



Appropriations Recommendations

for Fiscal Year 2008

“A report issued by the Medical Directors Council of the National Association of State Mental Health Program Directors states that persons with serious mental illness die, on average, 25 years earlier than the general population. Premature deaths among this population are largely due to preventable conditions such as cardiovascular, pulmonary and infectious diseases.”

**National Association of State Mental Health Program Directors
August 2006**

MENTAL HEALTH LIAISON GROUP

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

MENTAL HEALTH LIAISON GROUP

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

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Endorsing Organizations

Mental Health Liaison Group Member Organizations

American Academy of Child and Adolescent Psychiatry
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association of Pastoral Counselors
American Board of Examiners in Clinical Social Work
American Counseling Association
American Mental Health Counselors Association
American Occupational Therapy Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychoanalytic Association
American Psychological Association
American Psychotherapy Association
Anxiety Disorders Association of America
Association for Ambulatory Behavioral Healthcare
Bazon Center for Mental Health Law
Child Welfare League of America
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Clinical Social Work Federation
Clinical Social Work Guild
Depression and Bipolar Support Alliance
Eating Disorders Coalition for Research, Policy & Action
Federation of Families for Children's Mental Health
Mental Health America
National Alliance to End Homelessness
National Alliance for Mental Illness
National Association for Rural Mental Health
National Association of Anorexia Nervosa and Associated Disorders
National Association of County Behavioral Health Directors
National Association of Mental Health Planning and Advisory Councils
National Association of Psychiatric Health Systems
National Association of School Psychologists
National Association of Social Workers
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Disability Rights Network
Suicide Prevention Action Network US
Tourette Syndrome Association
US Psychiatric Rehabilitation Association
Volunteers of America

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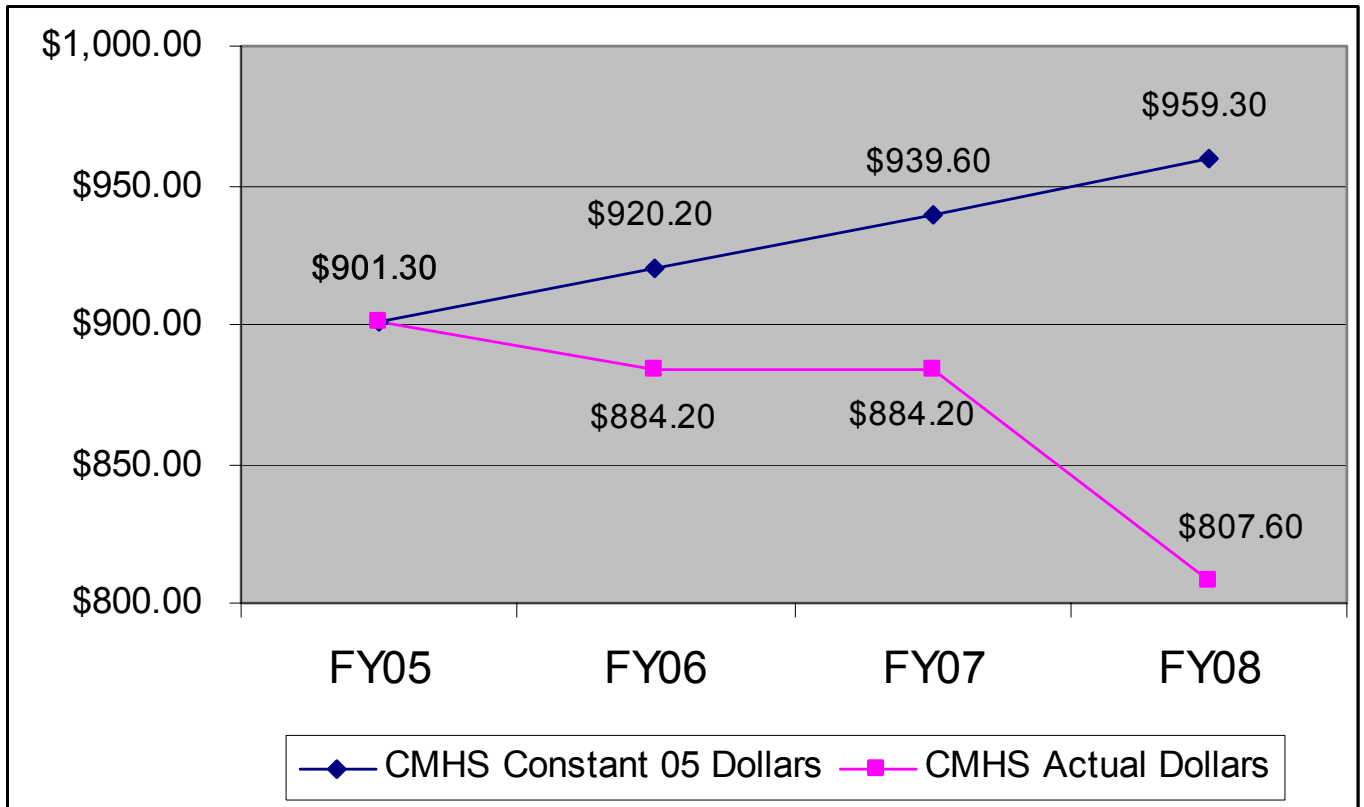
**Mental Health Liaison Group (MHLG) FY 2008
Appropriations Recommendations for the
Center for Mental Health Services and Key NIH Institutes**

(Dollars in Million)

PROGRAMS	FY 06 FINAL	FY07 FINAL	FY08 ADMIN REQUEST	FY08 MHLG REQUEST
CMHS				
CMHS TOTAL	\$884.0m <i>(-\$17.3m)</i>	\$884.2m <i>(-\$0.0m)</i>	\$807.6m <i>(-\$76.6m)</i>	\$959.3m <i>(+\$75.1m)</i>
Community Mental Health Services Performance Partnership Block Grant	\$428.5m <i>(-\$4.3m)</i>	\$428.5m <i>(-\$0.0m)</i>	\$428.5m <i>(-\$0.0m)</i>	\$460.7m <i>(+\$32.2m)</i>
Children’s Mental Health Services Program	\$104.1m <i>(-\$1.1m)</i>	\$104.1m <i>(-\$0.0m)</i>	\$104.1m <i>(-\$0.0m)</i>	\$112.0m <i>(+\$7.9m)</i>
PATH Homelessness Program	\$54.3m <i>(-\$0.5m)</i>	\$54.3m <i>(-\$0.0m)</i>	\$54.3m <i>(-\$0.0m)</i>	\$58.3m <i>(+\$4.0m)</i>
Protection and Advocacy (PAIMI)	\$34.0m <i>(-\$0.3m)</i>	\$34.0m <i>(-\$0.0m)</i>	\$34.0m <i>(-\$0.0m)</i>	\$36.6m <i>(+\$2.6m)</i>
Programs of Regional and National Significance	\$263.2m <i>(-\$11.1m)</i>	\$263.2m <i>(-\$0.0m)</i>	\$186.6m <i>(-\$76.6m)</i>	\$291.9m <i>(+\$28.6m)</i>
Youth Violence Prevention	\$93.3m <i>(-\$0.9m)</i>	\$93.3m <i>(-\$0.0m)</i>	\$75.7m <i>(-\$17.6m)</i>	\$100.3m <i>(+\$7.0m)</i>
Suicide Prevention	\$31.7m <i>(+\$15.2m)</i>	\$36.1m <i>(+\$1.4m)</i>	\$33.5m <i>(-\$2.6m)</i>	\$37.0m <i>(+\$0.9m)</i>
Post Traumatic Stress Disorder	\$29.5m <i>(-\$0.3m)</i>	\$29.5m <i>(-\$0.0m)</i>	\$28.1m <i>(-\$1.4m)</i>	\$31.7m <i>(+\$1.9m)</i>
State Incentive Grant	\$25.7m <i>(+\$5.9m)</i>	\$25.7m <i>(-\$0.0m)</i>	\$19.7m <i>(-\$6.0m)</i>	\$26.2m <i>(+\$0.5m)</i>
Jail Diversion Grants	\$6.93m <i>(-\$0.0m)</i>	\$6.93m <i>(-\$0.0m)</i>	\$3.9m <i>(-\$3.0m)</i>	\$7.44m <i>(+\$0.5m)</i>
Seniors	\$4.95m <i>(-\$0.01m)</i>	\$4.95m <i>(-\$0.0m)</i>	\$0.0m <i>(-\$4.95m)</i>	\$5.35m <i>(+\$0.4m)</i>
Community Technical Assistance Centers	\$1.98m <i>(-\$0.0m)</i>	\$1.98m <i>(-\$0.0m)</i>	\$0.0m <i>(-\$1.98m)</i>	\$2.18m <i>(+\$0.2m)</i>
Consumer Network Grants	\$1.5m n/a	\$1.5m <i>(-\$0.0m)</i>	\$0.0m <i>(-\$1.5m)</i>	\$1.7m <i>(+\$0.2m)</i>
Family Network Grants	\$3.4m n/a	\$3.4m <i>(-\$0.0m)</i>	\$0.0m <i>(-\$3.4m)</i>	\$3.6m <i>(+\$0.2m)</i>
Minority Workforce Training	\$3.8m n/a	\$3.8m <i>(-\$0.0m)</i>	\$0.0m <i>(-\$3.8m)</i>	\$4.0m <i>(+\$0.2m)</i>
NIH				
NIMH	\$1,403.5m <i>(-\$8.7m)</i>	\$1,403.6m <i>(+\$0.1m)</i>	\$1,405.4m <i>(+\$1.8m)</i>	\$1,497.6m <i>(+\$94.0m)</i>
NIDA	\$1000.0m <i>(-\$6.7m)</i>	\$999.4m <i>(-\$0.1m)</i>	\$1,000.4m <i>(+\$1.0m)</i>	\$1,067.3m <i>(+\$67.0m)</i>
NIAAA	\$435.9m <i>(-\$2.6m)</i>	\$436.3m <i>(+\$0.4m)</i>	\$436.6m <i>(+\$0.3m)</i>	\$465.5m <i>(+\$29.2m)</i>

CMHS Funding vs. FY 05 Plus Inflation (2.1%/yr)

	FY05	FY06	FY07	FY08
CMHS Constant 05 Dollars	\$901.30	\$920.20	\$939.60	\$959.30
CMHS Actual Dollars	\$901.30	\$884.20	\$884.20	\$807.60 (PROPOSED)
Loss in Purchasing Power	\$0.00	-\$36.00	-\$55.40	-\$151.70 (-17%)



Programs at a Glance

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

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

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

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

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

Community Mental Health Services Performance Partnership Block Grant — Represents the principal federal discretionary program for community-based mental health services for adults and children. The Block Grant gives states flexibility to fund services that are tailored to meet the unique needs and priorities of consumers in the public mental health system in that state.

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

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

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

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

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

Minority Fellowship Program — Provides grants to encourage more ethnic minorities to provide psychiatric, psychological and other mental health and substance abuse services to chronically underserved ethnic minority populations.

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

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

Protection and Advocacy (PAIMI) — Provides services for persons with a significant mental illness or emotional impairment in nursing homes, state psychiatric facilities, residential settings and in the community.

Statewide Consumer Network Grants — Enhance state capacity and infrastructure by supporting consumer organizations. These grants ensure that consumers are the catalysts for transforming the mental health and related systems in their state and for making recovery and resiliency the expectation and not the exception.

Statewide Family Network Grants — Provide peer-to-peer support, accurate information about mental health services, and training so that families can effectively participate in planning, designing, implementing and evaluating services for children with emotional, behavioral, or mental disorders. These grants serve as a key vehicle for disseminating information about evidence-based and effective practice.

