substance abuse treatment, early intervention, and prevention, and further the research that fuels new and more effective treatments.
- The Mental Health Liaison Group has proposed a campaign — similar to the doubling of NIH campaign — to increase CMHS funding by 50 percent over the next three years (from \$832 million to \$1,249 million).

Campaign Justification

- Congress and the Administration have singled out mental health services as a critical component of our public health infrastructure.
- Our advocacy for mental health funding increases is compatible with the President's new national priority for FY 2003 of addressing domestic security, including aid for local police and fire departments, and assistance for the public health system.
- With shrinking Medicaid benefits, discretionary federal funding for mental health services will be pivotal to ensure the American people's access to mental health care.
- The transition from institutionalized care to community-based care has never been adequately funded, even though we know that community based care is less expensive than institutional care.
- Undiagnosed and untreated mental and addictive disorders are fueling health care, crime, welfare, and social services costs at unprecedented levels.
- Criminal justice and corrections officials have called for stronger community mental health service systems in order to prevent unnecessary and costly "criminalization" of people with mental illnesses.
- In the words of the Surgeon General's Report on Mental Health, we must "overcome the gaps in what is known and remove the barriers that keep people from . . . obtaining . . . treatments."

Mental Health Services

Fiscal Year 2003
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.” (P.L. 106-310)

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

Substance Abuse and Mental Health Services Administration (SAMHSA)

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

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

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

As a result of these trends, the federal investment in community-based care is growing in importance. For example, the \$433 million in federal funds flowing through the Community Mental Health Services Performance Partnership Block Grant (formerly known as the Community Mental Health Services Performance Partnership Block Grant) administered by SAMHSA's Center for Mental Health Services (CMHS) is an increasingly critical source of funding for state and local mental health departments. Surveys have found that the Mental Health Performance Partnership Grant Program constitutes as much as 39.5 percent of all non-institutional services spending in some states. Moreover, these federal dollars are being used to fund a wider and more diverse array of community-based services.

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

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

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

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

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

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

Programs of Regional and National Significance — As our knowledge of mental illness has steadily increased, Americans’ access to care has paradoxically shrunk. Programs of Regional and National Significance are a catalyst for local communities to improve mental-health service delivery by implementing proven, evidenced-based practices for adults with serious mental illnesses and children with serious emotional disorders. These programs allow state and local mental health authorities to access information and “best practices.” Without these programs, we expand the gulf of time it takes for research to be applied to the field which the Institutes of Medicine estimates to be 10 years.

These programs allow state and local mental health authorities to access information about the most promising methods for improving the performance of programs. Current areas of importance include the criminal justice system, state welfare agencies; increasing support for community-based services through the Mental Health Services Performance Partnership Block Grants; increasing support for programs to treat psychiatric disorders in young people who are victims or witnesses of violence, helping to support new services for persons with co-occurring mental illnesses and addictions disorders, prevention of suicide particularly for children and adolescents, and preventing school violence.

Community Mental Health Services Performance Partnership Block Grant

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$433m	\$495.35m

What Is the Community Mental Health Services Performance Partnership Block Grant?

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

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

Why is the Community Mental Health Services Performance Partnership Block Grant Important?

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

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

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

What Justifies Federal Spending for the Community Mental Health Services Performance Partnership Block Grant?

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

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

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

The Mental Health Liaison Group has prioritized efforts to increase Performance Partnership Block Grant funding and to ensure that the Performance Partnership Block Grant provides evidence-based community services for populations most in need of services. These populations include:

Adults with severe mental illness who:

- have a history of repeated psychiatric hospitalizations or repeated use of intensive community services;
- are dually diagnosed with a mental illness and a substance use disorder;
- have a history of interactions with the criminal justice system; including arrests for vagrancy and other misdemeanors; or
- are currently homeless.

Children with serious emotional disturbances who:

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

Projects for Assistance in Transition from Homelessness (PATH)

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$39.9m	\$45.65m

What Does PATH Do?

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

Why is PATH Important?

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

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

PATH builds upon the previous Community Mental Health Services for the Homeless Block Grant, first authorized in the original Stewart McKinney Homeless Assistance Act, (P.L. 100-77, 1987). In FY 1991, because of a FY 1990 "advance funding" of \$6.904 million, the program's appropriation was \$33.055 million. Reductions to PATH funding, which occurred in FY 1996, were disruptive, and some innovative projects closed as a result. Fortunately, funding increases since FY1998 are steps in the right direction

for PATH, which has increased from \$20 million in FY 1997 to just under \$40 million in FY 2002.

What Justifies Federal Spending for PATH?

The President in his FY 2003 budget highlights the PATH program as a success: "A recent evaluation of SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) found that the formula grant is effective in helping states expand community mental health services, alcohol and drug treatment, and support services for homeless individuals facing a serious mental illness." Increases in federal appropriations for the PATH programs in FY2003 are recommended to reach these CMHS goals:

1. "These funds will allow SAMHSA to reach out to 163,000 homeless individuals in an effort to get them off the streets and into mental health and substance abuse treatment services as well as adequate housing."
2. Maintain at the level of at least 35 percent, the percentage of mentally ill homeless persons contacted who become enrolled clients, even though these persons will be more difficult to engage.
3. Maintain at the level of at least 84 percent, the percentage of participating agencies that offer outreach services to homeless persons with mental illness.

A PATH Success Story

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

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

Comprehensive Community Mental Health Services for Children and Their Families Program

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$96.69m	\$110.61m

What Does The Children's Program Do?

The Children's Mental Health Services Program provides six-year grants to public entities for providing comprehensive community-based mental health services for children with serious emotional disturbances (SED). The program assists states and localities to produce community-based structures, intake procedures and service mechanisms. Direct services provided through these initiatives include: diagnostic and evaluation services; outpatient services provided in a clinic, school or office; emergency services; intensive home-based services for the children and their families; intensive day-treatment services; respite care; 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.

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

Prior to the development of a **system-of-care-approach**, these children were typically underserved or served inappropriately by a fragmented mental health system. In response to these findings, Federal leadership, along with a growing family movement, began to emerge and promote a new paradigm for serving these children 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. 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 service planning and delivery.
- The locus and management of services are built upon multi-agency collaboration and grounded in a strong community base.
- A broad array of services and supports is provided in an individualized, flexible, coordinated manner, and emphasizes treatment in the least restrictive, most appropriate setting.
- The services offered, the agencies participating, and the programs generated are responsive to the cultural context and characteristics of the populations that are served.

The Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) has had the primary responsibility for translating this framework into a program of service and supports that now exists in 67 grant communities around the country.

Why Is The Children's Program Important?

It is estimated that 20 percent, or 13.7 million American children have a diagnosable mental or emotional disorder. Nearly half of these children have severe disorders — only one-fifth of whom are receiving appropriate services (NIMH, 1994). Despite the enormous need, the Children's Mental Health Services Program only serves approximately 50,000 children up to 21 years of age, who are diagnosed with serious mental and emotional disturbances.

According to 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 out-patient 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.

- Forty-three states including California, Kentucky, Pennsylvania and Ohio have implemented a Children's Mental Health Services Program. The programs operate under an innovative "systems of care" approach which coordinates all the public agencies in the state that provide services for each child involved in the program.

What Justifies Federal Spending for The Children's Program?

