



# Appropriations Recommendations

for Fiscal Year 2010

“In 2008, the National Suicide Prevention Lifeline answered over 545,000 calls, averaging 45,000 calls answered per month. Average monthly call volume increased approximately 24% from January 2008 through December 2008, and total volume increased 36% from 2007 to 2008.” (National Suicide Prevention Lifeline, 2009)

MENTAL HEALTH LIAISON GROUP

National Organizations Representing

Consumers, Family Members, Advocates, Professionals and Providers

# MENTAL HEALTH LIAISON GROUP

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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 Counseling Association  
American Group Psychotherapy Association  
American Hospital Association  
American Mental Health Counselors Association  
American Nurses Association  
American Occupational Therapy Association  
American Psychiatric Association  
American Psychological Association  
American Psychotherapy Association  
Anxiety Disorders Association of America  
Association for Ambulatory Behavioral Healthcare  
Bazelon Center for Mental Health Law  
Child Welfare League of America  
Children and Adults with Attention-Deficit/Hyperactivity Disorder  
Clinical Social Work Association  
Clinical Social Work Guild  
Depression and Bipolar Support Alliance  
Eating Disorders Coalition for Research, Policy & Action  
Emergency Nurses Association  
InnerWisdom, Inc.  
Mental Health America  
National Alliance on Mental Illness  
National Alliance to End Homelessness  
National Association for Children's Behavioral Health  
National Association of Anorexia Nervosa and Associated Disorders  
National Association of County Behavioral Health and Developmental Disability Directors  
National Association of Mental Health Planning & 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 Coalition of Mental Health Professionals and Consumers, Inc.  
National Council for Community Behavioral Healthcare  
National Disability Rights Network  
National Federation of Families for Children's Mental Health  
Suicide Prevention Action Network USA  
Therapeutic Communities of America  
Tourette Syndrome Association  
United Jewish Communities  
US Psychiatric Rehabilitation Association  
Volunteers of America  
Witness Justice**

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**Mental Health Liaison Group (MHLG) FY 2010  
Appropriations Recommendations for the  
SAMHSA and Key NIH Institutions**  
(Dollars in Millions)