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

Suicide Prevention for Children and Adolescents — Funds service and training programs in states and communities, with a focus on the needs of communities and groups experiencing high or rising rates of suicide. The Garrett Lee Smith Memorial Act is an important first step in addressing the mental and behavioral health needs of students on college campuses by funding hotlines, informational materials, and education and training programs.

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 addiction disorders.

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

MENTAL HEALTH – CRISIS after CRISIS

National Snapshot

The suicide rate among U.S. residents younger than age 20 increased by 18 percent from 2003 to 2004. **Suicide was the only cause of death for teens that increased during that time period, according to the report.**

(CDC report, 2/07) (Emphasis Added)

People who have cancer are two- to 2.5 times more likely to die as a result of suicide than people who don't have cancer. Among cancer patients, men were five times more likely to die as a result of suicide than women and were more likely to die immediately after diagnoses were made.

(Annals of Oncology, 10/06)

People who have depression are more likely to have hardening of the arteries, or arteriosclerosis. This condition can lead to cardiovascular diseases, but also cause body reactions that reinforce the depression. In addition, people with severe mental illnesses were up to three times more likely than others to die from cardiovascular diseases before age 50. And, older adults who feel persistently lonely are more likely than others to develop symptoms similar to those found in people who have Alzheimer's. *(Archives of General Psychiatry, 2/5/07)*

Up to 35,000 children who were displaced by Hurricane Katrina in 2005 are having emotional, behavioral or school problems. There was a nearly fourfold increase in the clinical diagnosis of depression or anxiety in children after the hurricane, and the prevalence of behavioral or conduct problems doubled. In addition, more than 60 percent of parents tested high for anxiety, depression and PTSD. *(Columbia University, 2/2/07)*

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

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

According to the Substance Abuse and Mental Health Services Administration, an estimated 17 million adults ages 18 and older (8.0%) reported experiencing at least one major depressive episode during the past year. *(SAMHSA Advisory Council, 11/18/05)*

Hurricane Katrina

The rate of severe mental illness in the Gulf Coast region about doubled in the six months after Hurricane Katrina.

(Harvard Medical School Psychologist, 8/06)

Calls made to SAMHSA's National Suicide Prevention Lifeline nearly doubled in the aftermath of Hurricane Katrina in September 2005. Before Hurricane Katrina, the Lifeline received on average 900 calls per week. After the hurricane, calls skyrocketed to 1,400 calls per week (a 55 percent increase).

(National Suicide Prevention Lifeline, 1/20/06)

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

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

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

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

Administration’s FY 2008 Budget

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

Mental Health Services Funding

Despite the release of an “Action Agenda” in July 2005 to ensure that people with mental illness have every opportunity for recovery, the Administration proposes a 9% cut (from \$884 to \$807 million) to mental health services at the Center for Mental Health Services (CMHS). Overall, the administration would cut funding for the Substance Abuse and Mental Health Services Administration (SAMHSA) by 5 % including proposals to:

- **Eliminate** the entire \$2 million budget for the Consumer Technical Assistance Centers;
- **Eliminate** the entire \$1.5 million budget for the Statewide Consumer Network Grants;
- **Eliminate** the entire \$3.4 million budget for the Statewide Family Network Grants;
- **Eliminate** the entire \$5 million budget for the Older Adults Outreach and Treatment program;
- **Eliminate** the entire \$3.8 million budget for the Minority Fellowship Program;
- **Cut** suicide prevention by \$3 million, from \$36 million to \$33 million;
- **Cut** youth violence prevention programs by \$18 million or 20 percent, from \$93 million to \$75 million;
- **Cut** post-traumatic stress disorder programs for youth by \$1.5 million, from \$29.5 million to \$28 million;
- **Cut** the Transformation State Incentive Grants by \$6 million, from \$25.7 million to \$19.7 million;
- **Cut** funding for substance abuse prevention by 20 percent, from \$193 to \$156 million; and
- **Level** funding (in ostensibly, a cut given inflation) in the children’s systems-of-care, the homelessness (PATH), PAIMI, and the mental health and substance abuse block grants.

Mental Health Research Funding

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

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

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

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

Consequently, Congress and the Administration should focus on funding community-based services, like those identified as model programs in the Commission’s report, and ensure that the CMHS has a budget sufficient to put proven prevention and treatment programs in place in every community across the country.

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

Just the Facts

- Mental illness, compared with all other diseases, ranks **first** in terms of causing disability in the U.S.
- Approximately 54 million Americans have a mental illness.
- 20 percent of the population experiences a mental illness in a given year.
- Persons with serious mental illness die, on average, 25 years earlier than the general population.
- About 5 percent of the population suffers from a severe and persistent mental illness such as schizophrenia, bipolar disorder, or major depression.
- Treatment outcomes for people with serious mental illnesses such as bipolar disorder and schizophrenia have higher success rates (60-80 percent) than well-established general medical or surgical treatments for heart disease such as angioplasty.

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

- The rate of teen suicide has tripled since the 1950s; overall, there are over 30,000 suicides in America every year.
- Mental illness plays a major role in the over 650,000 attempted suicides every year.
- An astounding 80 percent of children entering the juvenile justice system have mental disorders. Many juvenile detention facilities are not equipped to treat them.
- The gap between scientific discovery to service delivery is an astounding 15 years.
- The total yearly cost for mental illness in both the private and public sector in the U.S. is over \$200 billion. Of this amount, less than half (\$92 billion) comes from direct treatment costs, with \$105 billion due to lost productivity and \$8 billion resulting from crime and welfare costs. **The cost of untreated and mistreated mental illness to American businesses, the government and families has grown to \$113 billion annually.**
- When the mental health system fails to deliver the right types and combination of care, the results can be disastrous for our entire nation: school failure, substance abuse, homelessness, crime, and incarceration.
- While there are 50,000 beds in state psychiatric hospitals today, there are hundreds of thousands of people with serious mental illness in other settings not tailored to meet their needs – in nursing homes, jails, and homeless shelters.
- Criminal justice and corrections officials have called for stronger community mental health service systems in order to prevent unnecessary and costly “criminalization” of people with mental illnesses.
- The FY 2006 budget included significant changes to the \$21.8 million Mental Health Block Grant set-aside, including the transfer of CMHS’ State Data Infrastructure Grant (DIG) program to the set-aside. This change displaced approximately \$10 million in funding for state technical assistance and research and evaluation programs.

History of Chronic Neglect and Underfunding

- Mental illness is the leading cause of disability in the U.S., but only 7 percent of all healthcare expenditures are designated for mental health disorders.
- Funding for mental health services has averaged an increase of only **\$2.5 million** a year over the last eight years (FY 2001-8). This flat funding is occurring in a landscape of spiraling health care costs/inflation that, according to recent data published in Health Affairs, had skyrocketed **9.3 percent** in 2002 alone.
- The Administration’s FY 2008 budget proposes cuts for several vital CMHS programs for the *sixth* year in the last seven.
- More than 67 percent of adults and nearly 80 percent of children who need mental health services **do not** receive treatment.

- The reasons for this treatment gap include: (1) financial barriers, including discriminatory provisions in both private and public health insurance plans that limit access to mental health treatment and (2) the historical stigma surrounding mental illness and treatment.
- In the words of the Surgeon General’s Report on Mental Health, we must “overcome the gaps in what is known and remove the barriers that keep people from ...obtaining...treatments.”

Shift from Institutional Care to Community-Based Care

- Over the last several decades, the public mental health system has shifted its emphasis from institution-based care to community-based care – a more cost-efficient and effective way to promote recovery among many people with mental illnesses who can go on to lead productive lives in the community.
- Approximately two-thirds of state funding for mental health currently goes to provide community services. Similarly, most alcohol and drug treatment services are community-based.
- The 1999 U.S. Supreme Court decision in *Olmstead v. L.C. and E.W.* mandates that states develop adequate community services to move people with disabilities out of institutions – a blueprint for the President’s New Freedom Initiative.
- Without adequate funding, however, efforts to transition people out of institutions and better serve those currently living in our communities will continue to fail.
- The transition from institutional care to community-based care has never been adequately funded, even though we know that community-based care is less expensive than institutional care.

A Nation at Risk

- The President’s FY 2008 budget proposes to reduce by \$672,000 funding for the Substance Abuse and Mental Health Services (SAMHSA) National Suicide Prevention Lifeline (1-800-273-TALK), a network of more than 120 crisis centers located in communities across the country that respond, 24 hours a day, to individuals in emotional distress or suicidal crisis. Recently completed evaluations of crisis hotline processes and outcomes give evidence to support hotlines’ role in responding to crisis and suicidal callers. During follow-up calls, approximately 12 percent of suicidal callers spontaneously reported that the call saved his/her life.
- The President’s FY 2008 budget would also eliminate SAMHSA’s Linking Adolescents at Risk for Suicide to Mental Health Services (Adolescents at Risk) program, which funds local educational agencies and domestic public and private nonprofit entities working in conjunction with local educational agencies to evaluate voluntary school-based programs that focus on identification and referral of high school youth who are at risk for suicide or suicide attempts.
- The President’s budget proposal to eliminate the Adolescents at Risk program comes at a time when the suicide rate among youth is *increasing*. According to a February 2007 report issued by the CDC, the suicide rate among U.S. residents younger than age 20 increased by 18 percent from 2003 to 2004. Suicide is currently the third leading cause of death for those between the ages of 10 and 24.

Mental Health Disparities

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

Vanishing Safety Net

- Medicaid, the public health safety net, provides mental health services to low-income persons. However, financial changes at the federal level are pressuring states to restrict services.
- There are ten times more people with psychiatric illnesses in jails or prisons than in state psychiatric hospitals. In the course of the next year, almost 750,000 people with psychiatric illnesses will find themselves in jails or prisons.

- The strain of a stressed mental health infrastructure is evident at the local/county level across the country. In the majority of the country, local jurisdictions have the ultimate responsibility to provide care and services in their communities to those most in need.
- With shrinking Medicaid benefits, discretionary federal funding for mental health services will be pivotal to ensure the American people's access to mental health care.
- Our advocacy for mental health funding increases is compatible with the President's national priority of addressing domestic security, including aid for local police and fire departments, and assistance for the public health system.

Mental Health and Substance Abuse Services

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

Mental Health and Substance Abuse Research

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

Mental Health Services
Fiscal Year 2008
Funding Recommendations

for the

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

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

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

SAMHSA evolved from the former Alcohol, Drug and Mental Health Administration (ADAMHA) as a result of P.L. 94-123. The Children’s Health Act (P.L. 106-310), enacted in October 2000, reauthorized most of SAMHSA’s ongoing programs and added new programs to address emerging national priorities. The authorization of SAMHSA expired at the end of FY 2004. This document addresses appropriations recommendations for the Center for Mental Health Services within SAMHSA. These recommendations are derived from consultations with state and local mental health authorities, providers, researchers and consumers.

Substance Abuse and Mental Health Services Administration (SAMHSA)

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

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

Since 1995, changes in state and federal policy have served to compound the strain on state and local public mental health systems. In the wake of the 1999 Supreme Court decision in *Olmstead v. L.C. and E.W.* — which found that unjustified institutionalization of individuals with mental illness constitutes unlawful discrimination under the Americans with Disabilities Act — state and local contributions to community-based services have increased, **but federal investments to community care remain stagnant.**

Reform of the eligibility rules for the Supplemental Security Income (SSI) program impacting both children and persons whose disability was originally based on substance abuse has shifted a tremendous and growing burden to local communities. In addition, changes to the Medicaid Disproportionate Share (DSH) program have left states scrambling to make up for lost federal resources.