Since 1993, CMHS has awarded a total of 67 grants in 43 States, which demonstrate the ability to develop integrated, coordinated community-based services for children with serious emotional disturbance. Outcome data for all of the funded sites include the following:

1. 44 percent reduction in the number of children who were convicted of a crime.
2. 31 percent reduction in the number of children in a detention center or jail.
3. 25 percent reduction in the number of children attending school infrequently.
4. 20 percent or greater reduction in the level at which children's mental health or substance abuse problems are disruptive to their functioning at school, at home, or in the community. Children continued to improve to 2 years.
5. At intake, 58 percent of children had grade averages of C or above. By one year into the program, that percentage had risen to 71 percent.
6. 52 percent of children made clinically significant improvements in their behavioral and emotional strengths at 1 year.

The national evaluation data mentioned above show that children and youth enrolled in systems of care grant communities are experiencing noticeable improvements on both clinical and functional measures. In addition, communities and states are making changes in policy based on the successful work of the grantee communities. For instance:

- The city of Philadelphia formed a contract with the State of Pennsylvania to create a city-wide behavioral health managed care organization in which:

- Grant programs pioneered the position of Consultation and Education Specialists-mental health social worker-in 9 schools
- The position is now funded in 80 of the 300 Philadelphia schools
- The school district provides matching funds
- Florida revised a state law to mandate the development of systems of care across the state which:
 - Supports the development of CMHS's Tampa-Hillborough Integrated Network for Kids (THINK) System
 - Includes support for strong involvement of families in service delivery and governance of the system.

Child and Family Profile

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

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$32.5m	\$37.18m

What Does PAIMI Do?

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

During FY 2002, PAIMI programs nationwide addressed 30,000 abuse, neglect, and rights violation complaints. PAIMI staff also provided information and referral services to approximately 60,528 people, and education, training and outreach services to hundreds of thousands more.

Why Is PAIMI Important?

PAIMI staff maintain a presence in facilities that care for people with mental disabilities and investigate and remedy any abuse and neglectful conditions, including sexual assault, excessive restraint and seclusion,

inappropriate use of medication and the failure to carry out treatment programs and provide adequate nutrition. PAIMI staff also assist such individuals in making the transition to community living.

What justifies Increased Federal Spending for PAIMI?

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

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

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

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

Defending the Rights of People with Mental Illness

In a landmark case brought by the Washington P&A to address the long-time egregious abuse and neglect of residents in the state's largest psychiatric hospital, the agency reached a model settlement in 2001, assuring that the hospital provide residents with constitutionally adequate and timely dental and medical care, active treatment and programming, freedom from unnecessary restraint and seclusion, and appropriate discharge planning; it also puts into place systems to prevent physical and sexual assault and procedures for reporting and investigating incidents.

Other P&As have been actively investigating suspicious deaths of persons with mental illness and recommending appropriate reforms to policy and practice. For instance, Iowa is investigating the restraint-related death of an 11-year old boy in a residential treatment center; California has investigated about 20 restraint-related deaths in hospitals and is developing recommendations regarding unsafe restraint practices; and Delaware, Kansas and Illinois have filed wrongful death actions in cases involving particularly outrageous abuses.

Programs of Regional and National Significance (PRNS)

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

The Programs of Regional and National Significance (PRNS) includes the programs in its Knowledge Development and Application Program (KDA), its Targeted Capacity Expansion Program (TCE), as well as a number of other programs. On pages 22 -37, we describe the salient importance of the following PRNS programs:

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

Consumer and Consumer/ Supporter Technical Assistance Centers

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$2m	\$2.228m

What are the Consumer and Consumer/Supporter Technical Assistance Centers?

The goal of consumer and consumer-supported National Technical Assistance Center grants is to provide technical assistance to consumers, families, and supporters of persons with mental illness in two specific areas:

- Explicit training and assistance designed to enhance the skills persons need to be effective participants in policy development, decision-making, and strategic planning, including development of leadership skills; and
- Technical support for the creation and maintenance of a communication network among consumers, families, and supporters that facilitates the flow of information and provides opportunities for sharing lessons learned and good advice among peers.

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

The importance of supporting and promoting consumer-run mental health services was recognized by both the Surgeon General in the 1999 report *Mental Health: A Report of the Surgeon General*,

and in a recently published report by CMHS, entitled *Consumer/Survivor-Operated Self-Help Programs: A Technical Report*. The Surgeon General's report found that consumers in the role of peer-specialists integrated into case management teams led to improved patient outcomes and clients gain from being served by staff who are more empathic and more capable of engaging them in mental health services.

The CMHS report noted that consumer/survivor-operated programs have provided such benefits as coping strategies, role models, support, affordable services, education, and advocacy in a non-stigmatizing setting. In assessing the experience of consumer service programs, the CMHS report also noted that most consumer-run program sites indicated that:

- more training and technical assistance would have contributed to increased successes; and
- respondents felt "hindered by lack of knowledge and that coordinated, comprehensive approaches to meeting technical assistance needs would have been of benefit.

What Justifies Federal Spending on this Program?

As indicated in previous appropriations bills, "these low-cost services have an impressive record of assisting people with mental disorders to decrease their dependence on expensive social services and avoid psychiatric hospitalization." Thus, as a practical matter, funding such national technical assistance centers to advance self-help goals puts mental health care dollars to use where they have significant impact and proven effectiveness.

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

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$20m	\$22.88m

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

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

How can We Address this Problem?

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

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

The Surgeon General, as the nation's chief public health official, has helped the country understand the importance of mental health, and particularly the importance of mental health in children. However, while this country has appropriately invested extensively

in children's physical health and cognitive development, its record of support for healthy mental development has fallen far short. With the alarming phenomenon of children witnessing or experiencing violence in schools, their communities, and even in their homes, we must develop tools to help young people deal with the effects of such trauma, and prevent such exposures from festering into lifelong mental illness. But despite its importance in terms of the likely impact of trauma on youth, we know considerably less about this subject and how best to treat and prevent chronicity than many other areas of children's mental health. Expanding funding would support a broad network of centers of excellence in post-traumatic stress in children and could yield improved evaluation tools and treatment methods for vulnerable children who have been subjected to or have witnessed violence. This program offers the prospect of developing techniques to prevent the onset of mental health problems among youth who have experienced such trauma.

In FY02, an additional \$20 million was provided to this program, of which, \$10 million came from the Emergency Supplemental Appropriation (PL 107-38) in the wake of the September 11th tragedies. The non-emergency \$20 million of appropriated funds supports 27 centers across the country. The \$10 million in emergency supplemental funds increases by that another seven centers, bringing to 34 the number of centers participating in the innovative National Child Traumatic Stress Initiative. Estimates indicate that from 20-40,000 traumatized children and their families will directly benefit from services delivered as a result. Many thousands more will benefit from the improvements in treatment, the proliferation of training opportunities and the many technical, educational and practical information that will be made available from the Initiative's resource center.

Scientists have learned that post-traumatic stress syndrome can often take years to manifest destructively in a trauma survivor's life. For example, following the bombing of the Murrah federal building in Oklahoma, and the school shootings in Columbine, Colorado researchers discovered it frequently took up to three years for stress-related disabilities to overwhelm normal coping mechanisms and erode the survivor's lives through repeated nightmares, panic attacks, pervasive anxiety and diminished ability to function normally in school or the workplace.

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

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$3.0m	\$3.45m

What will the Integrated Treatment Program Do?

The Children's Health Act of 2000 authorized Integrated Treatment grants that will support the start-up of innovative programs directed to the special needs of people with co-occurring serious mental illnesses and addictions disorders. These programs stem from a research base that clearly demonstrates that mental and addictions disorders are often inter-related and that integrated treatment is more effective than parallel and sequential treatment to treat co-occurring disorders. It is necessary to use clinical staff who are cross-trained in the treatment of both kinds of disorder.