<b>PROGRAMS</b>	<b>FY 07 FINAL</b>	<b>FY08 CR FINAL</b>	<b>FY09 FINAL (Omnibus)</b>	<b>FY10 MHLG REQUEST<sup>1</sup></b>
<b>CMHS</b>				
<b>CMHS TOTAL</b>	\$883.9m (\$0.0m)	\$910.9m (+ \$27.0m)	\$969.2m (+58.3m)	\$1,121.4m (+ \$152.2m)
<b>Community Mental Health Services Performance Partnership Block Grant</b>	\$428.3m (\$0.0m)	\$421.0m (- \$7.3m)	\$420.8m (\$0.0m)	\$486.9m (+ \$66.1m)
<b>Children’s Mental Health Services Program</b>	\$104.1m (\$0.0m)	\$102.3m (- \$1.8m)	\$108.4m (+ \$6.1m)	\$125.4m (+ \$17.0m)
<b>PATH Homelessness Program</b>	\$54.3m (\$0.0m)	\$53.3m (- \$1.0m)	\$59.7m (+ \$6.4m)	\$69.1m (+ \$9.4m)
<b>Protection and Advocacy (PAIMI)</b>	\$34.0m (\$0.0m)	\$34.9m (+ \$0.9m)	\$35.9m (+ \$1.0m)	\$41.5m (+ \$5.6m)
<b>Programs of Regional and National Significance</b>	\$263.3m (\$0.0m)	\$299.3m (+ \$36.0m)	\$344.4m (+ \$45.1m)	\$398.5m (+ \$54.1m)
Youth Violence Prevention Initiatives	\$93.3m (\$0.0m)	\$93.5m (+ \$0.2m)	\$94.5m (+ \$1.0m)	\$109.3m (+ \$14.8m)
Suicide Prevention for Children and Adolescents	\$36.1m (+ \$1.4m)	\$48.6m (+ \$12.4m)	\$47.1m (- \$1.5m)	\$54.5m (+ \$7.4m)
Children and Adolescents with Traumatic Stress Disorder	\$29.5m (\$0.0m)	\$33.1m (+ \$3.6m)	\$38.0m (+ \$4.9m)	\$44.0m (+ \$6.0m)
Mental Health Transformation State Incentive Grants	\$26.0m (\$0.0m)	\$26.0m (\$0.0m)	\$26.0m (\$0.0m)	\$30.1m (+ \$4.1m)
Project LAUNCH	n/a	\$7.4m (\$0.0m)	\$20m (+ \$12.6m)	\$23.1m (+ \$3.1m)
Grants for Primary and Behavioral Health Care Integration	n/a	\$7.0m (\$0.0m)	\$7.0m (\$0.0m)	\$7.9m (+ \$0.9m)
Jail Diversion Program Grants	\$6.93m (\$0.0m)	\$6.80m (- \$0.13m)	\$6.7m (\$0.0m)	\$7.8m (+ \$1.1m)
Mental Health Outreach and Treatment to the Elderly	\$4.95m (\$0.0m)	\$4.86m (- \$0.09m)	\$4.8m (\$0.0m)	\$5.6m (+ \$0.8m)
Statewide Family Network Grants	\$3.40m (\$0.0m)	\$3.34m (- \$0.06m)	\$3.7m (+ \$0.36m)	\$4.3m (+ \$0.6m)
Minority Fellowship Workforce Training	\$3.8m (\$0.0m)	\$3.7m (- \$0.1m)	\$3.7m (\$0.0m)	\$4.3m (+ \$0.6m)
Rehabilitation Research and Training Centers	\$3.7m (\$0.0)	\$3.1m (- \$0.6m)	\$3.6m (+ \$0.5m)	\$4.1m (+ \$0.5m)
Mental Illnesses and Substance Abuse Disorder Grant	\$7.53m (\$0.0m)	\$3.61m (- \$3.92m)	\$3.61m (\$0.0m)	\$3.95m (+ \$0.34m)
Statewide Consumer Network Grants	\$1.50m (\$0.0m)	\$1.47m (- \$0.03m)	\$2.5m (+ \$1.03m)	\$2.9m (+ \$0.4m)
Consumer/Supporter Technical Assistance Centers	\$1.98m (\$0.0m)	\$1.95m (- \$0.03m)	\$1.95m (\$0.0m)	\$2.3m (+ \$0.35m)
<b>NIH</b>				
<b>NIMH</b>	\$1,403.6m (+ \$0.1m)	\$1,404.5m (+ \$0.9m)	\$1,450.5m (+ \$46.0m)	\$1552.0m (+ \$101.5m)
<b>NIDA</b>	\$1,000.3m (+ \$0.3m)	\$1,000.7m (+ \$0.4m)	\$1,032.8m (+ \$32.1m)	\$1,105.1m (+ \$72.3m)
<b>NIAAA</b>	\$436.3m (+ \$0.4m)	\$436.3m (\$0.0m)	\$450.2m (+ \$13.9m)	\$481.7m (+ \$31.5m)

<sup>1</sup> Administration request figures were unavailable as of the date this document went to press.

## 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 disorders, 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.

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

**Community Mental Health 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/Support 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 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 who 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 Workforce Training** – Provides grants to encourage more ethnic minorities to provide psychiatric, psychological and other mental health and substance abuse services in chronically underserved areas.

**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.

**Project LAUNCH** -- Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) is a new grant program designed to promote the wellness of young children ages birth to 8 years of age by addressing the physical, emotional, social, and behavioral aspects of their development.

**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.

**Project to Integrate Primary Care and Mental Health services** – A new program that co-locates primary care and specialty medical services in Community Mental Health Centers (CMHCs) and other community-based mental health and substance abuse provider agencies.

**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.

**Rehabilitation Research and Training Centers** – Engage in research, training, dissemination, and technical assistance regarding evidence-based and promising practices in psychiatric rehabilitation and recovery approaches for adults, and system-of-care service delivery models for children.

