



Appropriations Recommendations for FY 2004

for the

**Center for Mental Health Services
and Related Agencies**

National Institute of Mental Health

National Institute on Drug Abuse

**National Institute on Alcohol Abuse
and Alcoholism**

**"Our Nation's failure to prioritize mental
health is a national tragedy. So many
lives are at stake, so many families and
communities struggle to stay afloat."**

**— President's New Freedom Commission
on Mental Health 2002**

MENTAL HEALTH LIAISON GROUP

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.

For Further Information Contact:

Lizbet Boroughs
American Psychiatric
Association
1000 Wilson Boulevard
Arlington, VA 22205
(703) 907-8645

Julio C. Abreu
National Mental Health
Association
413 East Capitol Street, SE
Washington, DC 20003
(202) 675-8412

Paul Seifert
International Association of Psychosocial
Rehabilitation Services
601 N. Hammonds Ferry Road, Suite A
Linthicum, MD 21090
(410) 789-7054

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

Cindy Grooms, National Council for Community Behavioral Healthcare
José Escalante, National Council for Community Behavioral Healthcare

MENTAL HEALTH LIAISON GROUP

Endorsing Organizations

Mental Health Liaison Group Member Organizations

Alliance for Children and Families
American Academy of Child and Adolescent Psychiatry
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association for Psychosocial Rehabilitation
American Board of Examiners in Clinical Social Work
American Counseling Association
American Group Psychotherapy Association
American Mental Health Counselors Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association
American Psychotherapy Association
Anxiety Disorders Association of America
Association for Ambulatory Behavioral Healthcare
Association for the Advancement of Psychology
Bazelon Center for Mental Health Law
Child Welfare League of America
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Federation
Depression and Bipolar Support Alliance
Employee Assistance Professionals Association
Federation of Families for Children's Mental Health
International Association of Psychosocial Rehabilitation Services
National Alliance for the Mentally Ill
National Association for Children's Behavioral Health
National Association for Rural Mental Health
National Association of Anorexia Nervosa and Associated Disorders
National Association of County Behavioral Health Directors
National Association of Protection and Advocacy Systems
National Association of Psychiatric Health Systems
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Mental Health Association
Suicide Prevention Advocacy Network
Tourette Syndrome Association

Table of Contents

MHLG Appropriations Recommendations Chart.....	1
Executive Summary.....	2
Mental Health: A Call for National Priority	4
Mental Health Services at SAMHSA.....	7
Federal Dollars Help to Finance Community-Based Care.....	8
Community Mental Health Services Performance Partnership Block Grant.....	10
Comprehensive Community Mental Health Services	12
for Children and Their Families Program	
Projects for Assistance in Transition from Homelessness (PATH)	14
Protection and Advocacy for Individuals with Mental Illness (PAIMI)	15
Programs of Regional and National Significance (PRNS)	17
Youth Violence Prevention Initiatives	18
Addressing the Needs of Children and Adolescents.....	19
With Post Traumatic Stress	
Emergency Mental Health Center Grants	20
Jail Diversion Program Grants.....	21
State Data Infrastructure.....	22
Mental Health Outreach and Treatment to the Elderly	23
Statewide Family Network Grants.....	24
Grants to Provide Integrated Treatment for Co-occurring	25
Serious Mental Illnesses and Substance Abuse Disorders	
Consumer and Consumer/Supporter Technical Assistance Centers	26
Juvenile Justice: Aftercare Services for Youth Offenders.....	27
Community Action Grants	28
Improving Mental Health and Child Welfare Services Integration.....	29
Juvenile Justice: Youth Interagency Research, Training.....	31
Suicide Prevention for Children and Adolescents.....	32
and Technical Assistance Centers	
Training On Mental Disorders for Teachers and	33
Emergency Services Personnel	
Mental Health Research.....	34
National Institute for Mental Health (NIMH).....	35
National Institute On Drug Abuse (NIDA)	39
National Institute On Alcohol Abuse and Alcoholism (NIAAA)	44
Centers for Substance Abuse Treatment and Prevention.....	47
MHLG Appropriations Recommendations Chart.....	48
Executive Summary.....	49

Mental Health Liaison Group (MHLG) FY 2004

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

(Dollars in Millions)