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

Why are the Integrated Treatment Grants Important?

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

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

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

What Justifies Federal Spending for Integrated Treatment Grants?

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

In 2000, Congress, recognizing the need to reach this difficult to serve population with the best known treatment, authorized funding for integrated treatment for co-occurring mental health and substance abuse disorders. Unfortunately, the Children's Health Act of 2000 specifically bars states from blending dollars from the Mental Health and Substance Abuse Block Grants to fund integrated treatment programs. It is therefore critically important that Congress direct funding toward integrated treatment to make up for funding that the states cannot provide through their SAMHSA block grant programs.

Juvenile Justice: Aftercare Services for Youth Offenders

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$2.0m	\$2.3m

What Would the Aftercare Services for Youth Offenders Program Do?

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

Grant recipients would:

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

Why is the Program Important?

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

committed minor, non-violent offenses or status offenses, and their incarceration is often the result of systemic problems, including lack of access to mental health services.

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

What Justifies Federal Spending for the Program?

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

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

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

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

Training On Mental Disorders for Teachers and Emergency Services Personnel

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
N/A	\$5.0m

What Would this Program Do?

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

What Justifies Federal Funding for this Program?

As the Surgeon General advised in his 1999 Report on Mental Health, “prevention does work”, and it is vital to intervene early in children’s lives before

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

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

Mental Health Outreach and Treatment to the Elderly

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$5.0m	\$5.72m

What is the Program?

Within the total provided in last year's Labor, Health and Human Services Appropriations bill (P.L. 107-116), \$5,000,000 was allocated for evidence based mental health outreach and treatment to the elderly. By the year 2010, there will be approximately 40 million people in the U.S. over the age of 65 and more than 20 percent of them will experience mental disorders. Only a small percentage of Older Americans who require assistance currently receive specialty mental health services for reasons which include stigma, denial of problems, access barriers, lack of coordination between mental health and aging networks. The funding provided is intended to begin to address this problem.

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;
 - Depression contributes to the high rates of suicide among males in this population; and
 - Schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.
2. Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for mental disorders enjoyed by younger adults, when these interventions are modified for age and health status.
3. Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults. Opportunities are missed to improve mental health and general medical out-

comes when mental illness is underrecognized and undertreated in primary care settings.

4. Treating older adults with mental disorders accrues other benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider's directions and advice, particularly about taking medications.
5. Stressful life events, such as declining health and/or the loss of mates, family members, or friends often increase with age. However, persistent bereavement or serious depression is not "normal" and should be treated.
6. Important life tasks remain for individuals as they age. Older individuals continue to learn and contribute to the society, in spite of physiologic changes due to aging and increasing health problems.
7. Continued intellectual, social, and physical activity throughout the life cycle are important for the maintenance of mental health in late life.
8. Normal aging is not characterized by mental or cognitive disorders. Mental or substance use disorders that present alone or co-occur should be recognized and treated as illnesses.
9. There are effective interventions for most mental disorders experienced by older persons (for example, depression and anxiety), and many mental health problems, such as bereavement.
10. Barriers to access exist in the organization and financing of services for aging citizens. There are specific problems with Medicare, Medicaid, nursing homes, and managed care.

What Justifies Federal Spending for On this Initiative?

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

Suicide Prevention for Children and Adolescents

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
N/A	\$10.0m

What will the Suicide Prevention Program Do?

Congress authorized a program for Suicide Prevention for Children and Adolescents in P.L. 106-310 to support service and training programs in states and communities, with a focus on the needs of communities and groups experiencing high or rising rates of suicide. Programs must meet a number of specific criteria, including requirements that programs be based on the best evidence-based suicide prevention practices, provide culturally competent services, use primary prevention methods to educate and raise awareness in the local community, and include a plan for rigorously evaluating outcomes and activities. Suicide prevention programs are to be integrated with other delivery systems to assure coordinated treatment. Similarly, the legislation specifically requires collaboration among the federal agencies that share responsibility related to suicide, including the Substance Abuse and Mental Health Services Administration, the relevant institutes at the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Administration on Children and Families. Grants, contracts or cooperative agreements are to go to States, political subdivisions of States, Indian tribes, tribal organizations, public organizations, and private nonprofit organizations.

What Justifies Federal Funding for this Program?

Repeatedly over the last several years, the Federal Government has identified suicide as a serious and preventable public health problem. During the 105th Congress both chambers unanimously passed resolutions recognizing suicide as a national problem

and declaring suicide prevention to be a national priority (H.Res. 212, S. Res. 84). 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*. The National Strategy was developed by a broad public/private partnership, and was founded on research conducted over four decades. It lays out 11 Goals and 68 Objectives as a blueprint for tapping and coordinating the efforts and resources of government at all levels and the private sector to prevent or reduce deaths by suicide.

Suicide is the third leading cause of death among children aged 10-14 and among adolescents and young adults aged 15-24. The National Strategy sets numerous objectives aimed at preventing suicide among children and adolescents. These include increasing evidence-based suicide prevention programs in schools, colleges and universities, youth programs, and juvenile justice facilities; promoting training to identify and respond to children and adolescents at risk for suicide; and establishing guidelines for screening and referral (Objectives 4.2, 6.5, 8.3-8.6). Funding the Suicide Prevention for Children and Adolescents program, as authorized by Congress, would provide essential support for States and communities seeking to implement the National Strategy.

Other Suicide Prevention Initiatives

CMHS is the lead agency within SAMHSA for the National Strategy. In the last two years, Congress has earmarked CMHS funds for two specific suicide prevention programs. One provides funding for 3 years to certify, network and evaluate suicide prevention hotlines. This initiative will be important to the National Strategy (Objective 10.4, perform scientific evaluation studies of new or existing suicide prevention interventions). The second provides funds to establish a national suicide prevention technical resource center, a specific recommendation of the National Strategy (Objective 4.8).

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

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
N/A	4.0m

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

In the Children's Health Act (P.L. 106-310), Congress authorized funding to establish Youth Interagency Research, Training and Technical Assistance Centers to assist State and local juvenile justice authorities in providing state-of-the-art mental health and justice-related services and collaborative programs that focus on children and adolescents. This was not funded by CMHS in FY02.

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

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

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

Why is the Program Important?

Among the greatest unmet needs in communities is accessible, high-quality mental health services for children and their families. The dearth of such

resources has meant that behaviors which might have been successfully treated are instead addressed through juveniles justice systems. Those systems are ill-equipped to meet or even recognize the human service needs of children who become housed in juvenile justice facilities. Yet studies have found that the juvenile offender population has an acute need for mental health and substance abuse treatment. Studies show about half of all adolescents receiving mental health services have a co-occurring substance use disorder, and as many as 75-80 percent of adolescents receiving inpatient substance abuse treatment have a coexisting mental disorder. Adolescents with emotional and behavioral problems are nearly four times more likely to be dependent on alcohol or illicit substances than are other adolescents, and the severity of a youth's problems increases the likelihood of drug use and dependence. Among adolescents with co-occurring disorders, conduct disorder and depression are the two most frequently reported disorders that co-occur with substance abuse.

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

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

What Justifies Federal Spending for the Program?

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

Youth Violence Prevention Initiatives

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$95.0m	\$106.68m

What Do the Youth Violence Prevention Initiatives Do?

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 violence prevention and intervention funds to a program entitled the Safe Schools/Healthy Students (SS/HS) Initiative. This Initiative provides three-year grants to local school districts to fund programs addressing school violence prevention through a wide range of early childhood development, early intervention and prevention, suicide prevention, and mental health treatment services. The 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).