**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 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.

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

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

## MENTAL HEALTH – CRISIS after CRISIS

### National Snapshot

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The federal government should make preventing mental, emotional, and behavioral disorders and promoting mental health in young people a national priority, says a new report from the National Research Council and Institute of Medicine. These disorders -- which include depression, anxiety, conduct disorder, and substance abuse -- are about as common as fractured limbs in children and adolescents. Collectively, they take a tremendous toll on the well-being of young people and their families, costing the U.S. an estimated \$247 billion annually, the report says. (IOM, 2/09)

The suicide rate among U.S. soldiers in 2008 rose to its highest rate since record-keeping began in 1980, the Army announced on Thursday, USA Today reports. (USA Today, 1/29/09)

In 2008, the National Suicide Prevention Lifeline answered over 545,000 calls, averaging 45,000 calls answered per month. Average monthly call volume increased approximately 24% from January 2008 through December 2008, and total volume increased 36% from 2007 to 2008.

*Depression Makes It More Difficult To Control Diabetes:* People who have both depression and diabetes may have a more difficult time controlling their blood-sugar levels than other people who have diabetes, researchers report in the journal *General Hospital Psychiatry*. An estimated 30 percent of people with diabetes also have depression. The researchers speculate that depression makes it more difficult for people with diabetes to live healthy lifestyles. (Reuters, 11/19/08)

Children with serious mental health problems do not receive adequate care in more than one in five states, according to a Columbia University survey. (USA Today, 11/20/08)

*Nearly 20 Percent of Americans Missed Work Last Year Due to Depression* About 18 percent of American workers missed at least 10 workdays last year because of depression, reports healthcare consulting firm Watson Wyatt Worldwide. By comparison, a bit fewer employees missed at least 10 days of work due to anxiety or high blood pressure while about 30 percent of employees missed work due to heart disease and 22 percent for diabetes. (WSJ.com, 10/8/08)

Major mental disorders cost the nation at least \$193 billion annually in lost earnings alone, according to a new study funded by the National Institutes of Health's National Institute of Mental Health (NIMH). (American Journal of Psychiatry, 5/08)

The number of U.S. service members diagnosed with post-traumatic stress disorder increased by nearly 50% from 2006 to 2007, according to a Pentagon report. (Washington Post, 5/28/08)

[T]he United States saw the largest one-year jump [an 8 percent increase] in child and teen suicide rates in 15 years, according to the Centers for Disease Control and Prevention. (Reuters, 9/9/07)

Mental health disorders account for more than 1 billion sick days each year—about one-third of all days missed for chronic conditions from school and work—a study in the *Archives of General Psychiatry* indicates. Depression accounts for the most sick days, followed by social phobia, PTSD and generalized anxiety disorder. “If we treated the mental disorders,” which are often left unrecognized and untreated, “we could wipe out a lot of the impairment,” said Harvard Medical School professor Ronald Kessler, who was also the study’s senior author. (*Los Angeles Times*, 10/2/07)

"An October 2006 report by the National Association of State Mental Health Program Directors illustrates how dire the need is for people with mental illness. This report states that persons with serious mental illness die, on average, 25 years earlier than the general population." (*Morbidity and Mortality in People with Serious Mental Illness*, 10/06)

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### Chronic Diseases and Mental Health

Depression contributes to the risk of heart disease as much as diabetes, high cholesterol or obesity does according to a report of the American Psychosomatic Society meeting. (USA Today, 3/4/09)

*Depression Can Trigger Diabetes:* Depression appears to increase the risk that a person will develop the most common form of diabetes by 34 percent, Johns Hopkins University researchers report in the *Journal of the American Medical Association*. In reporting the finding, the researchers took into account obesity, lack of exercise and smoking. Depression can elevate levels of the stress hormone cortisol, the researchers explained. Elevated levels of the hormone can reduce the body's sensitivity to insulin, which can lead to diabetes. (Reuters, 6/17/08)

Depression, alone, is more damaging to everyday life than are many chronic physical conditions, such as diabetes, angina and asthma, a World Health Organization study published in the *Lancet* indicates. And, in combination with physical conditions, depression intensifies the severity of those conditions. (Reuters, 9/7/07)

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)

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)