As a result of these trends, the federal investment in community-based care is growing in importance. For example, the nearly \$428 million in FY 2007 federal funds flowing through the Community Mental Health Services Performance Partnership Block Grant administered by SAMHSA’s Center for Mental Health Services (CMHS) is an increasingly critical source of funding for state and local mental health departments. Surveys have found that the Mental Health Block Grant program constitutes as much as 39.5 percent of all non-institutional services spending in some states. Moreover, these federal dollars are used to fund a wider and more diverse array of community-based services.

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

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

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

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

Homelessness — The Projects for Assistance in Transition from Homelessness (PATH) program is the only federal program that provides mental health care and evaluates the implementation of innovative outreach services to homeless Americans, a third of whom have mental illnesses.

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

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

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

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

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

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

Community Mental Health Services Performance Partnership Block Grant

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$428.5m	\$428.5m	\$428.5m	\$460.7m

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

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

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

Why is the Block Grant Important?

Over the last three decades, the number of people in state psychiatric hospitals has declined significantly, from about 700,000 in the late 1960's to about 50,000 today. As a result, state mental health agencies have shifted significant portions of their funding from inpatient hospitals into community programs. About two-thirds of state mental health agency budgets are now used to support community-based care.

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

The Block Grant is vital because it gives states critical flexibility to: (1) fund services that are tailored to meet the unique needs and priorities of consumers of the public mental health system in that state; (2) hold providers accountable for access and

the quality of services provided; and (3) coordinate services and blend funding streams to help finance the broad range of supports — medical and social services — that individuals with mental illnesses need to live safely and effectively in the community.

The President's FY 2008 budget proposes level funding for this vital program. This would result in actual funding reductions in 29 states. (Congressional Justification, CMHS — 34-35)

What Justifies Federal Spending for the Block Grant?

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

Since its inception, the Mental Health Block Grant has been one of the highest funding priorities of the Mental Health Liaison Group. The MHLG has sought to increase block grant funding and to ensure that the Block Grant provides evidence-based community services for populations most in need of services. These populations include adults with severe mental illness who:

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

- have a history of interactions with the criminal justice system, including arrests for vagrancy and other misdemeanors; or
- are currently homeless.

Children with serious emotional disturbances who:

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

Furthermore, a \$30 million increase in the Block Grant in FY 2008 could provide:

- Assertive Community Treatment services for 4,054 individuals (based on a median annual cost of \$7,400 per person); or
- Supported employment services for 10,000 individuals (based on a median annual cost of \$3,000 per person); or

- Multi-Systemic Therapy (MST) for 5,263 children (based on a median annual cost of \$5,700 per child).

Community-Based Services Work

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

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

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

Comprehensive Community Mental Health Services for Children and Their Families Program

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$104.1m	\$104.1m	\$104.1m	\$112.0m

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

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

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

Prior to the development of a system-of-care-approach, these children were typically underserved or served inappropriately by fragmented service systems. In a 1990 survey, several states reported that thousands of children were placed in out-of-state mental health facilities, which cost states millions of dollars. In addition, thousands of children were treated in state hospitals — often in remote locations, away from family and other sources of support — despite the demonstrated effectiveness of community-based programs. In response to these findings, federal leadership, along with a growing family movement, promoted a new paradigm for serving children with SED and their families. Since first articulated by Stroul and Friedman in 1986, this system-of-care-approach has evolved into the principal organizing framework shaping the

development and delivery of community-based children’s mental health services in the United States.

What Does the Children’s Program Do?

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

Hallmarks of this approach include the following:

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

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

Why Is the Children's Program Important?

Although an estimated 13.7 million American children have a diagnosable mental or emotional disorder, and nearly half of these children have severe disorders, *only one-fifth of these youth receive appropriate services and treatment* (NIMH, 1994). In the past twelve years, the Children's Mental Health Services Program has provided services to nearly 70,000 children and youth, who are diagnosed with serious mental and emotional disturbances. However much more needs to be done.

As stated in the Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda published in 2000, "The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country." Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them." Often, services and supports for children with serious emotional disturbance and their families who are involved with more than one child-serving system are uncoordinated and fragmented. Typically, the only options available are outpatient therapy, medication, or hospitalization. Frequently there are long waits for these services because they are operating at capacity, making them inaccessible for new clients, even in crisis situations. These statements were echoed in the final report of the President's New Freedom Commission on Mental Health.

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

Justifying the Costs

The program has served children in 473 or 15 percent of the 3,142 counties in the U.S, representing a small proportion of the country being exposed to these highly successful systems-of-care services (the President's 2005 Budget). Key outcomes for children and families in comprehensive community mental health systems of care in 2005 include:

- **Decreased utilization of inpatient facilities.** The percentage of children who used inpatient facilities within the previous 6 months decreased 54 percent from entry into systems of care to 18 months after systems of care.
- **Reduced arrest results in per-child cost savings.** From entry into systems of care to 12 months after entry, the average reduction in number of arrests per child within the prior 6 months translated into an average per-child cost savings of \$784.
- **Mental health improvements sustained.** Emotional and behavioral problems were reduced significantly or remained stable for nearly 90 percent of children after 18 months in systems of care.
- **Suicide-related behaviors were significantly reduced.** The percentage of children and youth who had deliberately harmed themselves or had attempted suicide decreased 32 percent after 12 months in systems of care.
- **School attendance improved.** The percentage of children with regular school attendance (i.e., 75 percent of the time or more) during the previous 6 months increased nearly 10 percent with 84 percent attending school regularly after 18 months in systems of care.
- **School achievement improved.** The percentage of children with a passing performance (i.e., C or better) during the previous 6 months increased 21 percent with 75 percent of children passing after 18 months in systems of care.
- **Significant reductions in placements in juvenile detention and other secure facilities.** Children and youth who were placed in juvenile detention or other secure facilities within the previous 6 months decreased 43 percent from entry into services to 18 months after entering systems of care.
- **Reduced costs due to fewer days in inpatient care.** The average reduction in per-child inpatient hospital days from entry into services to 12 months translated into an average per-child cost savings of \$2,776.

Child and Family Profile

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

When Jordan first came to a system of care at age 10, he and his mother were having serious problems getting help for his mental health needs. Having been diagnosed with bipolar disorder at age 6, Jordan's needs were complex and compounded by his mother's own issues related to substance abuse, homelessness, and a chronic, life-threatening illness. When Jordan reached a critical moment where he was hospitalized, his mother considered giving up custody so he could receive residential care for his symptoms.

Once enrolled in the system of care, Jordan began to see substantial improvements in his life. Jordan's service providers included the hospital, his school, and the mental health department's children's intensive services system, which provided mobile mental health case management.

Initially Jordan's plan involved therapeutic respite care and a specialized camp for children with serious mental health needs, but additional supports and services were available because the entire county operated under the system of care's framework. The collaboration among all the service providers has led to more than just improvements at school.

The symptoms associated with Jordan's bipolar disorder have been substantially reduced. Jordan has far fewer hallucinations and periods of suicidal thoughts or behaviors than before. The personal situation of Jordan's mother improved because of the system of care's services. The system of care worked because of collaboration, shared resources, and the close connection between the system of care and the family.

Projects for Assistance in Transition from Homelessness (PATH)

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$54.3m	\$54.3m	\$54.3m	\$58.3m

What Does PATH Do?

The Projects for Assistance in Transition from Homelessness (PATH) formula grant program provides funding to states, localities and non-profit organizations to support individuals who are homeless (or are at risk of homelessness) and have a serious mental illness and/or a substance abuse disorder. PATH is designed to encourage the development of local solutions to the problem of homelessness and mental illness through strategies such as aggressive community outreach, case management and housing assistance. Other important core services include referral for primary care, job training and education. PATH requires states and localities to leverage funds through \$1 match for every \$3 in federal funds. Surveys indicate that PATH-funded agencies enrolled 58,500 individuals with the most disabling mental illness with a wide range of racial and ethnic diversity. The most common diagnoses were schizophrenia and psychotic disorders and affective disorders. More than half of homeless consumers at first contact had been homeless for more than 30 days.

Why is PATH Important?

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

A focus on ending chronic homelessness is critically important to addressing the enormous economic and social costs associated with individuals who stay homeless for long periods and impose enormous financial burdens on communities as they cycle

through hospital emergency rooms, jails, shelters and the streets. Through the Samaritan Initiative, the Administration hopes to make resources available to states and localities to fund some of the services needed by people experiencing chronic homelessness – including permanent housing and case management.

What Justifies Federal Spending for PATH?

For FY 2008, the President is requesting \$54.3 million for the PATH program, a freeze at current levels. Services funded by the PATH program provide a critical bridge for individuals with severe mental illness who are experiencing chronic homelessness. An increase for PATH for FY 2008 would afford Congress the opportunity to adjust the inequitable interstate funding formula that has left 20 rural and frontier states at the \$300,000 minimum allocation since the program's inception. Despite increases for PATH funding since the 1990s, these minimum allocation states are still receiving the same amount they did in FY 1993. Legislation increasing the minimum state allocation level – without adversely impacting large states was introduced in the 109th Congress by Senators Pete Domenici (R-NM) and Edward M. Kennedy (D-MA).

PATH and State and Local Plans to End Chronic Homelessness

In recent years, federal, state and local policy has shifted toward greater investment in strategies to address chronic homelessness, i.e. the needs of individuals who stay homeless for extended periods of time. Chronic homelessness is extremely costly to local communities in terms of increased utilization of emergency rooms, acute care and the criminal justice system. A recent University of Pennsylvania study found that placement in permanent supportive housing was (on average) only slightly more expensive than the cost of maintaining someone in chronic homelessness. More than 287 Mayors and County Executives have created 10-Year Plans to End Chronic Homelessness, and 53 Governors of states and territories have committed to state Interagency Councils on Homelessness.

In addition, the Interagency Council has evolved into a national partnership of every level of government and the private sector. This partnership organized around business principles, accountability, and results in ending homelessness, rather than managing, shuffling, or cycling homeless individuals with mental illness among various systems such as shelters, hospitals and jails. This partnership is demonstrating results in communities around the country. Cost benefit analysis is fueling political will across the country and the Council has linked those studies to solutions, housing, and services.

PATH is a critical resource for states and localities in reaching people with mental illness who experience chronic homelessness. In addition to the outreach and engagement services funded by PATH, local communities also need assistance in funding ongoing services in permanent supportive housing targeted to individuals who are exiting chronic homelessness, including permanent housing financed through HUD's McKinney-Vento Homeless Assistance Act.

GBHI & Services in Permanent Supportive Housing

To address chronic homelessness, the completed plans set forth by Congress, the President, governors and mayors across the nation call for developing 80,000 new permanent supportive housing units. This will require creating 16,000 units of new permanent supportive housing for chronically homeless people in each of the next 5 years. Federal funding at the level of \$5,000 per unit will leverage other resources to provide the comprehensive services needed to help chronically homeless people achieve housing stability and pursue recovery from mental illness and substance abuse problems.

Therefore, as an important step toward meeting the 2012 goal, Congress should include an additional \$80 million in services funding in the FY 2008 Labor,

Health and Human Services and Education appropriations bill within the Grants for the Benefit of Homeless Individuals Program (GBHI) administered by SAMHSA.

This increase is needed to complement ongoing investments, through other programs, including PATH and the Center for Substance Abuse Treatment's (CSAT) Targeted Treatment for Homeless Programs, in treatment services that assist homeless people in moving toward recovery and permanent housing.

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$34.0m	\$34.0m	\$34.0m	\$36.6m

What Does PAIMI Do?

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

Why is PAIMI Important?

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

- Successfully closed 25,475 cases of which 19 percent were related to abuse, 16 percent to neglect, and 65 percent to a violation of individual rights;
- Consistent with the sophisticated and comprehensive approach of the P&A system, utilized a broad range of strategies to resolve issues, including short-term and technical assistance, investigations, and administrative remedies; only 2 percent of cases resulted in legal action being taken;
- Served individuals with mental illness living in all settings, including public and private institutions and hospitals, prisons, foster care, provider-operated housing, and family’s and individual’s homes;
- Served over 7500 children and young adults and nearly 13,000 adults and elderly individuals with mental illness; and
- Provided information and referral services to almost 56,000 individuals.