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:

- Developing and maintaining a safe school environment;
- Alcohol and other drug and violence prevention, and early intervention programs;
- School and community mental health preventive and treatment intervention services;
- Early childhood development and psychosocial development programs;
- Educational reform; and
- Safe school policies.

Other Youth Violence Prevention Initiatives

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

- **School and Community Action Grants** to build community consensus and collaboration as

well as pilot an evidence based program to promote healthy childhood development and prevent youth violence.

- **A SS/HS Technical Assistance Center** that provides technical assistance to all SS/HS grantees in order to help them attain their goals of inter-agency collaboration and adoption of evidence-based on practices to reduce school violence and substance abuse and promote the health 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.

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

Why Is Additional Federal Funding Justified?

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 recent 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.

As CMHS' major school violence prevention program, the initiative was started in 1999. In fiscal years 1999 and 2000, grants were made to 77 school districts across the country. In FY 2001, 20 new grantee sites were funded and the initiative covered 97 local educational agencies across the nation. CMHS is planning to fund an additional 45 sites in FY 2002.

However, applications exceed current funding limits. With additional funds in FY 2003, CMHS could reach more unserved communities through the *Safe Schools/Healthy Students Initiative* and the *School and Community Action Grants*.

Emergency Mental Health Center Grants

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$9.0m	\$10.30m

What are Emergency Mental Health Centers?

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

Why are Emergency Mental Health Centers Important?

While mobile crisis teams have proven highly successful in many communities, they are unavailable in most areas of the United States. These mobile services often obviate the need for the involvement of police or other emergency services, providing a more effective

intervention when an individual in crisis is not in immediate danger. In addition, access to emergency mental health centers is inadequate in some communities — particularly in rural areas.

EMERGENCY RESPONSE INITIATIVES

Why Is an Emergency Response Capability Important?

Communities across the country are grappling with volatile issues like adolescent suicide and youth violence in the face of lack of access to culturally appropriate, quality care for youth with serious mental, emotional, behavioral, or substance abuse problems. Such problems can create real emergencies for communities. And many such communities and advocates alike recognize that local emergency situations can create a need that the deliberative, methodical competitive grant process cannot meet in a timely way. It is important in what amount to life-or-death circumstances to provide avenues to respond relatively quickly to well designed community efforts to cope with local crises. Providing start-up funds for this contingency mechanism will provide critical help to desperate communities, and potentially avert serious jeopardy.

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

Improving Mental Health and Child Welfare Services Integration

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
N/A	\$10m

What is the Program?

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

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

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

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

It is estimated that 85 percent of the 568,000 children living in foster care today in the U.S. have a developmental, emotional, or behavioral problem. Most of these children have experienced abuse and/or neglect and are at high risk of emotional, behavioral, and psychiatric problems. Upon entering foster care some children already have a diagnosed serious emotional disturbance and require significant services. In addition, all children who are separated from their families experience some trauma and may require mental health services.

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

What Justifies Federal Spending on this Initiative?

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

Jail Diversion Program Grants

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$4.0m	\$5m

In the course of the next year, almost three-quarters of a million people with psychiatric illnesses will find themselves in jails or prisons. That's ten times more people than are in state psychiatric hospitals. Mental health officials, criminal justice professionals, police officers and judges believe that nearly all these arrests and incarcerations are unnecessary and could be avoided if appropriate resources were available to the criminal justice system and more community mental health services were available. Jail Diversion programs will help those coming out of jail or diverted from jail get linked to key housing, medical, and employment services that will keep them out of jail in the future. It is a fact that in most large cities, a person with a mental illness coming out of jail is released in the middle of the night with nothing more than a bus token and no medications or referrals to services. Not surprising, most are rearrested within 30 to 60 days for another minor violation and re-incarcerated. Award winning programs like the one at Thresholds, a psychiatric rehabilitation program in Chicago, Illinois, showed a dramatic reduction in recidivism and hospitalizations when people with mental illness were connected to services and treatment when being discharged from jail. For example, post jail referral of just four individuals with mental illness from the Cook County jail in Chicago to Thresholds cut recidivism from a total of 554 jail days during the two years prior to receiving services at Thresholds to 138 jail days during the two years after receiving services at Thresholds--a 75 percent reduction. Thresholds received the Gold Achievement Award in 2001 by the American Psychiatric Association for their work on jail diversion. SAMHSA is also working with other federal agencies such as the Department of Justice program that funds mental health courts. These courts are successful in Broward County, FL, King County, WA and other jurisdictions. Jail diversion programs coupled with mental health courts would take immense pressure off crowded prisons and jails

and generate better treatment and care for people with psychiatric illnesses. Last year Congress approved \$4.0 million to develop and expand effective jail diversion programs like the one at Thresholds in Chicago. In his FY 2003 budget, the President recognized the growing need for these programs and requested a \$1 million increase for jail diversion funding to \$5.0 million. It is time to break the cycle and end this revolving door of non-treatment and injustice.

"The need for more ... community-based facilities is not at issue. (T)he (psychiatric) beds have disappeared: The District has lost 92 percent, Maryland 86 percent and Virginia 84 percent, all since 1955. There has not been a corresponding drop in the number of mentally ill, nor, for that matter, an analogous increase in community-based treatment facilities. The difference between now and then is that today the final destination of the mentally ill tends to be the criminal justice system, where costs are greater, the treatment setting is wrong and where there is a substantial probability the sick will be returned to the community without medication or rehabilitation programs to keep them out of trouble or from a return trip to jail."

"As a society, we know better. Seriously mental ill people, especially those who commit minor offenses, don't need precinct holding cells or jails with untrained corrections officers. They should be diverted to mental health treatment. We know that, but we don't do it. We know that society is better off when the mentally ill are helped rather than turned out on the streets to re-offend, but we don't provide the help. We know what works and what doesn't; what helps and what hurts. But we don't act. There's no excuse for that."

Criminalizing the Mentally Ill
— Washington Post Editorial
Tuesday, December 18, 2001

Statewide Family Network Grants

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$4.3m	\$4.91m

What Do the Statewide Family Networks Do?

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

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

Why Are Statewide Family Network Grants Important?

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

Statewide Family Networks are critical to achieving full participation of families in planning, designing, implementing and evaluating services for children with emotional, behavioral, or mental disorders. Over the past 15 years, there has been increasing evidence

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

Evidence of Effectiveness

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

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

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

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

State Data Infrastructure

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$6.0m	\$6.9m

What Is the Data Infrastructure Development Program?

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

Why Is the Data Infrastructure Development Program Important?

The development of performance and outcomes measures is a key component of evaluating and improving service delivery. Mental health performance measures provide states with the tools needed to more effectively award and monitor contracts with managed care and other providers, ensure quality while containing costs, and allocate resources most efficiently.

What Justifies Federal Spending for the Data Infrastructure Development Program?

Congress has recognized the importance of developing performance goals, rather than arbitrary process requirements, as a condition of participation in federal programs. Within the arena of mental health service delivery, the Children's Health Act of 2000, which converts the Community Mental Health Services Block Grant into a "performance partnership," requires HHS, in conjunction with states and other interested groups, to develop and submit plans for "creating more flexibility for states and accountability based on outcome and other performance measures." The development of such a plan will help the states and the federal government achieve shared goals including, but not limited to, quality improvement, expanding access to community-based mental health services, and increased accountability. Unfortunately, many states lack the capacity to adequately collect and analyze the data needed to make such a performance partnership effective. To the extent the federal government requires as part of the new performance partnership relationship enhanced data reporting, it would be appropriate for the federal government to contribute funds to help the states meet this burden. So doing would facilitate the success and effectiveness of the performance partnership goals of the Block Grant without diverting scarce resources from service delivery.