PROGRAMS	FY 02 FINAL	FY 03 FINAL	FY 04 ADMIN REQUEST	FY04 MHLG REQUEST
CMHS				
CMHS TOTAL	\$831.3m	\$862.1m (+\$30.8m)	\$834.1m (-\$28m)	\$960.0m (+\$97.9m)
Community Mental Health Performance Partnership Block Grant	\$433.0m	\$440.0m (+\$7m)	\$433.0m (-\$7m)	\$499.0m (+\$59.0m)
Children's Mental Health Services Program	\$96.5m	\$98.7m (+\$2.2m)	\$106.7m (+\$8m)	\$113.0m (+\$14.3m)
PATH Homelessness Program	\$39.9m	\$43.4m (+\$3.5m)	\$50.0m (+\$6.6m)	\$53.7m (+\$10.3m)
Protection and Advocacy (PAIMI)	\$32.5m	\$34.0m (+\$1.5m)	\$32.5m (-\$1.5m)	\$38.5m (+\$4.5m)
Programs of Regional and National Significance	\$229.5m	\$246.0m (+\$16.5m)	\$211.8m (-\$34.2m)	\$280.0m (+\$34.0m)
Youth Violence Prevention	\$95.0m	\$95.0m (+\$0m)	\$95.0m (+\$0m)	\$109.0m (+\$14.0m)
Post Traumatic Stress Disorder	\$20.0m	\$30.0m (+\$10m)	\$20m (-\$10m)	\$33.9m (+\$3.9m)
Jail Diversion Grants	\$4.0m	\$6.0m (+\$2m)	\$6.0m (+\$0m)	\$7.0m (+\$1.0m)
Seniors	\$5.0m	\$5.0m (+\$0m)	\$4.5m (-\$0.5m)	\$5.75m (+\$0.75m)
Community TA Centers	\$2.0m	\$2.0m (+\$0m)	\$0m (-\$2m)	\$2.30m (+\$0.30m)
Community Action Grants	\$5.5m	\$1.0m (-\$4.5m)	\$0m (-\$1.0m)	\$6.35m (+\$5.35m)
NIH				
NIMH	\$1245.3m	\$1349.8m (+\$104.5m)	\$1,382.1m (+\$32.3m)	\$1,484.7m (+\$134.98m)
NIDA	\$885.7m	\$968.0m (+\$82.3m)	\$995.6m (+\$27.6m)	\$1,064.8m (+\$96.8m)
NIAAA	\$383.2m	\$418.8m (+\$35.6m)	\$430.1m (+\$11.3m)	\$460.68m (+\$41.88m)



Executive Summary

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

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

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.

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).

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

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

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

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

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

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

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

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

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

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

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

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

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.

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

Youth Violence Prevention — Safe Schools/Healthy Students initiative (one example of Youth Violence Prevention) provides three-year grants to local school districts to fund programs addressing school violence prevention through a wide range of early childhood development, early intervention and prevention, suicide prevention, and mental health treatment services.

MENTAL HEALTH: A Call For National Priority

In its recent Interim Report, the President's New Freedom Commission on Mental Health found that **our nation's failure to prioritize mental health is a national tragedy**. One measure of the scope of that tragedy is the over 30,000 lives lost annually to suicide — a loss, the Commission states, that is largely preventable.

Mental illness is shockingly common, affecting almost every American family — directly or indirectly. No community is unaffected, no school or workplace untouched.

President's New Freedom Commission
on Mental Health Interim Report, October 2002

The Commission's Chairman, Michael Hogan, stated "The good news is that recovery from mental illness is a reality; a range of safe and effective treatments, services and supports exist for men, women and children with mental illness. Yet, half of all people who need treatment for mental illness do not receive it. The rate is even lower for racial and ethnic minorities and the quality of care they receive is poorer." At a time when state budgets are in the worst crisis since World War II, only the federal commitment to these programs will prevent the closures of mental health service facilities, and ensure that recovery is a reality.

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

Just the Facts

- Mental illness, compared with all other diseases, ranks **first** in terms of causing disability in the U.S.
- 20 percent of the population experiences a mental illness in a given year.
- For about 5 percent of the population, the mental disorder is a severe and persistent mental illness such as schizophrenia, bipolar disorder, or major depression.
- Treatment outcomes for people with serious mental illnesses such as bipolar disorder and schizophrenia have higher success rates (60-80 percent) than well-established general medical or surgical treatments for heart disease such as angioplasty.

The Cost of Failure

- Among adolescents aged 15-19, suicide is the second leading cause of death; overall, there are 30,000 suicides in America every year.
- Mental illness plays a role in the over 650,000 attempted suicides every year.
- An astounding 80 percent of children entering the juvenile justice system have mental disorders. Many juvenile detention facilities are not equipped to treat them.
- State-of-the-art treatments, based on decades of research, are not being transferred from research to community settings.
- The total yearly cost for mental illness in both the private and public sector in the U.S. is over \$200 billion. Only \$92 billion comes from direct treatment costs, with \$105 billion due to lost productivity and \$8 billion resulting from crime and welfare costs. **The cost of untreated and mistreated mental illness to American businesses, the government and families has grown to \$113 billion annually.**
- When the mental health system fails to deliver the right types and combination of care, the results can be disastrous for our entire nation: school failure, substance abuse, homelessness, minor crime, and incarceration.

- While there are 40,000 beds in state psychiatric hospitals today, there are hundreds of thousands of people with serious mental illness in other settings not tailored to meet their needs — in nursing homes, jails, and homeless shelters.