Older adults who have chronic depression are more likely to develop diabetes, a study in the *Archives of Internal Medicine* indicates. The results of the study held true even when the study researchers took into account risk factors for developing diabetes, such as inactivity, which leads to weight gain and possibly diabetes. Although the Northwestern University researchers did not design the study to possibly answer what biological mechanism might be responsible for the link, they speculate that people with depression have higher levels of stress hormones than others, which decrease individuals' sensitivity to insulin. (Reuters, 4/23/07)

### Confinement and Mental Health

People who have mental illnesses and who have committed crimes are less likely to be re-arrested in the future if they go through special mental health courts instead of the regular criminal justice system, researchers report in the *American Journal of Psychiatry*. In San Francisco, the mental health courts that were studied are designed to help people with severe disorders who frequently cycle through the justice system and who have committed murder or other extremely violent crimes. Within 18 months of going through the mental health courts, 42 percent of individuals were re-arrested for new crimes compared with 57 percent of individuals with severe disorders who went through the regular system. "The mental health court model has promise as one approach to reducing the unnecessary criminalization of people with mental disorders," one researcher said. (Reuters, 10/12/07)

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)

## Hurricane Katrina

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*Experts: PTSD Fading in New Orleans, but Depression Increasing* Although levels of anxiety and PTSD have begun to fade among New Orleans residents since Hurricane Katrina, more residents have begun dealing with depression as they continue to face obstacles to returning to their pre-hurricane lives, experts say. “The inability to finalize, to put closure on an event, brings depression,” said local social worker J. Chris Barrilleaux. Other experts say that, with the onset of hurricane season, residents can best stave off anxiety by being prepared and to “take control over the few things humans have power over in the face of a hurricane.” (The Times-Picayune, 8/4/08)

Nearly one-half of New Orleans residents had depression, panic disorder and PTSD in the seven months after Hurricane Katrina devastated the city, a study in the *Archives of General Psychiatry* indicates. The percentage of affected residents was significantly greater than the 25 percent of Gulf Coast residents similarly affected, which is a rate comparable to other disasters, the study’s researchers wrote. People who were most susceptible to the disorders were people with low incomes, who were unemployed before the storm and who were not married. More Gulf Coast Residents Have Suicidal Thoughts, Post-Traumatic Stress Disorder Symptoms, Survey Finds (*Reuters*, 12/3/07)

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## The President’s New Freedom Commission on Mental Health ([www.mentalhealthcommission.gov](http://www.mentalhealthcommission.gov))

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President Bush’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.**

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### 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 disorder.
- 20 percent of the population experiences a mental disorder 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 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

- Overall, there are over 32,000 suicides in America every year and the rate of teen suicide has tripled since the 1950s.
- 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.

### 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.
- 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 treatments – this will change in 2010 with the implementation of the parity law 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.

### **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 mental illnesses in jails or prisons than in state psychiatric hospitals. In the course of the next year, almost 750,000 people with mental 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 services, 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.
- Without access to care and support services, individuals with psychiatric and substance use disorders routinely visit emergency departments (EDs), and the number of people seeking care in EDs for mental illness and co-occurring disorders is climbing. In 2006, 4.3 million mental health-related ED visits occurred.
- The ED has increasingly become the safety net for a fragmented mental health infrastructure in which the needs of children and adolescents, among the most vulnerable populations, have been insufficiently addressed.
- A 27 percent decline in inpatient psychiatric beds over the past decade has contributed to holding or boarding psychiatric patients in the ED at a level that is double that of other ED-admitted patients.

### **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, 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 2010  
Funding Recommendations

for the

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

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

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

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.

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**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 \$421 million in FY 2008 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. 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 Block Grant

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$428.3m	\$421.0m	\$420.8m	\$486.9m

### What Is the Community Mental Health Services Block Grant?

The Community Mental Health Services 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 employment and housing assistance, case management (including Assertive Community Treatment), school-based support services, family and parenting education, 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. Recent data indicates that over 70 percent 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.

### 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**, an increase in the Block Grant in FY 2010 could provide:

- Housing opportunities across the continuum of residential options for consumers;
- Employment opportunities for consumers, including support in retaining employment;

- Outreach and treatment services focused on the needs of the elderly, or
- Transportation for consumers in rural areas to mental health services.