Community Action Grants

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$5.5m	\$6.29m

What are Community Action Grants?

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

Why are Community Action Grants Important?

As our knowledge of mental illness has steadily increased, Americans' access to care has paradoxically

shrunk. Community Action Grants are a catalyst for local communities to improve mental-health service delivery by implementing proven, evidenced-based practices for adults with serious mental illnesses and children with serious emotional disorders. Discontinuing these grants has the potential to hinder the *Olmstead* process, since these grants are designed to implement effective community-based services.

What Justifies Federal Spending on this Program?

The Community Action Grants Program builds community-based consensus for adoption of identified exemplary mental health service delivery practices, and provides technical assistance to spur adoption into practice, and synthesizes and disseminates new knowledge about effective approaches to the provision of comprehensive community-based services to persons with serious mental illnesses.

CMHS Direct Operations

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$13.2m	\$15.18m

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

What Is the CMHS Direct Operations Program?

CMHS has leadership responsibilities in policy development, data collection and analysis, and stewardship of federal resources. CMHS plays a critical leadership role in the development and dissemination of effective service delivery. The volume of CMHS programs and oversight responsibilities of the states, require, at the very least, an adequate staffing for each statutory function. Regrettably, this has not been the case since CMHS was established in 1992. Adequate staffing for the Center for Mental Health Services (CMHS) should be a priority in FY 2003 appropriations for mental health services.

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

- **Administering** the Mental Health Services Block Grant, including: compliance reviews and evaluations of the state block grant implementations;
- **Administering** the Children's Mental Health Services Program competitive grant and the

newly authorized Children & Violence programs that include School-based Violence Prevention as well as Children and Trauma grants;

- **Conducting Studies and Assisting States** on managed care and Medicaid services including capitation rates and outcomes measurements. This is especially important with over 22 Section 1115 waivers to the states;

Assuring quality services to underserved areas and populations, including: women, minorities, elderly, and those living in rural areas;

What Justifies CMHS Direct Operations Spending?

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

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

Mental Health Research

Fiscal Year 2003
Funding Recommendations

for the

**National Institute of Mental Health
National Institute on Drug Abuse, and
National Institute of 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).

Understanding the Line Item Recommendations: The Difference Between Research, Research Training, and Management and Support

Research

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

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

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

Research Training

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

Management and Support

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

Mental Health Liaison Group (MHLG) FY 2003

Appropriation Recommendations for Mental and Addictive Disorder Research at the NIH

	(Dollars in Millions)		
	FUNDING FY 2002	PRESIDENT'S BUDGET FY 2003	PROFESSIONAL JUDGEMENT BUDGET FY 2003
NIMH			
Research*	\$1,146.514	\$1,245.650	\$1,329.956
Research Training*	54.886	56.423	63.668
Research Management/ Support*	52.250	56.935	60.610
TOTAL	\$1,254.0	\$1,359.008	\$1,454.234
NIDA			
Research	\$825.552	\$897.879	\$959.149
Research Training	17.988	18.564	19.800
Research Management/ Support	44.193	48.170	50.822
TOTAL	\$890.93	\$979.90	\$1,033.5
NIAAA			
Research	\$355.934	\$386.352	\$412.883
Research Training	9.547	9.842	\$11.075
Research Management/ Support	20.465	22.293	\$23.740
TOTAL	\$385.946	\$418.5	\$447.7

Note: Some numbers do not "add up" because each line item has been rounded, dollars in millions.

* See following pages for explanation of these categories.

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

Mental Health Research

Fiscal Year 2003
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 burden of mental illness through research on mind, brain, and behavior. This public health mandate demands that NIMH harness powerful scientific tools to achieve better understanding, treatment, and eventually prevention and cure of mental illness.

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

NIMH is one of 25 components of the National Institutes of Health (NIH), the principal biomedical and behavioral research agency of the United States Government and part of the U.S. Department of Health and Human Services. Authorized in 1946, NIMH is one of the earliest NIH Institutes.

National Institute of Mental Health (NIMH)

Acting Director: Richard K. Nakamura, Ph.D. (301) 443-3675

Office of Legislative Analysis and Coordination

Director: Gjemma Weiblinger (301) 443-3673

National Institute for Mental Health (NIMH)

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$1254.0m	\$1454.2m

Mental Health in America

The National Institute of Mental Health (NIMH) leads the Federal effort to identify the causes and most effective treatments for mental illnesses. At this moment in history, there is a unique opportunity: Never before has the alliance of different areas of science and their related technologies offered such hope of achieving a better understanding of the defining features of our humanity: the brain and the behavior it controls. These findings will certainly help us to alleviate the pain and suffering of millions of Americans by reducing the impact of mental disorders on them and their families, on our healthcare system and on our economy.

Diseases such as schizophrenia, depression, autism, Alzheimer's disease, bipolar disorder, attention deficit hyperactivity disorder, personality disorders, and a broad array of other psychiatric disorders affect an estimated 22.1 percent of Americans ages 18 and over — about 1 in 5 adults suffers from a diagnosable mental disorder in a given year. This figure translates to 44.3 million people. In addition, 10-12 percent of children and adolescents have mental and behavioral conditions that need treatment. Many people suffer from more than one mental disorder. The most severe disorders affect nearly 5 million adults, and they can destroy the lives of their victims and devastate those who love them.

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

percent of disability worldwide. In the developed Nations major depression is second only to heart disease in life-years lost from illness. By 2020, it will be the second leading cause of disability in the world.

By the late 1990's, health care expenditures for mental disorders reached \$70 billion, about 7 percent of the total annual health care expenditures or about \$95 billion was lost to the economy due to reduced productivity associated with mental illness. Other costs amounted to about \$15 billion. Added together, the total cost to our economy from mental disorders is estimated at **\$180 billion** per year. In practical terms, recent research has shown that depressed employees take twice as many sick days and the likelihood of decreased performance on the job is seven times as high.² This is a hidden cost that results from reluctance to report mental illness as a legitimate reason for sick leave.

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

The Surgeon General Satcher's four recent reports: "Mental Health: A Report of the Surgeon General," a "National Action Agenda for Children's Mental Health," "The Surgeon General's Call To Action To Prevent Suicide," and "Youth Violence: A Report of the Surgeon General" have drawn attention to the need for more research on mental illnesses and the harm that stigma causes to those suffering from mental illnesses. On the strength of conclusions that mental disorders are real illnesses that impose an immense cost on our Nation, and that treatments of well-established efficacy exist, Dr. Satcher urged Americans who are experiencing mental health problems or who have a mental disorder to seek help. The recognition of mental illnesses in children also

¹ The Global Burden of Disease. A Comprehensive Assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020. (Murray CL, Lopez AD, eds. World Health Organization, World Bank, Harvard University, 1996.)

² May 2001 Am J Psychiatry

has helped to make all mental illness more accepted and understood.

The terrible events of September 11, 2001 have focused a spotlight on trauma and its aftereffects, including mental illnesses such as posttraumatic stress disorder and expanded the dialogue among Americans about treatment. NIMH has been actively involved on many fronts in the aftermath of the attacks. Staff members have played key roles in coordinating with other agencies and officials throughout the Government, directly reaching out to individuals involved in the disasters as well as the American public. Previous NIMH research has increased our understanding of the mental health consequences of traumatic events, including natural disasters and human-caused events, and efforts are underway to enhance existing epidemiological and clinical research studies by adding questions relevant to the impact of the recent disasters.