History Of Chronic Neglect And Underfunding

- Mental illness is the leading cause of disability in the U.S., but only 7 percent of all healthcare expenditures are designated for mental health disorders.
- The Administration's FY 2004 budget request represents cuts for several vital CMHS programs for the third consecutive year.
- 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.
- More than 67 percent of adults and nearly 80 percent of children who need mental health services do not receive treatment.
- The reasons for this treatment gap include: (1) financial barriers, including discriminatory provisions in both private and public health insurance plans that limit access to mental health treatment and (2) the historical stigma surrounding mental illness and treatment.

Shift from Institutional Care to Community-Based Care

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

Mental Health Disparities

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

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 convening around the country to look for ways to cut benefits.
- In the course of the next year, almost 750,000 people with mental 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.

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 and addiction services in the United States.
- CMHS promotes improvements in mental health services that enhance the lives of adults who experience mental illnesses and children with serious emotional disorders; fills unmet and emerging needs; bridges the gap between research and practice; and strengthens data collection to improve quality and enhance accountability.

Mental Health and Substance Abuse Research

- The National Institute of Mental Health, 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.

The President's New Freedom Commission on Mental Health

- The President's New Freedom Commission on Mental Health was established in April 2002 as part of the President's agenda to ensure that Americans with mental illness not fall through the cracks, that lives not be lost, and that recovery be a realistic goal of treatment.
- The Commission is comprised of 15 members, including providers, payers, administrators, and consumers of mental health services and family members of consumers, that were appointed by the President, as well as ex officio members representing several federal agencies.
- The mission of the Commission is to conduct a comprehensive study of the U.S. mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system. The Commission's final report (or set of recommendations) is expected to be completed by April 2003.

Move to National Priority

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

Mental Health Services

Fiscal Year 2004 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. The authorization of SAMHSA expires at the end of FY 2004. 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)

Administrator: Charles G. Curie, M.A., A.C.S.W., (301) 443-4795

SAMHSA Legislative Contact: Joe Faha (301) 443-4640

Center for Mental Health Services (CMHS)

Acting Director: Gail P. Hutchings, MPA (301) 443-0001

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 \$440 million in federal funds flowing through the Community Mental Health Services Performance Partnership Block Grant administered by SAMHSA's Center for Mental Health Services (CMHS) is an increasingly critical source of funding for state and local mental health departments. Surveys have found that the Mental Health Performance Partnership Grant Program constitutes as much as 39.5 percent of all non-institutional services spending in some states. Moreover, these federal dollars are being used to fund a wider and more diverse array of community-based services.

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

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

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

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

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

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

Programs of Regional and National Significance — 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 mental disorders in young people who are victims or witnesses of violence, helping to support new services for persons with co-occurring mental illnesses and addictions disorders, prevention of suicide particularly for children and adolescents, and preventing school violence.

Terrorism — Terrorism is a psychological assault that aims to destabilize society by spreading fear, panic, and chaos. The sustained threat of terrorism leads to significant mental health problems, including post-traumatic stress disorder, depression, suicide and substance abuse.

Psychological defenses are integral to Homeland Security — enabling first responders, communities and individuals to cope effectively and maintain stability and productivity. Today, clinicians, public health providers and first responders lack many of the skills necessary to address immediate or long-term psychological needs. Federal and state public health, mental health and substance abuse agencies rarely have the expertise, personnel or financial resources to respond adequately. Formal and informal community leaders are not prepared to actively stabilize their communities. In fact, people (including many first responders) may misunderstand the difference between psychological distress and mental illness, and may not seek or know how to access supportive services due to fear or stigma.

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

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

We further urge that future Homeland Security appropriations adequately support psychological readiness, including rapid response and mental health surge capacity. To most effectively assure that these funds meet community needs, we urge funding for grassroots collaboration with state and local governments, law enforcement, and other first responders to actively involve community leaders and organizations with efforts to cope with trauma and sustained threats.

Community Mental Health Services Performance Partnership Block Grant

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$440.0m	\$499.0m

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 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, 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.

Community-Based Services Work

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

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

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

Comprehensive Community Mental Health Services for Children and Their Families Program

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$98.7m	\$113.0m

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.

Projects for Assistance in Transition from Homelessness (PATH)

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$43.4m	\$53.7m

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).

What Justifies Federal Spending for PATH?

For FY 2004, President Bush is proposing \$50 million for the PATH program. This proposed \$6.5 million increase over FY 2003 is part of the President's "Samaritan Initiative" to end chronic homelessness over the next decade. Services funded by the PATH program provide a critical bridge for individuals with severe mental illnesses experiencing chronic homelessness. An increase for the PATH program in FY 2004 would also allow for a long overdue boost in funding for the 20 states that currently receive the minimum \$300,000 allocation under the program's interstate formula. Despite increases in PATH funding over each of the past four years, these states have seen their allocations remain level at the minimum \$300,000.