What Justifies Increased Federal Spending for PAIMI?

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

The congressional and administrative directives to the PAIMI Program are welcome for two reasons. First, they reflect the growing awareness of the need for reliable protection and advocacy services to

persons with mental illness in a variety of settings. Second, they are a strong sign of congressional trust in the P&A system. However, in order to meet the requirements of these directives, additional funding is critical. **The Administration proposes to level fund the P&A program, which would reduce funding in 13 states.** (Congressional Justification, CMHS—23-24)

PAIMI Success Stories

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

- The **Arkansas P&A** investigated the death of a resident who choked to death on a hot dog in a seclusion room of the Arkansas State Hospital. The man, dually diagnosed with schizophrenia and mild mental retardation, had been hospitalized at the state hospital for nearly 14 months at the time of his death. He had four teeth, was being generously medicated with Haldol (which has a known side effect of causing spasms of the larynx), and had been fed a double portion of hot dogs for supper. He then was left alone in a seclusion room. The P&A's death investigation found numerous hospital policy violations and, as a result, changes were made in policies for the use of time-out rooms; serving meals to psychiatric patients; and requiring dental assessment and dietary modifications for patients with poor teeth.
- The **Massachusetts P&A** represented a woman who was wrongly terminated from her job due to her mental health disability. The woman worked as a housekeeper and had become suicidal while on the job. Despite the fact that her direct supervisor transported her to the mental health crisis center for admission, her employer later terminated her for not calling in to work while in the hospital. The P&A filed a complaint, conducted discovery, and filed a probable cause brief. A favorable settlement was ultimately negotiated for the woman, and the employer agreed to conduct annual staff training on employment discrimination issues.
- Michigan school programs, especially those serving children with emotional impairments, generally include what is called a "time-out" room, where students have been inappropriately restrained and secluded. Following the death of a child, the

Michigan P&A worked systemically to address this type of restraint and seclusion, by completely working with a group to rewrite the state model policy on restraint and seclusion in schools.

- The **Texas P&A** worked with a 7-year-old who had been physically restrained 75 times during the school year and 53 times the year before. A review of educational records also indicated that the student was isolated for periods of time and that the isolation appeared punitive. The P&A worked with the school team to get agreement on bringing in a behavioral analyst to do a Functional Behavior Assessment (FBA), provide training to the teachers, and conduct ongoing observations/trainings. The school agreed to implement every reasonable recommendation from the behavior analyst and to place the student in a more appropriate class. The parents reported that their son loves the new class and teacher, and is no longer afraid to go to school. As a result of the placement change, staff, training, and behavior support plan, the student's behaviors have improved dramatically.

Programs of Regional and National Significance (PRNS)

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$263.3m	\$263.3m	\$186.6m	\$291.9m

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

The SAMHSA budget proposal would cut funding for the Programs of Regional and National Significance (PRNS) by roughly \$77 million. The proposed PRNS budget would cut funding for the Youth Violence Prevention program alone by almost 20 percent or \$18 million.

PRNS includes the programs in its Knowledge Development and Application Program (KDA) and its Targeted Capacity Expansion Program (TCE), as well as a number of other programs. On pages 26-41, we describe the salient importance of the following PRNS programs:

- Youth Violence Prevention Initiatives.....26
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Youth Violence Prevention Initiatives

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$93.3m	\$93.3m	\$75.7m	\$100.3m

What are the Youth Violence Prevention Initiatives?

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

Through grants made to local education agencies, the SS/HS Initiative provides schools and communities in urban, suburban, rural, and tribal areas across the United States with the funds and resources to build or enhance the infrastructure to strengthen healthy child development, thus reducing violent behavior and substance use. These three-year grants to local school districts fund programs addressing school violence prevention through a wide range of early childhood development, early intervention and prevention, suicide prevention, and mental health treatment services. The SS/HS program is administered jointly with the Department of Education (Safe and Drug Free Schools Office) and the Department of Justice (Office of Juvenile Justice and Delinquency Prevention). With financial and technical support from the three Federal partners, 190 communities are creatively linking new and current services to reflect their own specific needs, all with a vision to prevent violence among youth. While grantees work to correct problems as they arise, they also strive to prevent violence before it starts. Science-based approaches are being used to achieve aims such as promoting students' cooperation with their peers, setting standards of behavior, developing healthy student/family relationships, increasing parental involvement in schools, building emotional

resiliency and strengthening communication and problem solving skills.

As CMHS' major school violence prevention program, the initiative was started in 1999. Since then, this initiative has been expanded to 49 states and has been awarded to 230 local education agencies in urban, rural and suburban communities. Between FY 1999 and FY 2004, this program funded a total of 190 communities and approximately 5.6 million students. In FY 2005, 40 new grantees were funded.

Why Are Youth Violence Prevention Initiatives Important?

Each year qualified applications for the SS/HS Initiative exceed the availability of funds. With additional funds in FY 2008, CMHS could reach more communities with this comprehensive program designed to foster the healthy development of children and prevent youth violence.

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

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

- Early childhood psychosocial and emotional development programs. (This element may only be funded by SAMHSA);
- Supporting and connecting schools and communities. (This element may only be funded by the Department of Education);
- Safe school policies. (This element may only be funded by the Department of Education and Department of Justice); and
- Grantees focus on 6 core areas. Statutory restrictions limit how funding from each federal partner can be applied to these elements.

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

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

The program includes a Public Awareness/Communications Campaign to fulfill the needs of grantee partnerships and to ensure sustainability of the violence prevention grant programs.

Why Is Additional Federal Funding Justified?

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

Program Data

Academic Achievement Improved

In Toledo, OH: 73% and 52% increase in students passing 4th and 6th grade proficiency tests

In Westbury, NY: Statistically significant improvement in academic achievement among SS/HS students as compared to non-SS/HS students.

School Safety Increased

In Cook County, IL: Gang-related incidents dropped from 81 to fewer than 9.

In Los Angeles, CA: 72% of students indicated that SS/HS helped them take responsibility for their behavior; 68% reported that they learned to say "no" when someone pressed them to do something that was not safe or good; and 82% indicated a high sense of safety at school.

Discipline Referrals/Suspensions Decreased

In Covington, KY: 60% reduction in office referrals.

In Redmond, OR: 33% decrease in juvenile arrest rate.

In Springfield, OH: 24% decrease in discipline referrals and 24% decrease in fighting.

In Tyrone, PA: 61% reduction in suspensions for middle and high school students.

Attendance Increased

In Houston, TX: 11% decrease in students reporting missing school due to safety concerns.

In Seattle, WA: 30% decline in truancy.

Suicide Prevention for Children and Adolescents

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$31.7m	\$36.1m	\$33.5m	\$37.0m

What Do the Suicide Prevention Programs Do?

In 2004, Congress authorized a program for Youth Suicide Early Intervention and Prevention Strategies, the Garrett Lee Smith Memorial Act (P.L. 108-355) to: a) support the planning, implementation, and evaluation of organized activities involving statewide youth suicide intervention and prevention strategies, b) authorize grants to institutions of higher education to reduce student mental and behavioral health problems, and c) authorize funding for the national suicide prevention resource center. The Garrett Lee Smith program provides early intervention and assessment services, including screening programs, to youth who are at risk for mental or emotional disorders that may lead to a suicide attempt. The services are integrated with school systems, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, foster care systems, and other child and youth support organizations.

What Justifies Federal Funding for these Programs?

In 2004, 32,439 individuals died by suicide in the U.S. Of these suicides, more than 4,500 were young people between the ages of 10-24.

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

According to the Youth Risk Behavior Surveillance System, a survey of students across the nation administered by the Centers for Disease Control and Prevention (CDC), in 2005, 16.9 percent seriously considered attempting suicide, 8.4 percent of youth attempted suicide, and 2.3 percent made a suicide attempt that required medical treatment. The National Survey on Drug Use and Health, a separate survey administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), found that in 2005, 14 percent of youth between the ages of 12 and 17 (approximately 3.4 million youth) experienced at least one Major Depressive Episode

(MDE) and that approximately 712,000 attempted suicide during their worst or most recent episode.

Repeatedly over the last several years, the Federal Government has identified suicide as a serious and preventable public health problem. In 1999, the Surgeon General issued a *Call to Action to Prevent Suicide*, followed in 2001 by the *National Strategy for Suicide Prevention: Goals and Objectives for Action* (NSSP). The NSSP was developed by a broad public/private partnership and founded on research conducted over four decades. Many of its 11 goals and 68 objectives are aimed at preventing suicide among children and adolescents, and include increasing evidence-based suicide prevention programs in schools, colleges, universities, youth programs, and juvenile justice facilities; promoting training to identify and respond to children and adolescents at risk for suicide; and establishing guidelines for screening and referral. Funding for the Garrett Lee Smith Memorial Act, as authorized by Congress, provides essential support for States and communities seeking to implement the NSSP’s objectives.

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

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

Relationship to Other Suicide Prevention Initiatives

CMHS is the lead agency within SAMHSA for the NSSP. Congress has earmarked CMHS funds for two specific suicide prevention initiatives to assist in the implementation of the NSSP. The first initiative is a the National Suicide Prevention Lifeline (1-800-273-TALK), a network of more than 120 crisis centers across the country that respond, 24 hours a day, to individuals in emotional distress or suicidal crisis. The second initiative is the Suicide Prevention Resource Center, which provides prevention support, training, and materials to strengthen suicide prevention efforts.

These programs have helped put in place the essential building blocks to guide activities at the state and local level that will help reduce the tragic toll of suicide, particularly among our young people. The immediate need is for resources that will enable States and communities to provide the services that can save lives. Additionally, a public/private partnership should be developed by the Administration through SAMHSA. Such a partnership would do much to address the advancement and implementation of “a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.”

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

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$29.5m	\$29.5m	\$28.1m	\$31.7m

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

The Surgeon General’s landmark 1999 “Report on Mental Health” explored the roots of mental disorders in childhood, and documented the well-established relationship between childhood exposure to traumatic events and risk for child mental disorders. This report stated that in any given year, about 20 percent of children have a mental disorder requiring the attention of a mental health professional. In 2002, SAMHSA’s National Survey on Drug Use and Health reported that an estimated 5 to 9 percent of children and youth have a serious emotional disturbance in any one year. And yet, a 1995 RAND study notes that only 8 percent of children who need mental health care actually receive services – this leaves 92 percent of children who need care without any services. Many of these children and adolescents have been exposed to trauma or violence. The trauma exposure for children in the community has been well documented, with rates of exposure to at least one traumatic event for 25 percent of the children in the Great Smoky Mountain study. Higher rates have been found among institutionalized children; an NIMH/OJJDP study showed rates of 92 percent for trauma exposure and up to 18 percent experiencing PTSD.