In 2003, NIMH intends to focus on several new initiatives to create tools and technology: (1) The creation of an expert Schizophrenia Cognition Measurement Development Group. Cognitive impairment, rather than delusions and hallucinations, may be the major determinant of functional outcome in people with schizophrenia. Without measurement consensus, the Food and Drug Administration cannot recognize cognition as a valid treatment endpoint for industry-sponsored research and drug registration. NIMH also will support a Cognition Treatment Network to identify, evaluate, and acquire pharmacological agents to treat cognitive deficits in schizophrenia and related psychoses. The overall goal of the network is to conduct phase II clinical trials. (2) Funding a Depression Measurement Development Group. Broad scientific consensus will be sought to define elements of a standardized NIMH depression assessment tool along with procedures for ensuring reliable administration of the tool in clinical treatment trials. (3) Developing new ways to process and interpret data, and make them accessible. Advances are leading to the accumulation of vast quantities of data. For example, in genome research, new tools and technology will enable the exploration of neurobiological phenomena on a scale not previously possible (i.e., all genes in a genome, all transcripts in a cell, all metabolic processes in neural tissue).

In the area of treatment studies, NIMH will focus in 2003 on combination treatments and interventions in all age groups from adults and older individuals to children in diverse populations. NIMH is already supporting large-scale clinical trials exploring the use

of combination treatments (used in standard practice) for some subtypes of mental disorders, e.g., bipolar depression. The institute would extend those efforts to include a range of treatment modalities across the breadth of mental disorders. In young children, who by definition are in a state of rapid change and growth, psychotropic medications are being prescribed that lack both long-term safety and efficacy data, raising significant public health concerns. With rare exceptions, psychotropic medications have not been tested on children under age 6, and many have not been tested on children under age 16. NIMH has initiated studies to test sequenced treatments for attention deficit hyperactivity disorder in preschool and school-age children. However, there are many other disorders that would benefit from expansion of this research. NIMH will also expand studies to test the efficacy and safety of interventions for children with autism. Treatments with promising results in the pilot phase will be directed toward full clinical trials over the next several years. NIMH is particularly committed to expanding the portfolio of psychosocial/behavioral treatment research in autism.

Success Story

Royal Riddick's Story: Mr. Riddick is a single-parent and a Vietnam Veteran. His struggle with bi-polar disorder and post traumatic stress disorder was a downward two-year event. Mr. Riddick suffered from manic and aggressive behaviors, blackouts, and suicidal behavior. He had frequent job changes and unemployment, finally culminating in homelessness, multiple hospitalizations and his daughter being removed from his custody and placed in foster care.

His treatment is a combination of medication and psychotherapy. He credits his doctors at the Veterans Administration with being able to give him access to state of the art medications and ancillary services which allowed him to go from the street, to a shelter, finally his own apartment and the ultimate return of his daughter. Mr. Riddick is successfully employed with NAMI as a national trainer and coordinator for a public education program to de-stigmatize mental illness. He says, "Not only did I have to have to accept my illness, I also had to accept the steps I had to take to recover. I feel like I am light years away from the despair created by my illness."

Mental Health Research

Fiscal Year 2003
Funding Recommendations

for the

National Institute on Drug Abuse (NIDA)

National Institute on Drug Abuse (NIDA)

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

National Institute on Drug Abuse (NIDA)

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Office of Science Policy

Associate Director: Timothy Condon (301) 443-6036

National Institute On Drug Abuse (NIDA)

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$890.93m	\$1033.5m

Background

The National Institute on Drug Abuse (NIDA) supports over 85 percent of the world's research on all drugs of abuse, both legal and illegal, with the exception of alcohol. NIDA addresses the most fundamental and essential questions about drug abuse, ranging from detecting and responding to emerging drug use trends to understanding how drugs work in the brain to developing and testing new treatment and prevention approaches. The ultimate aim of our Nation's investment in drug abuse research is to enable society to prevent drug abuse and addiction, and to reduce the adverse individual, social, health, and economic consequences associated with drugs. NIDA is making great progress toward this end.

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

Directly or indirectly, we are all affected by drug abuse and addiction. The fact that more than 14 million Americans were current users of illicit drugs (marijuana, cocaine, heroin, hallucinogen and inhalants) in 2000, over half (54 percent) of Americans have tried an illicit drug by the time they finish high school, and close to one million high school students used MDMA or “ecstasy” last year, demonstrates the widespread problem that NIDA's portfolio must continue to address.

Drug abuse is also very costly at many levels. At the economic level, the cost of illegal drugs to our Nation was estimated to be a staggering \$161 billion in 2000. When one adds the cost of the Nation's deadliest addiction — use of tobacco products, the cost soars to

nearly \$300 billion annually. Beyond these tremendous economic costs are the societal costs. Illicit drug use is inextricably linked with the spread of infectious diseases such as HIV/AIDS, tuberculosis, and hepatitis C, and is also associated with domestic violence, child abuse, and other violent behavior.

NIDA's Research Priorities

NIDA's scientific portfolio continues to be grounded in basic neuroscience research. NIDA is very interested in identifying basic research discoveries in the field of drug abuse research, and related disciplines, and translating these basic research findings into clinical and research tools, medications and treatments. Examples of how NIDA is facilitating the use of basic findings into other areas of its portfolio abound. For example, NIDA's new prevention, treatment, and nicotine initiatives are all grounded in basic science research.

NIDA is ushering in a new era of prevention research. NIDA is bringing together a broader array of scientific disciplines to determine the most effective ways to reduce drug use in this country. By bringing together basic, clinical, and applied researchers, NIDA will be in a better position to develop and implement more effective preventive strategies at the individual, family and community levels. NIDA's multi-pronged approach outlined in its National Prevention Research Initiative (NPRI) will include the creation of Trans-disciplinary Prevention Research Centers modeled after the successful centers established through collaboration with NIDA, NCI and the Robert Wood Johnson Foundation to address the problem of tobacco use. The Prevention Centers will bring researchers and practitioners together to tackle unanswered research questions, such as how the adolescent decision-making process occurs and how we can use the media and other communication strategies to reach adolescents. The Initiative also includes a basic neurobiology component, as well as the establishment of multi-site prevention trials that will test the effectiveness of drug abuse prevention programs in diverse populations across the country and encourage the local adoption of programs that are vigorously evaluated.

NIDA also plans to broaden its treatment portfolio even further, by expanding the National Drug Abuse Treatment Clinical Trials Network (CTN) to even more of our Nation's communities. This infrastructure, established in 1999, is now enabling us to move treatment research into practice throughout the

United States. NIDA will continue to increase the number of research treatment protocols and patients participating in the geographically dispersed research centers that comprise the CTN. In FY 03, NIDA plans to expand the reach of the CTN to new populations and regions underrepresented in the health care system, including individuals who have co-morbid mental illnesses, those suffering from HIV/AIDS or other infectious diseases, and court-diverted populations. NIDA also plans to establish CTN nodes into regions of the country that may not have easy access to quality treatment and/or are not currently part of the CTN structure.

To ensure that we continue to have a pipeline of safe and effective medications to bring to the CTN, several new medications will begin Phase III Clinical Trials through NIDA's Medications Development Program. NIDA will begin Phase III studies this year on two medications (selegiline and disulfiram) that are showing great promise in treating cocaine addiction.