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.

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$34.0m	\$38.5m

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 18,566 abuse, neglect, and rights violation complaints. PAIMI staff also provided information and referral services to approximately 44,656 people, and education, training and outreach services to hundreds of thousands more.

Why Is PAIMI Important?

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

What Justifies Increased Federal Spending for PAIMI?

In the past few years, the PAIMI program has been substantially expanded and the eligible population dramatically increased. For example, it is estimated that 1 in 5 adults in the United States will receive treatment for a mental health condition at some point in their lives. At the same time that it expanded PAIMI's coverage to all individuals with significant mental illness, Congress also asked PAIMI programs to continue to prioritize the original PAIMI-eligible facility-based population in before serving people in the community. Congress also included language giving PAIMI the authority to investigate incidents of death and serious injury from the inappropriate use of restraint and seclusion techniques in both institutional and community settings.

The Children's Health Act of 2000 added even more responsibilities to the PAIMI program, including the specific authority to monitor all public and private residential care and treatment facilities for children and youth to ensure they are not at risk for inappropriate use of seclusion and restraint, and to investigate all incidents involving serious injuries and deaths related to seclusion and restraint abuse at those facilities. PAIMI advocates are also playing an increasingly critical role in correctional facilities such as jails and prisons, where many individuals with mental illness are incarcerated. PAIMI advocates work to ensure that needed mental health treatment services and medications are provided, and that inmates are protected from physical and sexual abuse by corrections staff and other inmates.

Finally, the Senate Labor-Health and Human Services-Education (L-HHS-ED) Appropriations Subcommittee included language in its FY 2002 and 2003 Senate LHHS Committee report that State P&A systems have a significant role in addressing the community integration needs of individuals identified in the Supreme Court **Olmstead** decision.

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

PAIMI Success Story

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

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

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 17–32, we describe the salient importance of the following PRNS programs:

Addressing the Needs of Children and Adolescents with Post-Traumatic Stress	19
Community Action Grants	28
Consumer Technical Assistance Centers	26
Emergency Mental Health Centers	20
Grants to Provide Integrated Treatment for Co-occurring Serious Mental Illness	25
and Substance Abuse Disorders	
Improving Mental Health and Child Welfare Services Integration	29
Jail Diversion Grants	21
Juvenile Justice: Aftercare for Youth Offenders	27
Juvenile Justice: Youth Interagency Research, Training, and Technical Assistance Centers	31
Mental Health Outreach and Treatment to the Elderly	23
State Data Infrastructure	22
Statewide Family Network Grants	24
Suicide Prevention for Children and Adolescents	32
Training on Mental Disorders for Teachers and Emergency Services Personnel	33
Youth Violence Prevention Initiatives	18

Youth Violence Prevention Initiatives

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$95.0m	\$109.0m

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 interagency 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 40 sites in FY 2003.

However, applications exceed current funding limits. With additional funds in FY 2004, CMHS could reach more unserved communities through the **Safe Schools/Healthy Students Initiative** and the **School and Community Action Grants**.

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

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$30.0m	\$33.9m

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 mental 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.

Emergency Mental Health Center Grants

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$9.0m	\$10.2m

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 mental health 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 mental health 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.

Jail Diversion Program Grants

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$6.0m	\$7.0m

In the course of the next year, almost three-quarters of a million people with mental illnesses will find themselves in jails or prisons. That's ten times more people than are in state mental 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 mental illnesses. Last year Congress approved \$6.0 million to develop and expand effective jail diversion programs like the one at Thresholds in Chicago. 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

State Data Infrastructure

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$6.0m	\$11.0m

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.

In his proposed FY 2004 budget, President Bush requested a \$5 million increase for state data infrastructure grants in recognition of the growing need for accountability in the provision of mental health services. This funding request would represent the most significant increase in the history of this program.

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 proposes to convert 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 would 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.

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

Mental Health Outreach and Treatment to the Elderly

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$5.0m	\$5.75m

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 outcomes 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.

Statewide Family Network Grants

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$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 waiver which allows families to be authorized service providers in Kansas.
- Georgia Parent Support Network has become a state contracted service provider developing a network of specialized foster homes and working with sex-offending adolescents.

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

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$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.



Consumer and Consumer/ Supporter Technical Assistance Centers

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$2m	\$2.3m

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.

Juvenile Justice: Aftercare Services for Youth Offenders

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$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.

Community Action Grants

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$1.0m	\$6.35m

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. For FY 2003, Congress allocated only \$1 million for new Community Action Grants. This has placed funding for grantees moving from Phase I to Phase II in jeopardy. Additional funds for FY 2004 will ensure that these Community Action Grant sites can complete their grant cycle.