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#### **Community-Based Services Work**

*Linda was first diagnosed with a mental illness after her first son was born. Each time she went into crisis, she was hospitalized for 5-7 days. After release, it would take months before she was back to her “groove.” A few years later, Linda was admitted to the State Hospital and she lost her children, her home, and her car. She fought guardianship 5 times while in the State facility, but eventually failed. While at the hospital, a peer support agency (PSA) staff person visited her, gave her a Pre-Crisis Respite Interview, and gave her information about the peer-run agency. Linda began to reconnect with her community while in crisis respite and attended groups at the PSA. Linda describes her stay as “powerful” and that it empowered her. Now, she does not see herself as a person in crisis, but as one of courage and confidence. She states that she is an “individual that has gained independence through peer support.”*

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

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$104.1m	\$102.3m	\$108.4m	\$125.4m

### 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. 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.

### PROGRAM COST SAVINGS

- **Number Of Days In Inpatient Care And Inpatient Costs Reduced** In FY 07, an average decrease of 1.78 days of care in inpatient facilities was observed among children served in systems of care at 6 months. During this same period, inpatient care costs decreased by \$2,376,000 per 1000 children participating in systems of care.
- **Cost Savings Resulted From Decreases In Inpatient Hospitalizations** The estimated number of children served by funded system of care communities in FY 2007 was 8,384, and the estimated total cost savings due to decreases in utilization of inpatient hospitalization were \$6,933,568.00. This translates to a cost savings of \$827.00 per child served in the CMHI program.
- **Costs Savings Resulted From A Reduction In Number Of Arrests** The estimated number of children served by funded system of care communities in FY 2007 was 8,384, and estimated total cost savings due to decreases in number of arrests were \$5,913,486.72. This translates to a cost savings of \$705.33 per child served in the CMHI program.

### 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.

#### 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).

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.

#### Demonstrated Successful Outcomes

The program has served children in 496 or nearly 16 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:

- **Functional Impairment Was Reduced Or Remained Stable** 94% of children improved or remained stable in their level of functional impairment from entry into system of care services to 6 months after program entry.
- **Clinical Symptoms Improved Or Remained Stable** Almost 90% of children improved or remained stable in their clinical symptoms from entry into system of care services to 6 months after beginning program services.
- **Family Functioning Improved Or Remained Stable** About 90% of caregivers reported improvement or stability in family functioning from program entry to 6 months, 12 months, and 18 months, respectively.
- **Reduction In Suicide-Related Behavior** Significantly fewer children and youth engaged in self-harmful and suicide-related behaviors 6 months after entering services in Systems of Care; 36% of children and youth decreased self-harmful or suicide-related behaviors.
- **Children And Youth Depression Symptoms Improved** Almost 95% of children and youth improved or remained stable in their level of depression from entry into system of care services to 6 months, 12 months and 18 months after beginning program services.
- **Children And Youth Anxiety Symptoms Improved** Almost 90% of children and youth improved or remained stable in their level of anxiety from entry into system of care services to 6 months, 12 months and 18 months after beginning program services.

- ***Substance Dependence Decreased Or Remained Stable*** Almost 91% of children and youth improved or remained stable in their level of substance dependence from entry into system of care services to 12 months after beginning program services.
- ***School Grades Improved*** At entry into services, about 63% of children received passing grades (a grade average of C or better) during the 6 months prior to entry. During the 6 months after entering system of care services, nearly 68% of children received passing grades. Passing performance increased to 73% at 18 months; the change from entry to 18 months was statistically significant.
- ***School Suspensions/Expulsions Decreased*** Children and youth who were suspended or expelled from school decreased 17% after their first six months in systems of care, a statistically significant decrease.
- ***Caregivers Report Their Child's School Performance Improved*** At entry into services, 44% of caregivers reported that poor school performance was a very significant problem for their children. After 6 months of program services, this percentage decreased significantly to 27%. Problematic school behavior decreased significantly from 46% at entry into services to 29% after 6 months of program services.
- ***No Law Enforcement Contacts After Entering Systems Of Care*** In FY 07, nearly 71% of children and youth participating in the CMHI program had no law enforcement contacts 6 months after entering systems of care. This figure exceeded the FY 07 GPRA target of 70%.
- ***Law Enforcement Contacts Decreased*** The percentage of youth who were arrested in the previous 6 months decreased significantly over time. Nearly 20% of children had been arrested at intake, dropping to just over 13% at 6 months and nearly 11% at 12 months, a statistically significant decrease.
- ***Caregiver Employment Increased Because Of CMHI Services*** 40% of caregivers who