Another major priority area for NIDA will be to further explore the link between stress and drug abuse. As our Nation continues to recover from the terrorist attacks that occurred in September 2001 and to cope with the fear of ongoing threats against our country, NIDA will expand its research portfolio to further examine the role that stress plays in the initiation and reinstatement of drug use. At the basic research level, NIDA will examine the role that both acute and chronic stress play in changing circuitry in the brain that in turn affects behavior. Epidemiologists, ethnographers, and prevention researchers will be looking more closely at drug use prevalence rates following the September attacks.

NIDA will also continue to support research that helps to reduce the burden of tobacco-related diseases. Recognizing that it is addiction to the drug nicotine that drives the continued use of tobacco in this country and abroad and that smoking cessation remains among the most cost-effective approaches to reducing cancer and cardiovascular disease risk, NIDA will work with the National Cancer Institute (NCI) and other NIH institutes to identify promising new compounds that can be developed and tested in clinical trial settings.

Other key research priorities for NIDA include: using rapidly developing technologies such as microarrays and neuroimaging to discover the mechanisms underlying the transition from use to addiction; studying the genetic and environmental components of vulnerability to addiction; predicting, preventing, and combating emerging drug problems, such as increases in use of "club drugs" and the abuse of

prescription drugs, such as Oxycontin; developing new behavioral treatments for addiction; supporting research that focuses on children and adolescents; reducing health disparities; determining the most effective ways to integrate drug abuse treatment and the criminal justice system; and understanding the developmental consequences of prenatal drug exposure, particularly for emerging drug problems such as MDMA (ecstasy) and methamphetamine.

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

Advances in Science

Marijuana Use in Early Adolescence Can Lead to Psychiatric Problems as an Adult. There's an age-old question in the addiction and mental health arena: Which comes first — the drug use or the psychiatric disorder? In both clinical and general population samples of adolescents and adults, psychiatric disorders have been found to be related to drug use. A recent study investigating the link between marijuana use, depressive symptoms, anxiety, and interpersonal aggression was conducted using two sets of interviews two years apart with over 2,200 Colombian teens between the ages of 12 and 17. Trained interviewers talked to adolescents in their homes in three Colombian cities, obtaining information about frequency of marijuana use and symptoms of anxiety and depression. They then performed two sets of analysis. Unlike other studies, this study did not find that anxiety and depression led to increased marijuana use. Instead, the researchers found that marijuana use in early adolescence is associated with higher levels of anxiety, depressive symptoms, and interpersonal aggression in late adolescence all of which may persist into adulthood. This suggests that at certain stages of adolescent development, drug use should be considered a risk factor for the later development of psychiatric disorders and problem behaviors, as well as the inability to assume adult roles in society.

Mental Health Research

Fiscal Year 2003
Funding Recommendations

for the

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

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

- conducting and supporting research directed at determining the causes of alcoholism, discovering how alcohol damages the organs of the body, and developing prevention and treatment strategies for application in the Nation's health care system;
- supporting and conducting research across a wide range of scientific areas including genetics, neuroscience, medical consequences, medication development, prevention, and treatment through the award of grants and within the NIAAA's intramural research program;
- conducting policy studies that have broad implications for alcohol problem prevention, treatment and rehabilitation activities;
- conducting epidemiological studies such as national and community surveys to assess risks for and magnitude of alcohol-related problems among various population groups;
- collaborating with other research institutes and Federal programs relevant to alcohol abuse and alcoholism, and providing coordination for Federal alcohol abuse and alcoholism research activities;
- maintaining continuing relationships with institutions and professional associations; with international, national, state and local officials; and voluntary agencies and organizations engaged in alcohol-related work; 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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Office of Policy, Legislation and Public Liaison

Director: Geoffrey Laredo (301) 443-9970

National Institute On Alcohol Abuse and Alcoholism (NIAAA)

APPROPRIATIONS FY 2002	MHLG RECOMMENDATION FY 2003
\$385.9m	\$447.7m

Background

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

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

Alcohol misuse is associated with increased risk of accidents and injuries including motor vehicle crashes, suicides, domestic violence, child abuse, fires, falls, rapes, robbery and assaults. Almost 25 percent of victims of violent crime report that the offender was under the influence of alcohol. Homicides are even more likely to involve alcohol (at 50 percent) than less serious crimes, and the severity of injuries is also increased. In addition, 67 percent of all domestic attacks involve alcohol. For juvenile populations, alcohol has an equally severe impact. Alcohol-related traffic crashes are the number one leading cause of teen deaths, and is also involved in homicides and suicides, the second and third leading causes of teen deaths respectively.

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

NIAAA SCIENTIFIC ADVANCES

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

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

impulsive behaviors researchers measured — signs like nicotine and drug dependence, antisocial personality disorder, and behavioral conduct disorder — predicted which 11-year-olds would try alcohol by age 14. This indicates that these behaviors pre-dated the early drinkers' alcohol use, strengthening the case for a common vulnerability that underlies a range of problems, including both early drinking and alcoholism.

Even though these findings suggest a common basis for an array of problems, they don't necessarily exclude early drinking itself as a factor that contributes to development of alcoholism. In addition, young people who drink are at risk of the harm associated with drunk driving, risky sexual behavior, and violence, regardless of why they drink. Other research also suggests that alcohol interferes with neurological development in adolescents. For these and other reasons, preventing children from drinking remains paramount. The challenge these findings raise for researchers is to definitively establish that there is a common basis for the wide range of problems examined in this study and to identify the mechanisms that underlie it. In so doing, they will identify potential targets for pharmaceutical or behavioral interventions.