The Surgeon General’s 2001 “Report on Youth Violence” noted that exposure to violence can disrupt normal development of both children and adolescents, with profound effects on mental, physical, and emotional health. As the Surgeon General reported, adolescents exposed to violence are more likely to engage in violent acts themselves. Children are exposed to many kinds of trauma and violence, including physical and sexual abuse, accidental or violent deaths of loved ones, domestic and community violence, natural disasters and terrorism, and severe accidents or life-threatening illnesses. Any of these exposures can have severe and long-term effects. A 2002 GAO Report (GAO-02-813) on child trauma documented that large numbers of children experience trauma-related mental health problems, while at the same time facing barriers to receiving appropriate mental health

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

The U.S. DHHS Child Maltreatment Report from the National Child Abuse and Neglect Data Systems, which annually aggregates state child protection reports, estimated that 906,000 children were confirmed victims of child abuse and neglect in 2003. Exposure to violence and trauma is a daily experience for many children. A 2003 report in the Journal of the American Medical Association reported that of the 4,000 children in the Los Angeles Unified School District included in this study, 90 percent of students in some neighborhoods had been exposed to multiple incidents of violence, as witnesses and victims, and that 27 percent of them had clinical levels of PTSD and 16 percent of them had clinical levels of depression. Without treatment, long-term consequences can result. A 1996 study of severely maltreated children showed that 40 percent were diagnosed with PTSD at the time of the removal from their abusers, with 33 percent still suffering from the disorder two years later. Without early intervention with children exposed to trauma, the symptoms may re-emerge following a subsequent trauma, and can affect development, physical health, ability to function, and relationships in adulthood. The ACEs (Adverse Childhood Experiences) study showed that as the number of adverse childhood experiences increases, there is a related increase in the number of serious health problems such as alcoholism, drug abuse, suicide attempts, smoking, and poor general health.

How Can We Address this Problem?

Congress, in the Children’s Health Act of 2000 (Public Law 106-310), established the National Child Traumatic Stress Initiative (NCTSI) to help address the growing problems arising from children and adolescents witnessing or experiencing violence and trauma. These grants fund a national network of child trauma centers, including community service programs to provide services to children and families who are victims or witnesses of violence and trauma, treatment development centers that collaborate closely with community providers in the development of evidence-based practices and research on the treatment and prevention of trauma-related mental disorders, and a national coordinating and resource center to guide the network’s efforts.

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

Despite widespread exposure to trauma and violence and serious consequences for children and youth, we have failed to provide the resources necessary to strengthen research and services for these children. Expanding funding of this program would support and strengthen a broad network of centers of excellence on children, trauma, and violence and would yield improved evaluation tools and evidence-based treatment methods for vulnerable children exposed to violence. This program will support the further development of treatment and services that will prevent the onset of mental health problems among children and youth who have experienced such trauma.

The Children’s Health Act originally authorized the NCTSI program at \$50 million. In its first year, \$10 million was appropriated. In FY 2002, an additional \$20 million was provided to this program; of this, \$10 million came from the Emergency Supplemental Appropriation (PL 107-38) for the recovery efforts after 9/11. The NCTSI grew rapidly from 17 to 54 centers from 2000-2004, with funding at \$30 million. In 2005, funding remained at \$30 million, but the

level funding (and the loss of the supplemental funds) led to a reduction in the total number of funded centers, from 54 to 45 centers, and the inability to renew funding for the many experienced trauma professionals in the Network.

The innovative program has developed a strong, collaborative network of committed community and treatment development centers that work together to help children who have experienced trauma and develop new and more effective interventions. The program has developed training programs, resource materials, new interventions, and has a strong internal and external evaluation program in place. Recent yearly estimates indicate that more than 50,000 individuals – children, adolescents and their families – will directly benefit from services through this network, and over 200,000 professionals will be trained in trauma-informed interventions. Over 700 external partnerships have been established by Network members in their work to integrate trauma-informed services into all child-serving systems (such as schools, foster care, correctional facilities, residential care, shelters, and more).

The NCTSI was immediately mobilized in the aftermath of Hurricanes Katrina and Rita in 2005, and deployed staff and disseminated resources, training, and materials throughout the country, serving as a major national resource to the interagency federal response. With additional support for the NCTSI, many thousands more will benefit from the improvements in treatment, the expansion of educational opportunities, the development of community and national collaborative partnerships, the ongoing internal and national program evaluations, and the widespread dissemination of public awareness programs and materials that are made available through the coordinating center (the National Center for Child Traumatic Stress, based at Duke University and UCLA) and the affiliated National Resource Center. The ongoing federal evaluation of this program has determined that it is “exceeding expectations.”

Mental Health Transformation State Incentive Grant Program

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$25.7m	\$25.7m	\$19.7m	\$26.2m

What Is the Mental Health Transformation State Incentive Grant Program?

The Mental Health Transformation State Incentive Grants (SIGs) support states’ efforts to create comprehensive mental health plans and enhance the use of existing resources to serve persons with mental illnesses. SAMHSA awarded seven Transformation State Incentive Grants in FY 2005; two additional SIGs were awarded in 2006. Grantees engage in State planning and coordination activities with involvement from agencies, such as criminal justice, housing, child welfare, Medicaid and education. In the second year of funding, States may use 85 percent of funds to support programs at the community level as proposed in their State Plan. The remaining 15 percent is used to support planning activities.

Why are the State Incentive Grants Important?

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

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

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

What Justifies Federal Spending for The Transformation State Incentive Grants?

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

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

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$12.0m	\$7.6m	\$2.1m	\$12.8m

What will the Integrated Treatment Program Do?

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

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

Why are the Integrated Treatment Grants Important?

Our country faces a serious treatment gap in addressing the treatment and service needs of people with co-occurring disorders. Although evidence supports integrated treatment for co-occurring disorders, it is only available in a limited number of communities, and the 1999 Surgeon General’s Report on Mental Health cites an estimate that 10 million Americans have co-occurring disorders. Individuals with severe levels of co-occurring disorders are more likely to experience a chronic course and to over-utilize health and expensive emergency room services than are those with either type of disorder alone. Clinicians, program developers, and policy makers need to be aware of these high rates of comorbidity and service use — about 15 percent of those with a mental disorder in 1 year.

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

What Justifies Federal Spending for Integrated Treatment Grants?

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

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

Jail Diversion Program Grants

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$6.93m	\$6.93m	\$3.93m	\$7.44m

Why are Jail Diversion Program Grants Important?

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

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

What are Jail Diversion Program Grants?

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

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

What Justifies Federal Spending on this Program?

The SAMHSA-funded Knowledge Development and Application (KDA) study found that:

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

Taken together with the findings from previous studies on jail diversion, these findings provide evidence that jail diversion results in positive outcomes for individuals, systems, and communities. These Targeted Capacity Expansion Jail Diversion Program grants, awarded by CMHS since 2002, are currently allowing communities across the country to identify for diversion and link individuals to the evidence-based services and supports they need. The Jail Diversion Program should continue based not only on its efficacy, but also because, for people inappropriately warehoused in jails, appropriate and effective community-based treatment is needed now.

Mental Health Outreach and Treatment to the Elderly

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$4.95m	\$4.95m	\$0.0m	\$5.35m

What is the Program?

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

Although \$4,950,000 was allocated for evidence-based mental health outreach and treatment to the elderly in 2007, this allocation falls short because there will be approximately 40 million people in the U.S. over the age of 65 and more than 20 percent of them will experience mental disorders by the year 2010. **The Administration proposes to eliminate funding for this program in 2008.**

Normal aging is not characterized by mental or cognitive disorders.

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

1. Disability due to mental illness in individuals over 65 years old will become a major public health problem in the near future because of demographic changes. In particular, dementia, depression, and schizophrenia, among other conditions, will all present special problems in this age group:
 - Dementia produces significant dependency and is a leading contributor to the need for costly long-term care in the last years of life; and
 - Depression contributes to the high rates of suicide among males in this population; and schizophrenia continues to be disabling in spite of recovery of function by some individuals in mid to late life.
2. Older individuals can benefit from the advances in psychotherapy, medication, and other treatment interventions for younger adults, when these interventions are modified for age and health status.

3. Primary care practitioners are a critical link in identifying and addressing mental disorders in older adults. Opportunities are missed to improve mental health and general medical outcomes when mental illness is under recognized and under treated in primary care settings.
4. Treating older adults with mental disorders accrues other benefits to overall health by improving the interest and ability of individuals to care for themselves and follow their primary care provider’s directions and advice, particularly about taking medications.
5. Stressful life events, such as declining health and/or the loss of mates, family members, or friends often increase with age. However, persistent bereavement or serious depression is not “normal” and should be treated.

What Justifies Federal Spending for this Initiative?

As the life expectancy of Americans continues to increase, the sheer number-although not necessarily the proportion-of persons experiencing mental disorders of late life will expand. This trend confronts 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 members.

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

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

Statewide Family Network Grants

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$3.4m	\$3.4m	\$0.0m	\$3.6m

Why Are Statewide Family Network Grants Important?

Families raising children with emotional, behavioral, or mental disorders need emotional support, accurate information about mental health services, and help protecting the rights of their children. Research on systems of care has indicated that strengthening families enhances resilience in children. **Yet the Administration proposes to eliminate funding for this program in 2008.**

The Surgeon General recognized that families have become essential partners in the delivery of mental health services to children and adolescents. Family-run organizations linked to a national network are the means by which families can fulfill this important role. Goal 2 of the final report of the President’s New Freedom Commission on Mental Health envisions a transformed mental health system that is “consumer and family driven” and declares that, “Local, State, and Federal authorities must encourage consumers and families to participate in planning and evaluating treatment and support services.” The Federal Action Agenda, developed by the Substance Abuse and Mental Health Services Administration to implement the Commission’s recommendations, states very clearly that, “A keystone of the transformation process will be the protection and respect of the rights of adults with mental illnesses, children with serious emotional disturbances, and their parents.” Family-run organizations linked to a national network are the means by which families can fully realize these important decrees.

What Do the Statewide Family Networks Do?

The Statewide Family Networks program enhances the capacity of States by providing additional infrastructure focused on the needs of children and adolescents with serious emotional disturbances and their families. This program is designed to support families and youth as the natural catalysts for transforming the child-serving systems in their State. Grantees accomplish this by informing key decision makers about the experiences of children and youth with mental health needs and their families.

Grantees work in tandem with community coalitions, policymakers, program administrators, and service providers. Grantees promote leadership and provide management skills for boards and staff of their agencies. By providing technical assistance, grantees are the nation’s foundation for shaping a better quality of life for children with mental health needs and their families. Several grantees in this program specifically focus on the needs of ethnic minorities and eliminating the additional challenges experienced by families who live in rural areas. Statewide Family Network activities are all critical to supporting the implementation of “Transforming Mental Health Care in America: the Federal Action Agenda.”

- *Developing and conducting peer support groups* helps families: address issues of stigma, shame, guilt, and blame; learn how to constructively and successfully manage their own child’s disorder; and actively participate in care planning for themselves and their child;
- *Disseminating information and technical assistance* through clearinghouses, websites, newsletters, sponsoring conferences and conducting workshops changes attitudes, reduces stigma and discrimination, transfers knowledge, and links families to resources;
- *Providing outreach to families* through toll-free telephone numbers and through information and referral networks prepares youth and family members to request and obtain needed or wanted services;
- *Serving as a liaison* with various human service agencies and educating states and communities about effective ways to improve children’s services and inform providers about emotional disorders and services, including need for care, access to services, and effectiveness of treatments; and
- *Training skills for effective advocacy* for children’s services and successful organizational management and financial independence.

Evidence of Effectiveness

A study of the impact of the Statewide Family Network Grants groups the benefits received into three categories:

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

Family members interviewed for the study felt that they were better able to advocate for their children, were more in control of their lives, and were able to make lasting changes because of the help and support that they received through the statewide family networks.

In the Government and Performance and Results Act (GPRA) report for 2004-2005, the Statewide Family Network grantees reported providing at least one service to 166,309 family members and youth. In the same period, 38 grantees reported that 3,755 family members and youth held seats on a mental health policy board or commission in their community or state.