Improving Mental Health and Child Welfare Services Integration

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
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 547,000 children living in foster care today in the U.S. have a developmental, emotional, or behavioral problem. Most of these children have experienced abuse and/or neglect and are at high risk of emotional, behavioral, and mental problems. Upon entering foster care some children already have a diagnosed serious emotional disturbance and require significant services. In addition, all children who are separated from their families experience some trauma and may require mental health services.

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

What Justifies Federal Spending on this Initiative?

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

Need for Collaboration

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

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

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

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

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

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
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 new grant program could support up to four regional centers which would:

- Provide training on mental health and substance abuse service-delivery and collaborative program-ming 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.

Suicide Prevention for Children and Adolescents

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
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). Since that time, a series of authoritative reports has provided comprehensive information about the problem, and effective responses and actions that are needed.

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.

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

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

Interim Report to the President, 10/29/02

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.

Relationship to Other Suicide Prevention Initiatives

CMHS is the lead agency within SAMHSA for the National Strategy. Congress has earmarked CMHS funds for two specific suicide prevention programs. One ongoing project now certifies, networks and evaluates 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 is the new national suicide prevention technical resource center, a specific recommendation of the National Strategy (Objective 4.8).

These programs have begun to put in place the exxential building blocks to guide activities at the state and local level that will reduce the tragic toll taken by suicide, particularly among our young people. The need now is for resources to enable States and communities to provide the services that can save lives. In addition the Administration, through SAMHSA, is now developing a plan for the “public/private partnership” recommended in the National Strategy to advance and coordinate implementation. Continued funding for this initiative is essential to assure continuity and progress toward the important national objective of reducing suicide.

Training On Mental Disorders for Teachers and Emergency Services Personnel

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
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 Research

Fiscal Year 2004 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).

National Institutes of Health (NIH)

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

Mental Health Research

Fiscal Year 2004 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 27 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 original NIH Institutes.

National Institute of Mental Health (NIMH)

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

Constituency Relations and Public Liaison

Director: Gemma Weiblinger (301) 443-3673

National Institute for Mental Health (NIMH)

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$1349.8m	\$1484.7m

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 mental disorders affect an estimated 22.1 percent of Americans ages 18 and over — about 1 in 5 adults suffers from a diagnosable mental disorder in a given year. This figure translates to 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.

To help people with mental illnesses, NIMH supports the design of new interventions and the refinement of existing therapeutic approaches through randomized, controlled clinical trials to demonstrate their efficacy. NIMH emphasizes clinical research and human subject

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

protections: To help ensure the success of this research, NIMH assigns high priority to investigating research ethics, including the ongoing process of informed consent and the use of surrogate decision-makers (legally authorized representatives). While rigorously controlled clinical efficacy trials will remain an essential step in bringing new treatments to the public, “real-world” relevant information is vital to the Nation’s public health. NIMH has launched a series of community-based effectiveness trials of interventions for adolescent depression, treatment-resistant depression in adults, bipolar disorder, and the effectiveness of newer atypical antipsychotic medications in Alzheimer’s disease and schizophrenia. During FY 2004, all of these trials will be working to attain the targeted number of research participants.

An NIMH-wide priority in FY 2004 will be the enthusiastic pursuit of research and related activities that will complement and further the efforts of the President’s New Freedom Commission on Mental Health. The Commission is in the process of completing a comprehensive study of the U.S. mental health service delivery system, including the public and private sectors, and will submit its Report and recommendations to the President in mid-FY 2003. While the Report will focus on recommended improvements in the Nation’s mental health service system, its findings will serve to identify research questions of interest to policymakers, clinicians, and consumers of mental health services as well as to NIMH. The Commission’s report also will encourage and facilitate development of more effective bridges between the Institute and the services community. NIMH research has increased our understanding of the mental health consequences of traumatic events, including natural disasters and human-caused events, and efforts are underway to enhance existing epidemiological and clinical research studies by adding questions relevant to the impact of the recent disasters.

PTSD

PTSD is an anxiety disorder that occurs after exposure to an extreme stressor in which a person experiences, witnesses, or is confronted with actual or threatened death or serious injury to self or others. Events most often associated with PTSD are physical or sexual assault, childhood neglect or physical abuse, natural disasters,

accidents, combat exposure, and bioterrorism. Given its prevalence, disability impact, chronicity, and treatment resistance, PTSD represents a major public health risk. Building on what we have learned about the psychological aspects of traumatic stress reactions and links to many neurobiologic systems, as well as brain imaging studies that have shown neuroanatomical differences in people with PTSD, NIMH intends to accelerate clinical research studies to determine whether chemicals that block abnormal stress responses after a trauma can prevent or reduce development of PTSD. Other trials will look at the optimal duration, timing, and methods of combining pharmacological and psychosocial intervention.