Choline, Growth Factors Prevent Alcohol's Brain Damage in Mammal Fetus

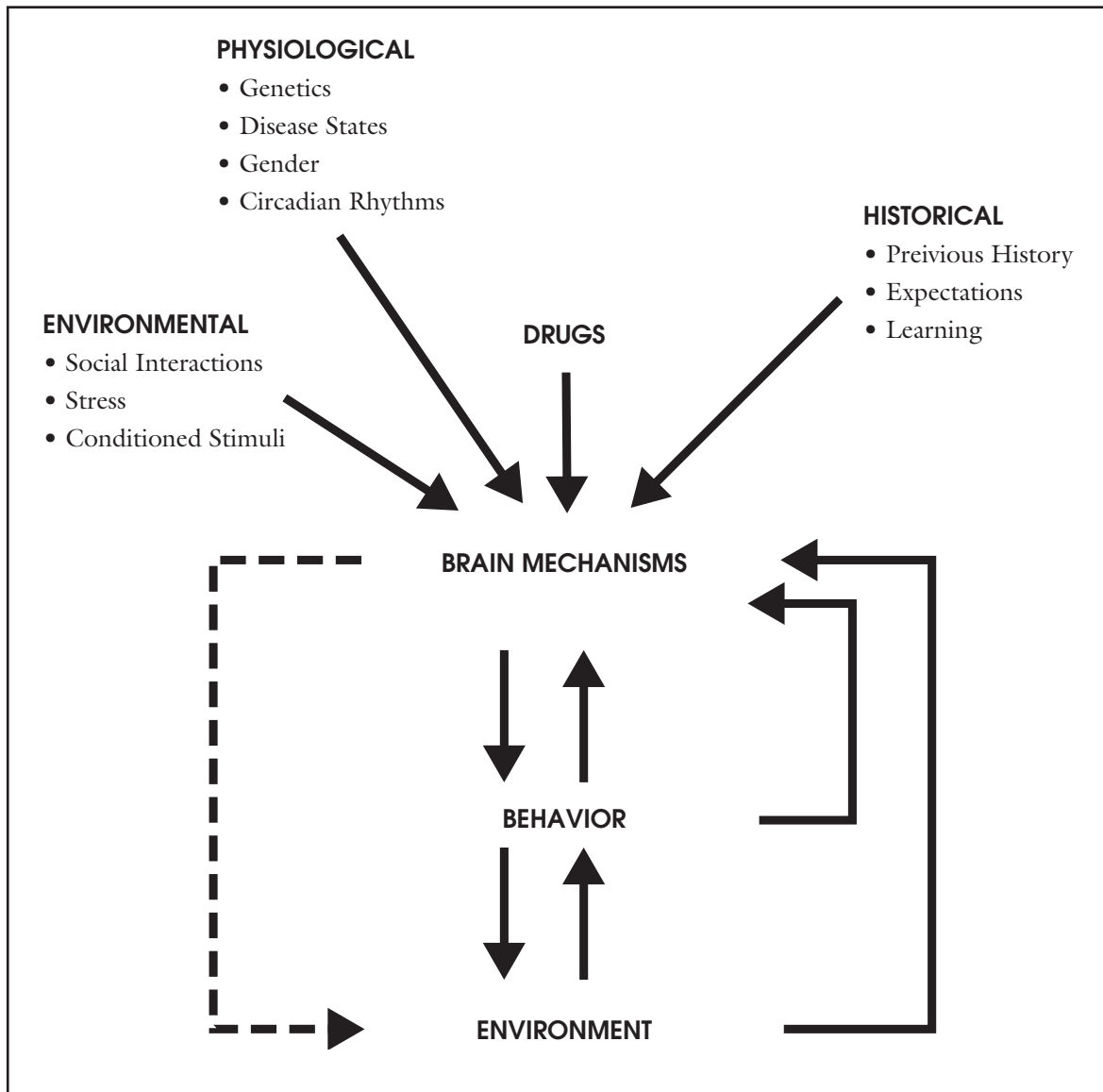
Alcohol is, by far, the greatest inducer of birth defects, compared with any of the illegal drugs in use today. It causes fetal alcohol syndrome (FAS) in some children of women who drink during pregnancy, which results in life-long, debilitating neurological damage and behavioral deficits. At present, no treatments exist for infants exposed to alcohol through maternal drinking. Two new findings suggest potential avenues

for treating FAS children while they're still in the uterus or after birth.

For the first time in a living mammal model, scientists have shown that genetic manipulations that increase production of nerve growth factor protect a fetal brain region normally sensitive to damage from alcohol. Nerve growth factor is among the substances that regulate survival of fetal brain cells and their differentiation into specialized cells of the nervous system. Alcohol interferes with these developmental processes. Increasing other neurological growth factors may prove to protect other alcohol-sensitive fetal brain regions. If we find that this is the case, we may be able to develop therapeutic **in-utero** treatments that maintain effective levels of these growth factors.

Scientists also have new evidence, in an animal model, that it may be possible to offset at least some of the neurological deficits of FAS **after** birth. Scientists fed pregnant rats alcohol, then gave their offspring supplements of choline — an essential nutrient, in humans — for 3 weeks after birth. This period corresponds to the third trimester of human pregnancy, during which important developmental neurological events, including a "brain-growth spurt," occur. Baby rats that got choline supplements performed learning and memory tasks better than those that didn't get supplements. The benefits of choline were long-lasting and may be permanent. Choline and the by-products of its metabolism are known to perform important functions in the nervous system. They're among the factors that enable nerve cells to send electrical messages to each other, to help regulate memory and muscle control. They contribute to cells' ability to send and receive chemical messages to and from each other and their environments. Choline also plays a role in the integrity of the membrane that surrounds nerve cells, which enables the cells to perform crucial functions.

Factors Influencing Drug Use and Addiction



SOURCE: National Institute on Drug Abuse

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

Centers for Substance Abuse Treatment and Prevention

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

Center for Substance Abuse Treatment-CSAT

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

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

Center for Substance Abuse Prevention-CSAP

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

CSAP carries out its mission through the following strategies:

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

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

Mental Health Liaison Group (MHLG) FY 2003
Appropriation Recommendations
for the Center for Mental Health Services

(Dollars in Millions)			
PROGRAMS	FINAL FY 02	FY 03 ADMIN REQUEST	FY03 MHLG REQUEST
CMHS			
CMHS TOTAL	\$832.1m	\$832.1m (0)	\$953.59m (+121.49m)
Mental Health Performance Partnership Block Grant	\$433.0m	\$433.0m (0)	\$495.35m (+\$62.35m)
Children's Mental Health Services Program	\$96.69m	\$96.69m (0)	\$110.61m (+\$13.92m)
PATH Homelessness Program	\$39.9m	\$46.9m (+\$7m)	\$46.9m (+\$7m)
Protection and Advocacy (PAIMI)	\$32.5m	\$32.5m (0)	\$37.18m (+\$4.68m)
Programs of Regional and National Significance	\$230.1m	\$223.1m (-\$7m)	\$263.65m (+\$33.55m)
Youth Violence Prevention	\$95.0m	\$95.0m (0)	\$108.68m (+\$13.68m)
Post Traumatic Stress Disorder	\$20.0m	\$20.0m (0)	\$22.88m (+\$2.88m)
Jail Diversion Grants	\$4.0m	\$5.0m (+1m)	\$5m (+\$1m)
Seniors \$5.0m	\$5.0m (0)	\$5.72m (+\$0.72m)	
Community Technical Assistance Centers	\$2.0m	\$0m (-2m)	\$2.228m (+\$0.288m)
Community Action Grants	\$5.5m	\$0m (-5.5m)	\$6.29m (+\$0.79m)
NIH			
NIMH	\$1,254.0m	\$1,359.0m (+\$111m)	\$1,454.2m (+\$200m)
NIDA	\$890.93m	\$967.90m (+\$80m)	\$1,033.5m (+\$143m)
NIAAA	\$385.9m	\$418.5m (+\$34m)	\$447.7m (+\$62m)

Executive Summary

Mental Health Performance Partnership Block Grant — The principal federal discretionary program for community-based mental health services for adults and children.

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

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

Protection and Advocacy (PAIMI) — Provides services for persons with a significant mental illness or emotional impairment who are inpatients or residents of a facility rendering care or treatment.

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.

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.

Juvenile Justice: Interagency Research, Training and Technical Assistance — Assists state and local juvenile justice authorities in providing state-of-the-art mental health and justice-related services and collaborative programs that focus on children and adolescents.

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

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

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

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.

Training for Teachers and Emergency Services Personnel — Programs provide teachers and emergency personnel with training on mental disorders, as they, in the course of their work often encounter individuals with mental disorders, but lack the training to recognize or respond appropriately.

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

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

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

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.

Assertive Community Treatment — The Center for Mental Health Services should continue investing in dissemination of evidence-based practices, especially assertive community treatment (ACT). ACT is the most well-researched community treatment, rehabilitation, and support model available to people with severe mental illnesses. ACT is particularly effective for people with co-occurring severe mental illness and substance abuse disorders. ACT is effective as diversion from jail and treatment upon release from incarceration. ACT achieves reductions in hospitalization and incarceration because it is an outreach-oriented, treatment team approach that provides services 24 hours a day, 7 days a week. ACT services are comprehensive including direct provision of substance abuse treatment, supported housing and vocational assistance.

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

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

Notes



MENTAL HEALTH LIAISON GROUP

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