Examples of Effectiveness

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

Some examples are:

- **AK** *Alaska Youth and Family Network's* curriculum helped 26 youth ages 16-21 who have repeatedly been in emergency rooms and residential treatment facilities avoid unnecessary and costly levels of care.
- **CA** *United Advocates for Children of California* is a critical partner ensuring that family members participated in the oversight of the Mental Health Services Act (Proposition 63).
- **CT** *Families United* developed a skill-building curriculum to teach the volunteer support group workforce to provide ongoing computer and phone support to hundreds of caregivers each year.
- **FL** *The Florida Institute for Family Involvement* developed a family-to-family response to disasters, providing information in several languages to help families of children with mental health needs be better prepared to respond to and recover from the trauma caused by natural disaster.
- **GA** *The Georgia Parent Support Network's* initial investment of \$10,000 in a youth Peer Center has been annually funded by the state with \$138,000. Youth peer mentors are approved for Medicaid billing.
- **IA** *Federation of Families* has developed a *Dare to Dream* program that assists youth to identify and focus on their aspirations.

- **ID** *The Idaho Federation of Families' Art from the Heart* anti-stigma campaign reached urban, rural, frontier, and Native American reservations.
- **KS** *Keys for Networking's* Director service on New Freedom Commission provided pivotal voice for children and families. Keys has moved parent support to a best practice with research investment and work on fidelity measures.
- **KY** *KY Partnership for Families* helped the State achieve its goal of braided funding for more effective services for children, youth and families.
- **MA** *Parent/Professional Advocacy League* has worked with the State toward eliminating custody relinquishment, increasing budgets, instituting parity for mental health care, and establishing relationships with private health insurers.
- **MD** *The Maryland Coalition* instituted a study that stimulated policy recommendations to eliminate the practice requiring families to relinquish custody of their children in order to get necessary mental health services.
- **MI** *Association for Children's Mental Health* planned a symposium on family involvement in partnership with the State to engage family leaders and mental health administrators as partners in solution building.
- **MS** *Mississippi Families As Allies* is a member of the Interagency Coordinating Council; helped shift the juvenile justice response to youth; coordinate an interagency system; and helped MS access alternatives to residential facilities and procure a five-year demonstration Center for Medicaid Services waiver for children's mental health.
- **NY** *Families Together* has delivered direct support to over 2,000 youth with serious mental health needs and their families in crisis situations. Since suicide has become the second leading cause of death for adolescents in NY, these services are a lifeline to many of New York's families.
- **OR** Established the Children's System Advisory Committee, a sub-committee of the State Planning and Management Advisory Committee as part of the Children's System Change Initiative (CSCI).
- **RI** *Parent Support Network* has organized a strong collective group of over 2000 diverse families and youth who are rich in ethnicity, language and culture who support, educate and advocate with one another and work in partnership to promote policy and practice changes for youth and their families.
- **TN** - *Tennessee Voices* has improved mental health status for children and youth, reduced the number of children committed to custody, fewer restrictive placements, and increased parent satisfaction. Efforts have led to infrastructure changes through the formation of a Governor's-level Children's Cabinet Council and a Mental Health Resolution for an improved children's mental health system.
- **WI** *Wisconsin Family Ties* has helped families be strengthened and more children have access to services. Children have more effective school plans, enabling them to experience increased academic and social success.
- **WY** *UPLIFT*, is at the forefront of advocacy efforts for system transformation for children's mental health across the state. They have a proven track record for business integrity and effective work with families, communities, state agencies, policy makers, and the Governor's office.

Statewide Consumer Network Grants

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$1.5m	\$1.5m	\$0.0m	\$1.7m

What Do the Statewide Consumer Networks Do?

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

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

Approximately \$1.5 million is provided to support 19 grantees at \$70,000 each per year. **The Administration’s budget proposes to eliminate funds for this program in 2008.** This will result in a major loss in mental health transformation efforts and will significantly curtail the efforts of grass-roots consumers to promote systems change.

Why are the Statewide Consumer Networks Important?

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

For example, the SCNGs:

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

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

Consumer and Consumer-Support Technical Assistance Centers

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$1.98m	\$1.98m	\$0.0m	\$2.18m

What are the Consumer and Consumer-Support Technical Assistance Centers?

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

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

Why are Consumer and Consumer-Support Technical Assistance Centers Important?

Despite the importance of supporting and promoting consumer-run mental health services being recognized by the President’s New Freedom Commission Report, the Administration proposes to eliminate funding for this program in 2008. The 2003 report of the President’s Commission and the Surgeon General’s 1999 report, *Mental Health: A Report of the Surgeon General* declared recovery from mental illnesses the goal of the nation’s mental health system. It also pointed to evidence of the important role played by consumer-run organizations in achieving this goal. In addition, the Surgeon General’s report found that consumers in the role of peer-specialists provide services that improve patient outcomes.

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

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

Funding was not provided for this program in the FY 2008 Administrative request.

What Justifies Federal Spending on this Program?

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

Community Action Grants

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$0.0m	\$0.0m	\$0.0m	\$2.0m

What are Community Action Grants?

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

Why are Community Action Grants Important?

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

What Justifies Federal Spending on this Program?

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

Congress did not fund the Community Action Grants in FY 2005, FY 2006 or in FY2007. Funding was not provided for this program in the FY 2008 Administrative request.

Minority Fellowship Programs

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$3.8m	\$3.8m	\$0.0m	\$4.0m

What is the Minority Fellowship Program?

The Minority Fellowship Program helps to reverse disparities in mental health services and the quality of those services to minority populations by training minority mental health professionals to provide culturally competent, accessible mental health and substance abuse services for diverse populations.

Unfortunately, the Administration’s FY 2008 funding request proposes to eliminate funding for the program, which received \$3.8 million in FY 2007.

Why is the Minority Fellowship Program Important?

The Surgeon General’s Report, *Mental Health: Culture, Race and Ethnicity*, as well as the Bush Administration’s *President’s New Freedom Commission on Mental Health* identified the existence of health disparities in the mental health system, with minorities receiving less mental health treatment and of a lower quality. A major recommendation in these reports was to increase funding for training minority mental health professionals and to train mental health professionals to become culturally competent.

Severe shortages of mental health professionals often arise in underserved areas due to the difficulty of recruitment and retention in the public sector. Studies have shown that ethnic minority mental health professionals practice in underserved areas at a higher rate than non-minorities. Furthermore, a direct positive relationship exists between the numbers of ethnic minority mental health professionals and the utilization of needed services by ethnic minorities.

What Justifies Federal Spending on this Program?

Minorities currently represent 30% of our nation’s population and are projected to account for 40% in 2025. To ensure that minorities have access to culturally sensitive and effective mental health services, federal support for programs that train minority psychologists and other behavioral health professionals is vital.

The mental health needs of ethnic minorities in the United States have been, and continue to be, grossly underserved. The available assistance often did not answer the pressing needs of those being served. At their inception in the 1970’s, the National Institute of Mental Health (NIMH) Minority Fellowship Programs (MFPs) were to create a nucleus of ethnic minority mental health practitioners trained at the doctoral level and equipped to provide leadership, consultation, training, and administration to those public mental health agencies and organizations particularly concerned with the development and implementation of programs and services for ethnic minority clients and communities.

The Minority Fellowship Programs have succeeded in educating many more professionals and in producing leaders in mental health services. It is critical to continue to provide clinical training support to address the shortage of mental health care providers to better serve minority and underserved patients.

The CMHS clinical training program is a cost effective way to address some of our most serious social and public health problems and should be continued.

Mental Health Research

Fiscal Year 2008 Funding Recommendations

for the

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

National Institutes of Health (NIH)

The National Institutes of Health (NIH) is the world's premier medical and behavioral research institution, supporting more than 50,000 scientists at 1,700 research universities, medical schools, teaching hospitals, independent research institutions, and industrial organizations throughout the United States. It is comprised of 27 distinct institutes, centers and divisions.

Each of the NIH institutes and centers was created by Congress with an explicit mission directed to the advancement of an aspect of the biomedical and behavioral sciences. An institute or center's focal point may be a given disease, a particular organ, or a stage of development. The three institutes which focus their research on mental illness and addictive disorders are the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

The NIH was reauthorized at the end of the 109th Congress via the National Institutes of Health Reform Act of 2006, P. L. 109-482.

National Institutes of Health (NIH)
Director: Elias Zerhouni, MD (301) 496-4000

**Fiscal Year 2008
Funding Recommendations**

for the

National Institute of Mental Health (NIMH)

National Institute of Mental Health (NIMH)

The mission of the National Institute of Mental Health (NIMH) is to reduce the public health burden of mental and behavioral disorders through research on mind, brain, and behavior. Mental disorders are fundamentally brain disorders. Mental disorders are common health conditions that affect children, adolescents and adults. Each year more than 44 million people experience significant symptoms caused by mental illnesses of the ten leading causes of disability in the United States and internationally for ages 15-44, four are mental disorders including major depression, bipolar disorder, schizophrenia and obsessive-compulsive disorder. These disorders can be chronic and disabling and interfere with everyday living for those who experience them. If untreated, a mental disorder can become more severe and difficult to treat.

This public health mandate demands that NIMH harness science to achieve the fundamental understanding of how mental illnesses begin and progress, to discover new treatments, and eventually to prevent and cure them.

National Institute of Mental Health (NIMH)

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

Constituency Relations and Public Liaison

Director: Gemma Weiblinger (301) 443-3673

National Institute of Mental Health (NIMH)

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$1,403.5m	\$1,403.6m	\$1,405.4m	\$1,497.6m

Scientific Research

NIMH supports innovative research and research training that will significantly transform the prevention, diagnosis and treatment, and the recovery from them. NIMH-funded research has made great progress in revealing the complexities of mental disorders. With the completion of the Human Genome Project, researchers can begin to understand how genes give rise to basic biological functions, and how disruptions in function can lead to mental and behavioral disorders.

Over the past decade, scientists have come to realize that the relationship between genes and disease is complex. Research suggests that it is unlikely there is a single gene responsible for causing any particular mental disorder. Instead, it is likely that multiple genes and environmental influences together contribute to complex disorders such as autism, schizophrenia, and bipolar disorder. In addition, researchers have yet to discover how epigenetic mechanisms-ways that the environment influences gene function-factor into the etiology of these disorders.

The NIMH Program on Human Genetics, Epigenetics, and Genomics

This program funds research to identify gene variants and epigenetic mechanisms and interactions that contribute to risk for mental and behavioral disorders. This work will eventually give us the tools to predict vulnerability, validate diagnosis, and identify targets for new, effective, and personalized treatments.

Another important accomplishment in the area of scientific study is the NIMH Human Genetics Initiative (<http://nimhgenetics.org>), which established a repository of DNA, cell cultures, and clinical data and serves as a national resource for researchers studying the genetics of complex mental disorders. When the Human Genome Project was announced in the late 1980s, the cost of sequencing a single human genome was estimated at \$3 billion; soon it may be as low as \$1,000. These advancements promise that

NIMH-funded genome studies will yield a great deal of information at a reduced cost.

As a result of building this genetics repository, NIMH investigators are able to participate in the Genetic Association Information Network (GAIN). Using samples collected from previous clinical studies, GAIN will evaluate the subtle differences between the genomes of healthy people and those suffering from common diseases in order to determine how genetic variability contributes to disease susceptibility. The resulting data will be made available in a central database managed by NIH for no-cost access by the scientific community. Of the six initial studies receiving funding through GAIN, four will target mental disorders: schizophrenia, bipolar disorder, major depression, and attention deficit hyperactivity disorder.

Clinical Research

NIMH is committed to translating the discoveries made in scientific research into clinical practices that will predict who is at risk for disease; pre-empt the disease process by developing interventions; personalize interventions based on knowledge of individual biological, environmental, and social factors; and increase participation in clinical trials. To ensure the success of the clinical research program, NIMH assigns high priority to research ethics including the process of informed consent.