were unemployed because of their child's emotional and behavioral problems became employed within 12 months after entry into system of care services.

- ***Caregivers Reported Improved Or Stable Levels Of Strain*** Over 90% of caregivers in systems of care reported either decreased or stable levels of objective strain associated with caring for a child with a serious emotional disturbance from intake into services to 6 months, 12 months, and 18 months following intake, respectively.

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### Child and Family Profile

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

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.

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**Projects for Assistance in Transition from Homelessness (PATH)**

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$54.3m	\$53.3m	\$59.7m	\$69.1m

**What Does PATH Do?**

The Projects for Assistance in Transition from Homelessness (PATH) formula grant program provides funding to states, localities and non-profit organizations to support individuals who are homeless (or are at risk of homelessness) and have a serious mental illness and/or a co-occurring substance abuse disorder. PATH is designed to encourage the development of local solutions to the problem of homelessness and mental illness through strategies such as aggressive community outreach, case management and housing assistance. Other important core services include referral for primary care, job training and education. PATH requires states and localities to leverage funds through \$1 match for every \$3 in federal funds. Surveys indicate that, in 2005, 463 PATH-funded local agencies enrolled more than 82,000 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 2009, the President is requesting \$59.7 million for the PATH program, a \$ 6.4 million increase over FY 2008. 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 2009 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. SAMHSA reauthorization currently pending in the Senate would increase this minimum state allocation level without adversely impacting large states

**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 300 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 constellated a national partnership of every level of government and the private sector. A 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 to 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 continue to invest in funding services in permanent supportive housing. For FY 2008, Congress allocated more than \$9 million for this purpose as part of appropriation for SAMHSA's Grants for the Benefit of Homeless Individuals Program (GBHI). These funds 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.

The MHLG therefore joins our colleagues at the National Alliance to End Homeless, the Corporation for Supportive Housing, the Enterprise Foundation and National AIDS Housing Coalition in support of additional funds for the GBHI program targeted to services in permanent supportive housing in the FY 2010 Labor, Health and Human Services and Education appropriations bill.

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

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$34.0m	\$34.9m	\$35.9m	\$41.5m

**What Does PAIMI Do?**

In 1986, Congress authorized the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act. PAIMI is funded through the Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA). The program originally was established to provide protection and advocacy services to individuals with mental illness, who were or had recently resided in institutional settings. In 2000, Congress greatly expanded the PAIMI mandate to include all individuals with significant mental illness, including people living in the community in all settings.

In FY 2007, the PAIMI program was level funded at \$34.0 million. In FY 2008, while gaining an increase for the first time in four years, the across-the-board cut that was also included in the omnibus bill resulted in an FY 2008 budget of \$34.9 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 Bush’s New Freedom Initiative, these funding levels have had a detrimental effect on Protection & Advocacy (P&A) organizations’ ability to serve all those who need their services.

**Why is PAIMI Important?**

Under the PAIMI Program, 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 2007, the PAIMI program:

- Successfully closed over 18,600 cases of which over 3,900 were related to abuse, 3,330 to neglect, and 8,500 to a violation of individual rights;
- Conducted investigations into the deaths of over 3,100 individuals with mental illness in hospitals, institutions, and community settings;
- 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 6,400 children and young adults and nearly 12,000 adults and elderly individuals with mental illness; and
- Provided information and referral services to almost 53,000 individuals. In addition, the PAIMI program provided training to over 119,000 individuals.