Genetics

NIMH will assign priority in FY 2004, to its Human Genetics Initiative. Tremendous advances have occurred in mapping and cloning genes for some diseases that follow Mendelian patterns in families. In contrast, the discovery of genes that influence vulnerability to mental disorders has proceeded at a much slower pace. NIMH’s Human Genetics Initiative is meant to assemble and make available to the scientific community large data sets that contain high statistical power to detect genes producing vulnerability to mental disorders. The institute will intensify efforts to recruit into the study individuals/families with bipolar disorder, major depression, autism, obsessive-compulsive disorder, and attention-deficit hyperactivity disorder. (It is likely that sufficient numbers of individuals/families with schizophrenia have been obtained to proceed with mapping efforts.) Special emphasis will be placed on fostering large-scale collaborations, by which combined meta-analyses of all available data may occur. Characterization of these vulnerability genes will significantly advance drug discovery and individualized treatment selection.

Suicide

Recognizing that in the United States, deaths by suicide consistently outnumber deaths by homicide, and that suicide is the third leading cause of death for 10-24 year olds, and the eighth leading cause of death for males of all ages, NIMH will encourage a variety of studies focused on the reduction and prevention of suicide. While research on risk factors has identified diverse

social, biologic, and genetic factors associated with suicide, the most consistent factors are major mental illnesses, which affect up to 90% of all people who die by suicide. Despite the high correlation between mental illness and suicide, only a small proportion of persons with mental disorders engage in suicidal behavior, making it difficult to test treatments aimed at preventing or reducing suicidality. In FY 2004, NIMH will encourage research to further characterize protective factors against suicide, as well as new treatments to reduce suicide. NIMH plans to encourage research on suicidality by highlighting research gaps and opportunities, including measurement (e.g., risk and protective factors, treatment response), biological bases, and interventions for underserved populations (rural, racial/ethnic minority populations). The invitation for research applications also will note the need for studies of safe approaches to providing public health messages about suicide, its risk factors, and how to obtain treatment.

Children

NIMH has initiated studies to test sequenced treatments for attention deficit hyperactivity disorder in preschool and school-age children. However, there are many other disorders that would benefit from expansion of this research. NIMH will also expand studies to test the efficacy and safety of interventions for children with autism. Treatments with promising results in the pilot phase will be directed toward full clinical trials over the next several years. NIMH is particularly committed to expanding the portfolio of psychosocial/behavioral treatment research in autism.

Success Story

Royal Riddick's Story: Mr. Riddick is a single-parent and a Vietnam Veteran. His struggle with bipolar 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 2004 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)

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

Office of Science Policy

Associate Director: Timothy Condon (301) 443-6036

National Institute On Drug Abuse (NIDA)

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$968.0m	\$1064.8m

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 nearly 16 million Americans were current users of illicit drugs (marijuana, cocaine, heroin, hallucinogen and inhalants) in 2001, 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.

Clinical Trials Network

NIDA also plans to broaden its treatment portfolio even further, by expanding various components of the National Drug Abuse Treatment Clinical Trials Network (CTN) to ensure it reaches into 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. The CTN has grown from its original five sites to now include 17 regional sites across the country, including the recent awarding of three new sites in September 2002 (New Mexico, California/Arizona Node and a Northern New England Node). (See CTN map on page 42.) With each node working with a growing number of community treatment programs across the country, treatments are being delivered by community participants at the

community level. 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 04, NIDA is committed to enrolling thousands more patients for the 13 new protocols that are in various stages of development. These new protocols will include studies of pregnant drug-abusing women, adolescent drug abusers, drug abusing women with PTSD (Post Traumatic Stress Disorder), a study conducted in Spanish for Spanish speaking drug abusers, 3 HIV risk reduction interventions, and a cigarette smoking cessation intervention for in-treatment drug addicts. Additionally, to reduce the lag time between research and practice even more, NIDA will continue to work with the Substance Abuse and Mental Health Services Administration (SAMHSA) to facilitate the dissemination and integration of NIDA's evidence-based treatments into practice via SAMHSA's Addiction Technology Transfer Centers and other means. The CTN will continue to mature in the upcoming year and continue to address diverse populations in need of treatment.

Prevention

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 Transdisciplinary 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.

Additional Initiatives

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 are in 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.