NIMH has made great strides in moving the science from the laboratory and into clinical settings. NIMH has completed primary and secondary phases of several practical clinical trials involving more than 10,000 patients at over 200 sites throughout the country. These are the largest and longest trials of their kind to examine treatment effectiveness for mental disorders such as schizophrenia, bipolar disorder, and depression in adolescents and adults. Traditional clinical trials focus solely on how treatments affect patient symptoms, but practical trials examine not only changes in symptoms but changes in real world functioning like quality of life,

care-giving burden, or use of health services. These clinical trials are examining the effectiveness of many current, widely-used treatments as part of a rigorous effort to discover what therapies work best and for whom.

The infrastructure developed for each of these large multi-site trials has forged efficient, effective, and collaborative relationships between scientists and clinicians throughout the country. This network of clinical sites will continue to serve as an extensive resource for more rapid research aimed at answering real world questions involved in treating mental disorders, such as better ways to determine the likelihood of an individual developing adverse side effects from specific medications.

In order to capitalize on these national networks established for the trials on depression, schizophrenia, and bipolar disorder, NIMH has decided to fund, infrastructure-only support for the “platform” of clinical sites and an administrative core. This platform is to serve as a critical foundation for supporting participant enrollment, facilitating communication between trial sites, maintaining up-to-date training in diagnosis and treatment, and providing needed administrative organization. This network also represents a potential impetus for public-private partnerships. These networks are designed to inter-connect with other NIH disease networks to accomplish the broader goals of NIH-creating multidisciplinary teams that work toward improving patients' quality of life and the nation's overall public health.

NIMH is making a wide ranging effort to seek input from the clinical research community, mental health professionals, patient advocates and individuals living with mental illnesses, private and public mental health service systems and providers, the pharmaceutical and biotechnology industry, and other interested groups about important public mental health research questions that could be addressed using the infrastructure provided by three NIMH clinical research networks - the Bipolar Trials Network, the Depression Trials Network, and the Schizophrenia Trials Network.

Antidepressants and Suicide

Studies have shown that most individuals suffering from moderate and severe depression, even those with suicidal thoughts, can substantially benefit from antidepressant medication treatment. However, use of selective serotonin reuptake inhibitors (SSRIs) in children and adolescents has become controversial. In

2005, the U.S. Food and Drug Administration (FDA) adopted a "black box" warning-the most serious type of warning in prescription drug labeling-for all SSRIs to alert doctors and patients of the potential for SSRIs to prompt suicidal thinking in children and adolescents. The warning urges diligent clinical monitoring of individuals of all ages taking these medications. This can be particularly challenging because it is difficult for patients, their family members and practitioners to determine whether suicidal thoughts may be related to the depression, the medication, or both. Five new NIMH research projects are striving to shed light on antidepressant medications, notably SSRIs, and their association with suicidal thoughts and actions (suicidality). Specifically, these new projects will help determine why and how SSRIs may trigger suicidal thinking and behavior in some people but not others, and may lead to new tools that will help us screen for those who are most vulnerable.

Workplace Research Highlights Toll of Mood Disorders

Mental illness accounts for almost 11 percent of disability worldwide and is the leading cause of disability in the United States. Recently funded NIMH services research studies on the toll of mood disorders on the workplace have revealed that it may be in society's and employers' best interests to offer programs that actively seek out and treat depression in the workforce. A simulation based on dozens of studies revealed that providing a minimal level of enhanced care for employees' depression would result in a cumulative savings to employers of \$2,898 per 1,000 workers over 5 years. Even though the intervention would initially increase use of mental health services, it ultimately would save employers money, by reducing absenteeism and employee turnover costs.

Depression exacts economic costs totaling tens of billions of dollars annually in the United States, mostly from lost work productivity. Savings from reduced absenteeism and employee turnover and other benefits of the intervention begin to exceed the costs of the program by the second year.

Other research in this area showed that bipolar disorder exacts twice depression's toll in the workplace. Each U.S. worker with bipolar disorder averaged 65.5 lost workdays in a year, compared to 27.2 for major depression. Even though major depression is more than six times as prevalent, bipolar disorder costs the U.S. workplace nearly half as much - a disproportionately high \$14.1 billion

annually. Researchers traced the higher toll mostly to bipolar disorder's more severe depressive episodes rather than to its agitated manic periods.

Poor functioning while at work accounted for more lost days than absenteeism. Although only about 1 percent of workers have bipolar disorder in a year, compared to 6.4 percent with major depression, the researchers projected that bipolar disorder accounts for 96.2 million lost workdays and \$14.1 billion in lost salary-equivalent productivity, compared to 225 million workdays and \$36.6 billion for major depression annually in the United States. Future effectiveness trials could gauge the return on investment for employers offering coordinated evaluations and treatment for both mood disorders. Related NIMH-funded research found that many aspects of job performance are impaired by depression and that the effects linger even after symptoms have improved. Noting that 44 percent of the depressed patients were already taking antidepressants when they began the study and still met clinical criteria for depression -and that job performance continued to suffer despite some clinical improvement - the researchers recommended that the goal of depression treatment should be remission.

Scientists also suggest that health professionals pay more attention to recovery of work function and that workplace supports be developed, perhaps through employee assistance programs and worksite occupational health clinics, to help depressed patients better manage job demands.

Enhancing Collaboration through Autism Centers of Excellence

Over the past several years, the NIMH autism research portfolio has expanded significantly. Much of this expansion has been through collaborations with multiple NIH institutes, including the National Institute of Child Health and Human Development (NICHD), the National Institute of Neurological Disorders and Stroke (NINDS), the National Institute on Deafness and Other Communication Disorders (NIDCD), and the National Institute of Environmental Health Sciences (NIEHS). Together, these Institutes have created several research centers and networks to enhance the coordination and focus of autism researchers throughout the country. Primary among these are the eight centers established in 2002-2003 as part of the *Studies to Advance Autism Research and Treatment (STAART) Network*.

NIH has initiated a new, unified centers program called the Autism Centers of Excellence (ACE). To facilitate data sharing among autism researchers, NIH has created the *National Database for Autism Research* (NDAR). NDAR will allow scientists to share data, as well as reach consensus on common measures and methodologies to enhance the comparison of data among various centers. NDAR will also coordinate data with other Federal databases, such as the NIMH genetics repository.

Fiscal Year 2008 Funding Recommendations

for the

National Institute on Drug Abuse (NIDA)

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

Like addiction, mental illnesses, such as depression, bipolar disorder, and schizophrenia are chronic diseases, which, without proper treatment, can be devastating to individuals, families, and society—exactng costs magnified well beyond those associated with substance abuse alone. And while we now know that drug abuse and mental illness frequently co-occur, we still do not know whether they share a common etiology, whether early drug abuse is a vital marker for mental illness, vice versa, or both. New studies examining this issue aim to develop interventions for high-risk individuals, such as children with mental health disorders or those involved with the criminal justice system.

The ultimate aim of our Nation’s investment in drug abuse research is to enable society to prevent drug abuse and addiction and to reduce these adverse individual, social, health, and economic consequences. As the world’s largest supporter of research on the health aspects of drug abuse and addiction, NIDA brings the force of science to bear in addressing this important national goal. NIDA then strives to ensure the swift and effective dissemination of the results of that research to significantly improve prevention and treatment efforts.

National Institute on Drug Abuse (NIDA)
 Director: Nora D. Volkow, MD (301) 443-6480
Office of Science Policy
 Director, Timothy P. Condon, Ph.D. (301) 443-6036
 Public Liaison, Geoffrey Laredo (301) 443-6036

National Institute on Drug Abuse (NIDA)

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$1,000.0m	\$999.4m	\$1,000.4m	\$1,067.3m

Background

In 2005, 19.7 million Americans or 8.1% of the population aged 12 or older were current (past month) illicit drug users. (2005 National Survey on Drug Use and Health, SAMHSA) This rate has remained relatively unchanged since 2002. Clearly, there is work to do.

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

NIDA’s comprehensive research portfolio continues to address the most essential questions about drug abuse, ranging from understanding how drugs work in the brain to developing and testing new treatment and prevention approaches to detecting and responding to emerging drug use trends. New knowledge about addiction and the multiplicity of biological, behavioral, and social factors that influence it continue to emerge.

Addiction is a chronic, relapsing disease that affects the brain. As a society, we do not demonize people with other chronic relapsing diseases like diabetes or high blood pressure. But we do with addiction. The stigmatization of drug abuse and addiction is a relevant public health issue for it goes to the heart of how we choose to fix the problem—or not.

Nora Volkow, M.D., NIDA Director

Decades of research progress have positioned NIDA to take advantage of accumulated research findings by applying new tools, techniques, and knowledge

that could change the course of drug addiction in this country. Innovative use of brain imaging technologies allows us to literally see into the brains of people addicted to drugs and discover the impact on brain function. Advances in genetics are identifying genes of vulnerability or protection so that interventions can be tailored for the greatest impact. Growing knowledge about the dynamic interactions of genes with environment confirms addiction as a complex and chronic disease of the brain with many contributors to its expression in individuals.

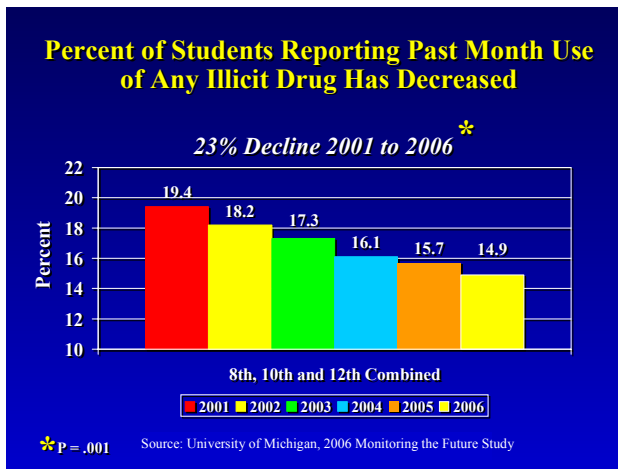
NIDA continues to support research and dissemination activities designed to elucidate the effects of drugs on the brain and behavior as well as identify and test effective interventions. One way this occurs is through NIDA’s Drug Abuse Treatment Clinical Trials Network (CTN), which tests drug abuse treatment approaches directly in the community settings where they will be used by counselors trained to implement them. This process not only involves treatment practitioners in formulating research protocols, but also in providing real-world feedback on their success and feasibility. NIDA is taking a similar approach to enhance treatment for drug-addicted individuals involved with the criminal justice system through its CJ-DATS (Criminal Justice-Drug Abuse Treatment Studies) initiative. Whereas NIDA’s CTN has as its overriding mission to improve the quality of drug abuse treatment by moving innovative approaches into the larger community, research supported through CJ-DATS is designed to effect change by bringing new treatment models into the criminal justice system and thereby improve outcomes for offenders with substance use disorders.

NIDA also monitors drug use patterns and trends and uses the power of science to prevent emerging drug problems from becoming national epidemics. A long-standing tool in this regard is the annual Monitoring the Future (MTF) Survey of 8th, 10th and 12th graders, supported by NIDA. Results from the 2006 MTF Survey indicate that **over the last 5 years, illicit drug use has declined—down 23 percent** for

past month use of any illicit drug by 8th, 10th, and 12th graders combined (see figure).

But drug abuse can apply to more than illicit substances, a notion reflected in the following trends revealing an uneven picture of latest drug use patterns:

- **Cigarette smoking** continues to fall and is at the lowest rate in the MTF survey's history. But the rate of decline is slowing, especially among the youngest students surveyed—a trend to watch in future years.
- Prescription drug abuse has been on the rise in teens and young adults for the last several years, and now represents 5 of the top 6 most commonly reported abused drugs by high school seniors—marijuana being number 1.
- For the first time, MTF included a question on the **non-medical use of over-the-counter cough or cold medicines**—with nearly 7% of 12th graders reporting past year abuse of these medicines to get high. Younger adolescents are also getting high on cough medicine, whose active ingredient is dextromethorphan, or DXM.