**What Justifies Increased Federal Spending for PAIMI?**

The numbers above clearly demonstrate the need already being served for mental health protection and advocacy services. However, unlike the appropriations for the program, the role of the PAIMI program has been expanded the last few years. In addition to the expansion of the PAIMI program to cover all individuals with significant mental illness whether they are located in the community or an institution, HHS has 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, Congress has also affirmed that P&A programs have a significant role in addressing the

community integration needs of individuals identified in the 1999 Supreme Court Olmstead decision.

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 not only the needs of those already being served, but the requirements of these many expansions, additional funding is critical.

### PAIMI Success Stories

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

- The **Arizona** P&A assisted an adult with Bipolar Disorder by providing representation throughout the Equal Employment Opportunity Commission charge filing process. The client's offer to be a hospital pharmacist had been rescinded upon discovering his condition.
- The **California** P&A, after a thorough investigation into the death of an individual with a disability, concluded that the facility's seclusion and restraint policy lacked clear language about when an individual should be released from restraint or require staff to provide the routine range of motion of individuals while in restraints. In follow-up meetings with the facility's management staff, the P&A confirmed that the facility had instituted an appropriate plan of correction that included appropriate policy revisions, re-training of staff, and periodic chart audits for compliance.
- The **D.C.** P&A advocated on behalf of an individual when the D.C. public school failed to provide the student with an Individualized Education Plan (IEP) following his transfer to a school upon discharge from a residential treatment center. PAIMI staff advocated on the individual's behalf at several IEP meetings to help the individual obtain an IEP including specialized instruction in the regular classroom in addition to counseling and speech and language services.
- The **Idaho** P&A investigated alleged

abusive restraint of a 13 year old at an adolescent behavioral unit. PAIMI staff filed a complaint with the Bureau of Facility Standards after uncovering that the teen was being strapped face down on a gurney, heavily medicated, and continually locked in her room. As a result of the PAIMI staff's intervention, the adolescent behavioral health unit was required to change its policy and procedures regarding disciplinary practices and documenting injuries resulting from restraints.

- The **Native American** P&A assisted a 16 year old student with Attention Deficit Disorder and mental illness who was struggling in school after his grandmother voiced concern that he was not receiving proper educational services. As a result of a Native American PAIMI advocate's assistance, an appropriate IEP plan was implemented and the student's grades improved from F's to C's & B's.
- The **North Dakota** P&A assisted a soldier diagnosed with Post Traumatic Stress Disorder and major depression who was ordered to redeploy to Iraq for a third time. The soldier was denied an exemption from involuntary active duty to continue his treatment. With the help of PAIMI staff and Senator Byron Dorgan, the Army reconsidered the merits of the soldier's exemption request. He was subsequently granted an honorable discharge from the Army and able to resume mental health treatment.
- The **Wisconsin** P&A launched a thorough investigation of a mental health day treatment center when a seven year old girl with an emotional disturbance and attention deficit hyperactivity disorder died during a prone restraint episode after blowing bubbles in her milk during "quiet time." At the conclusion of the investigation, it was recommended that the facility be closed and that a moratorium be put on the use of prone restraint for children in state licensed facilities throughout the state. The state shut down the facility shortly thereafter. A statewide task force, including the P&A was initiated by the state to review the definitions, policies and rules regarding the use of restraint on children.

**Programs of Regional and National Significance (PRNS)**

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$263.3m	\$299.3m	\$344.4m	\$398.5m

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.

PRNS includes the programs in its Knowledge Development and Application Program (KDA), its Targeted Capacity Expansion Program (TCE), as well as a number of other programs. On pages **24-46** we describe the salient importance of the following PRNS programs:

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### Youth Violence Prevention Initiatives

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$93.3m	\$93.5m	\$94.5m	\$109.3m

#### 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 four-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, 336 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 with local education agencies in urban, rural and suburban communities. Between FY 1999 and FY 2007, this initiative funded a total of 336 communities and approximately 8.1 million students. In FY 2008, 60 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 2010, 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, a local juvenile justice agency, and family members and students. These partnerships must demonstrate evidence of an integrated, comprehensive community-wide strategy that addresses:

- Safe school environments and violence prevention activities;
- Alcohol, tobacco, and other drug prevention activities;
- Student behavioral, social, and emotional supports;
- Mental health services. (This element may only be funded by SAMHSA);
- Early childhood social and emotional learning programs. (This element may only be funded by SAMHSA);

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

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**

A Cross-Site Evaluation of the 1999, 2000, and 2001 cohorts found that:

- Elementary school teachers reported a significant reduction in classroom bullying (5%), a reduction in classroom fighting (8%), a reduction in verbal abuse of teachers

by a student (11%), and a reduction (21%) in teachers feeling threatened by a student.