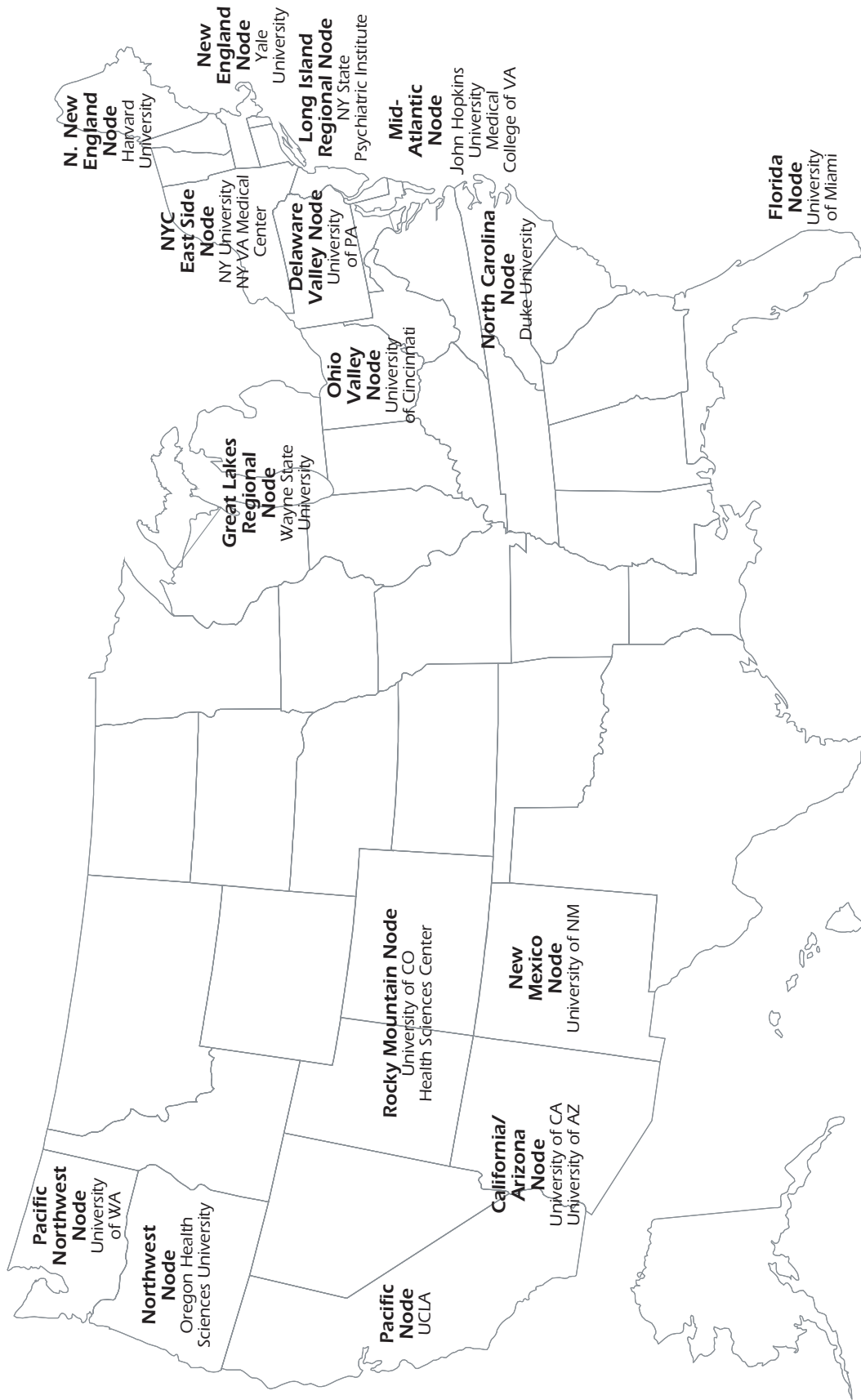
All of these priority areas build upon NIDA’s core programs — basic neuroscience, epidemiology, neuroimaging, prevention, treatment development, behavioral research, health services research, and research on AIDS and other medical consequences of drug abuse — together they will continue to provide us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

Advances in Science

The number of individuals suffering from heroin and other opiate addictions is about to be reduced thanks in large part to a public/private research undertaking led by NIDA that has resulted in the approval of a new medication. Over a decade of NIDA-supported research finally came to fruition as the medication buprenorphine was approved by the Food and Drug Administration (FDA) on October 8th. Buprenorphine products are the first medications available for the treatment of opiate addiction that can be prescribed in a physician’s office. It is buprenorphine’s pharmacology that makes it an attractive, clinically relevant, treatment option.

Buprenorphine is a partial agonist that functions on the same brain receptors as morphine, but does not produce the same high, dependence, or withdrawal syndrome. Buprenorphine actually prevents morphine from binding to opiate receptors, thus blocking its pleasurable effects. Buprenorphine also blocks withdrawal discomfort by keeping the receptors occupied. It is long-lasting, less likely to cause respiratory depression, well tolerated by addicts and, when combined with naloxone, has very limited diversion potential. Not only will it expand availability of treatment, but its method of administration and dosing schedule will make it more likely that recovering addicts will adhere to the treatment regimen. Another major benefit of this new treatment option is its potential to reduce the treatment gap. According to the White House Office of National Drug Control Policy, currently there are approximately 900,000 chronic heroin users who could potentially benefit from this treatment. The approval of buprenorphine by the FDA helps to underscore that addiction is a treatable disease. It will also help alleviate some of the stigma associated with addiction treatment.