One of the cruel ironies of addiction is that the brain circuits needed to control behavior and render good judgments are the same ones that addiction undermines. This is why many addicted people cannot simply stop using drugs by sheer force of will, and calls for more comprehensive medical approaches to dealing with drug abuse and addiction and the many societal and health problems they engender.

Nora Volkow, M.D., NIDA Director

In search of promising new targets for anti-addiction medications. Breakthrough discoveries in the last decade have led to a profound transformation in the understanding of the mechanisms and consequences of drug abuse and addiction.

NIDA has called for studies to stimulate research for the design, synthesis, and pharmacological evaluation of new classes of compounds as potential treatment agents for cocaine, methamphetamine, or marijuana addiction—a major push of NIDA's medications development program. Another strategy for treating drug addiction, in which NIDA is currently investing, is immunotherapy, including support for development of a methamphetamine vaccine. Addiction immunotherapies would cause the body to generate antibodies that bind specific drugs while they are still in the bloodstream, blocking their entry into the brain. The resulting reduction of reinforcing effects is expected to prevent relapse.

Health Disparities: drug abuse and HIV/AIDS.

HIV/AIDS, in which drug abuse is a major factor, continues to disproportionately affect African Americans and other minority populations. In response, NIDA released two program announcements in 2006 calling for drug abuse and mental health research on HIV/AIDS among African Americans, along with research on criminal-justice-related health disparities in this population.

NIDA will also take advantage of its CTN to assess interventions to reduce risk behaviors for HIV and other sexually transmitted infections among at-risk populations in community drug treatment settings. NIDA is eager to advance new HIV rapid-screen technologies and counseling in CTN-affiliated community treatment programs and test HIV screening practices in the criminal justice system through CJ-DATS.

Methamphetamine — still on the move.

Methamphetamine continues to blight communities across the country, evincing marked increases in abuse consequences (e.g., treatment admissions rising from 28,000 to about 150,000 a year from 1993–2004). NIDA is pursuing several different therapeutic approaches, including both medications and behavioral therapies aimed at abstinence, relapse prevention, and cognitive dysfunction caused by long-term abuse. NIDA-supported research to understand the mechanisms of methamphetamine-

induced brain changes will be instrumental in identifying potential target molecules that can be either blocked or enhanced to prevent, treat, or mitigate the damage caused by methamphetamine.

Prescription drug abuse and the role of pain in opioid abuse. The MTF reports that again in 2006, approximately one in ten 12th graders used the prescription pain reliever Vicodin nonmedically during the past year—abuse second only to marijuana. In general, prescription drug abuse is an increasing problem, particularly in certain populations, and therefore is the subject of several NIDA initiatives. NIDA’s multi-pronged strategy encompasses epidemiological studies and basic, preclinical, and clinical research, including: (1) a collaboration with the National Institute on Aging and the National Institute of Dental and Craniofacial Research on a major solicitation for cross-disciplinary studies to investigate the use of opioids for pain treatment and to better understand the nexus of abuse and addiction to them; and (2) research on the development of therapeutic agents with reduced abuse liability. Examining factors that predispose or protect against opioid abuse and addiction will help develop screening and diagnostic tools for primary care physicians to assess the potential for prescription drug abuse in their patients.

NIDA is encouraging research that assesses the effects of chronic use over the lifespan and elucidates those factors (genetic, biological, and environmental) that predispose patients to, or protect them from, opioid abuse and addiction.

***RESEARCH SPOTLIGHT:
Criminal Justice Drug Abuse Treatment Research
Studies — Integrating Drug Abuse Treatment in
Public Health and Safety Settings***

The concept of drug addiction as a complex disease needs to be understood if society is to effectively address the burgeoning problem of drug-related crime and addicted offenders in this country. In addition, the prevalence of co-occurring mental health problems among criminal justice populations calls for more common sense approaches that address the constellation of brain and behavioral issues that characterize drug-addicted offenders. If not effectively treated, these offenders will return to communities and to the vicious cycle of drug abuse, crime, and incarceration. Conversely, recent studies show the value of drug abuse treatment in reducing drug use and re-incarceration. But because addiction is still frequently seen as a moral failing, or a “personal” problem, the needed public health response has been overshadowed by the public safety concern.

Combining the two—public health and public safety—NIDA launched CJ-DATS in 2002 to more rapidly move promising science-based drug addiction treatments into community settings. It represents a collaboration of NIDA with the Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, Department of Justice agencies, and a host of drug treatment, criminal justice, and health and social service professionals. A 5-year research program, CJ-DATS will be renewed in 2008 to continue support for research focusing on how drug abuse treatment and the criminal justice system interact, including research to determine how to implement and maintain effective treatment over the long term.

Fiscal Year 2008 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, medications 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 the magnitude of alcohol-related problems among various population groups;
- Collaborating with other research institutes – in this country and abroad -- and Federal programs relevant to alcohol abuse and alcoholism, and providing coordination for Federal alcohol abuse and alcohol 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) 443-3885

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

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

APPROPRIATIONS FY 2006	FY 2007 CR	ADMINISTRATION REQUEST FY 2008	MHLG RECOMMENDATION FY 2008
\$435.9m	\$436.3m	\$436.6m	\$465.5m

Background

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

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

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

Additional investments are required to pursue a number of key NIAAA initiatives including:

- Efforts to accelerate discoveries on nerve cell networks and their application to clinical issues surrounding tolerance, physical dependence, physical withdrawal and relapse, by integrating the efforts and findings of investigators from various scientific fields and disciplines;
- New technologies to advance identification of the genes likely to influence the risk for alcoholism, and advancing discovery of new behavioral treatments and medications development; and
- Acquiring scientific expertise in the areas of novel biosensors for the measurement of alcohol, computational neurobiology of alcohol, and geomapping to improve policies surrounding alcohol prevention. Of equal importance is NIAAA’s agenda on health disparities and conducting research on high alcohol content malt and wine specialty consumption and its health and social impacts on minority communities. The initiatives targeted at underage drinking also require additional attention for epidemiological studies and evaluation of intervention and outreach programs on college campuses.

NIAAA ADVANCES

Finding May Explain Link between Alcohol & Certain Cancers

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

framework for understanding the underlying chemical pathway that could explain the association between drinking and certain types of cancer.

Initiative on Underage Drinking

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

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

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

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

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

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

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

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

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

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

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

SAMHSA Centers for Substance Abuse Treatment and Prevention

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

Center for Substance Abuse Treatment — CSAT

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

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

The Administration is proposing to cut CSAT by \$47 million for FY 2008.

Center for Substance Abuse Prevention — CSAP

The Center for Substance Abuse Prevention (CSAP) provides national leadership in the development of policies, programs, and services to prevent the onset of illegal drug use, to prevent underage alcohol and tobacco use, and to reduce the negative consequences of using substances. CSAP carries out its mission through the following strategies:

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

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

The Administration is proposing to cut CSAP by \$37 million or 19 percent for FY 2008.

**Mental Health Liaison Group (MHLG) FY 2008
Appropriations Recommendations for the
SAMHSA and Key NIH Institutes**

(Dollars in Million)

PROGRAMS	FY 06 FINAL	FY07 FINAL	FY08 ADMIN REQUEST	FY08 MHLG REQUEST
CMHS				
CMHS TOTAL	\$884.2m	\$884.2m <i>(-\$0.0m)</i>	\$807.6m <i>(-\$76.6m)</i>	\$959.3m <i>(+\$75.1m)</i>
Community Mental Health Services Performance Partnership Block Grant	\$428.5m	\$428.5m <i>(-\$0.0m)</i>	\$428.5m <i>(-\$0.0m)</i>	\$460.7m <i>(+\$32.2m)</i>
Children's Mental Health Services Program	\$104.1m	\$104.1m <i>(-\$0.0m)</i>	\$104.1m <i>(-\$0.0m)</i>	\$112.0m <i>(+\$7.9m)</i>
PATH Homelessness Program	\$54.3m	\$54.3m <i>(-\$0.0m)</i>	\$54.3m <i>(-\$0.0m)</i>	\$58.3m <i>(+\$4.0m)</i>
Protection and Advocacy (PAIMI)	\$34.0m	\$34.0m <i>(-\$0.0m)</i>	\$34.0m <i>(-\$0.0m)</i>	\$36.6m <i>(+\$2.6m)</i>
Programs of Regional and National Significance	\$263.3m	\$263.3m <i>(-\$0.0m)</i>	\$186.6m <i>(-\$76.6m)</i>	\$291.9m <i>(+\$28.6m)</i>
Youth Violence Prevention	\$93.3m	\$93.3m <i>(-\$0.0m)</i>	\$75.7m <i>(-\$17.6m)</i>	\$100.3m <i>(+\$7.0m)</i>
Suicide Prevention	\$31.7m	\$36.1m <i>(+\$1.4m)</i>	\$33.5m <i>(-\$2.6m)</i>	\$37.0m <i>(+\$0.9m)</i>
Post Traumatic Stress Disorder	\$29.5m	\$29.5m <i>(-\$0.0m)</i>	\$29.1m <i>(-\$1.4m)</i>	\$31.7m <i>(+\$1.9m)</i>
State Incentive Grant	\$25.7m	\$25.7m <i>(-\$0.0m)</i>	\$19.8m <i>(-\$5.9m)</i>	\$26.2m <i>(+\$0.5m)</i>
Jail Diversion Grants	\$6.93m	\$6.93m <i>(-\$0.0m)</i>	\$3.9m <i>(-\$3.0m)</i>	\$7.44m <i>(+\$0.5m)</i>
Seniors	\$4.95m	\$4.95m <i>(-\$0.0m)</i>	\$0.0m <i>(-\$4.95m)</i>	\$5.35m <i>(+\$0.4m)</i>
Community Technical Assistance Centers	\$1.98m	\$1.98m <i>(-\$0.0m)</i>	\$0.0m <i>(-\$1.98m)</i>	\$2.18m <i>(+\$0.2m)</i>
Consumer Network Grants	\$1.5m n/a	\$1.5m <i>(-\$0.0m)</i>	\$0.0m <i>(-\$1.5m)</i>	\$1.7m <i>(+\$0.2m)</i>
Family Network Grants	\$3.4m n/a	\$3.4m <i>(-\$0.0m)</i>	\$0.0m <i>(-\$3.4m)</i>	\$3.6m <i>(+\$0.2m)</i>
CSAT				
Block Grant	\$1,758.6m	\$1,758.6m <i>(-\$0.0m)</i>	\$1,758.6m <i>(-\$0.0m)</i>	\$1,858.6m <i>(+\$100.0m)</i>
Programs of Regional and National Significance	\$398.9m	\$395.2m <i>(-\$3.7m)</i>	\$348.0m <i>(-\$47.2m)</i>	\$410.0m <i>(+\$14.8m)</i>
CSAP				
Programs of Regional and National Significance	\$192.9m	\$193.0m <i>(+\$0.1m)</i>	\$156.0m <i>(-\$37.0m)</i>	\$210.0m <i>(+\$17.0m)</i>
NIH				
NIMH	\$1,403.5m	\$1,403.6m <i>(+\$0.1m)</i>	\$1,405.4m <i>(+\$1.8m)</i>	\$1,497.6m <i>(+\$94.0m)</i>
NIDA	\$1,000.0m	\$999.4m <i>(-\$0.1m)</i>	\$1,000.4m <i>(+\$1.0m)</i>	\$1,067.3m <i>(+\$67.0m)</i>
NIAAA	\$435.9m	\$436.3m <i>(+\$0.4m)</i>	\$436.6m <i>(+\$0.3m)</i>	\$465.5m <i>(+\$29.2m)</i>