National Drug Abuse Treatment Clinical Trials Network





Mental Health Research

Fiscal Year 2004 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; and
- disseminating research findings to health care providers, researchers, policymakers, and the public.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

Director: Ting-Kai Li, MD (301) 943-3885

Office of Policy, Legislation and Public Liaison

Director: Geoffrey Laredo (301) 443-9970

National Institute On Alcohol Abuse and Alcoholism (NIAAA)

APPROPRIATIONS FY 2003	MHLG RECOMMENDATION FY 2004
\$418.8m	\$460.7m

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.

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

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

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.

Multi-site, Collaborative Initiative on Fetal Alcohol Syndrome

Children with fetal alcohol syndrome (FAS) and alcohol-related neurodevelopmental disorders have serious neurobehavioral deficits and other physical problems that impair daily function and often persist throughout

life. In the U.S., these conditions disproportionately affect American Indians, Native Alaskans, and African Americans. The NIAAA Collaborative Initiative on Fetal Alcohol Spectrum Disorders will support a consortium of individual investigators, multi-site collaborations, and collaborations between basic-science investigators and clinical scientists. This initiative will ensure that laboratory findings reach the clinical research setting and that they reach the populations most affected. At present, no treatments exist for infants exposed to alcohol through maternal drinking.

However, two new findings suggest potential avenues for treating FAS children while they're still in the uterus or after birth.

For example 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.

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 2004

Appropriation Recommendations for the Center for Mental Health Services

(Dollars in Millions)				
PROGRAMS	FY 02 FINAL	FY 03 FINAL	FY 04 ADMIN REQUEST	FY04 MHLG REQUEST
CMHS				
CMHS TOTAL	\$831.3m	\$862.1m (+\$30.8m)	\$834.1m (-\$28m)	\$960.0m (+\$97.9m)
Community Mental Health Performance Partnership Block Grant	\$433.0m	\$440.0m (+\$7m)	\$433.0m (-\$7m)	\$499.0m (+\$59.0m)
Children's Mental Health Services Program	\$96.5m	\$98.7m (+\$2.2m)	\$106.7m (+\$8m)	\$113.0m (+\$14.3m)
PATH Homelessness Program	\$39.9m	\$43.4m (+\$3.5m)	\$50.0m (+\$6.6m)	\$53.7m (+\$10.3m)
Protection and Advocacy (PAIMI)	\$32.5m	\$34.0m (+\$1.5m)	\$32.5m (-\$1.5m)	\$38.5m (+\$4.5m)
Programs of Regional and National Significance	\$229.5m	\$246.0m (+\$16.5m)	\$211.8m (-\$34.2m)	\$280.0m (+\$34.0m)
Youth Violence Prevention	\$95.0m	\$95.0m (+\$0m)	\$95.0m (+\$0m)	\$109.0m (+\$14.0m)
Post Traumatic Stress Disorder	\$20.0m	\$30.0m (+\$10m)	\$20m (-\$10m)	\$33.9m (+\$3.9m)
Jail Diversion Grants	\$4.0m	\$6.0m (+\$2m)	\$6.0m (+\$0m)	\$7.0m (+\$1.0m)
Seniors	\$5.0m	\$5.0m (+\$0m)	\$4.5m (-\$0.5m)	\$5.75m (+\$0.75m)
Community TA Centers	\$2.0m	\$2.0m (+\$0m)	\$0m (-\$2m)	\$2.30m (+\$.30m)
Community Action Grants	\$5.5m	\$1.0m (-\$4.5m)	\$0m (-\$1.0m)	\$6.35m (+\$5.35m)
CSAT				
Block Grant	\$1,725.0m	\$1,702.8m (-\$22.2m)	\$1,785.0m (+\$82.2m)	\$1,875.0m (+\$172.2m)
PRNS	\$291.57m	\$319.4m (+\$28.8m)	\$556.6m (+\$237.2m)	\$556.6m (+\$237.2m)
CSAP				
PRNS	\$198.1m	\$198.4m (+\$0.9m)	\$148.1m (-\$50.3m)	\$227.0m (+\$28.6m)
NIH				
NIMH	\$1245.3m	\$1349.8m (+\$104.5m)	\$1,382.1m (+\$32.3m)	\$1,484.7m (+\$134.98m)
NIDA	\$885.7m	\$968.0m (+\$82.3m)	\$995.6m (+\$27.6m)	\$1,064.8m (+\$96.8m)
NIAAA	\$383.2m	\$418.8m (+\$35.6m)	\$430.1m (+\$11.3m)	\$460.68m (+\$41.88m)

Executive Summary

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

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

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.

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).

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

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

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

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

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



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

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

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

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

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

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

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

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.

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

Youth Violence Prevention — Safe Schools/Healthy Students initiative (one example of Youth Violence Prevention) provides three-year grants to local school districts to fund programs addressing school violence prevention through a wide range of early childhood development, early intervention and prevention, suicide prevention, and mental health treatment services.

MENTAL HEALTH LIAISON GROUP