- Middle school students reported a reduction in witnessing violence at school (student bullying/fighting) (6%), a reduction in any alcohol use during the past 30 days (11%), a reduction in cigarette use on school property during the past 30 days (19%), and a reduction (7%) in feeling unsafe at school.
- High school students reported significant reductions in use of alcohol (10%) and tobacco (13%) during the past 30 days. They also reported a significant reduction (6%) in feeling unsafe at school.

**Suicide Prevention for Children and Adolescents**

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$36.1m	\$48.6m	\$47.1m	\$54.5m

**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 2005, 32,637 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 2007, 14.5 percent seriously considered attempting suicide, 6.9 percent of youth attempted suicide, and 2 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 2006, 12.8 percent of youth between the ages of 12 and 17 (approximately 3.2 million youth) experienced at least one Major Depressive Episode (MDE).

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 report of the 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. CMHS funds two specific suicide prevention initiatives to assist in the implementation of the NSSP. The first initiative is the National Suicide Prevention Lifeline (1-800-273-TALK), a network of more than 130 crisis centers across the country that respond, 24 hours a day, to individuals in emotional distress or suicidal crisis. In 2007, SAMHSA and the Department of Veterans’ Affairs partnered to expand the reach of the Lifeline to provide for specialized veteran services. 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**

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$29.5m	\$33.1m	\$38.0m	\$44.0m

**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 relationship is further underscored by a 2007 report from the Great Smoky Mountains Study (GSMS), a representative longitudinal study of children in the primarily rural western counties of North Carolina. The GSMS report found that by age 16, more than 67.8% of the participants were exposed to one or more traumas, such as child maltreatment, domestic violence, traffic injury, major medical trauma, traumatic loss of a significant other, or sexual assault. Higher levels of trauma exposure were related to higher levels of psychopathology, especially anxiety and depressive disorders, and more functional impairments, such as disruption of important relationships and school problems. Even higher rates of exposure and PTSD 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.

A number of government reports during the last decade have also recognized the impact of violence and trauma on child mental health and development. 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.

Federal agencies also participate in the documentation of the impact of specific forms of trauma. 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.

The National Incidence Studies (NIS) were mandated by the U.S. Congress to establish the incidence of child maltreatment. To date, there have been three NIS studies conducted and analyzed (results reported in 1981 (NIS-1), 1988 (NIS-2), and 1996 (NIS-3). These three studies represent the ‘gold standard’ for incidence of child maltreatment and provide the only standardized, general population-based, data-collection methodology that systematically tracks changes in maltreatment rates over time. The NIS studies use a “sentinel” methodology in which official field observers report all cases of suspected child abuse encountered during a fixed sampling frame. The NIS estimates include children investigated at Child Protective Services agencies, but also include maltreated children who are identified by professionals in a wide range of agencies in representative communities. The most recent National Incidence Study (NIS-3) findings indicated that the total number of abused and neglected children was two-thirds higher in the NIS-3 published report than in the NIS-2 published report.

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, and 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. Findings from the Adverse Childhood Experiences (ACE) Study and other related studies have shown that adverse childhood experiences predispose children towards negative trajectories from infancy to adolescence that contribute significantly to adult outcomes such as depression, posttraumatic stress disorder (PTSD), substance abuse, low occupational attainment, and poor health.

Accessibility to treatment that could help with acute symptoms and prevent long-term consequences is problematic. The National Institute of Mental Health (NIMH) reported in 2007 that adults who were abused or neglected as children have increased risk of major depression, which often begins in childhood and has lingering effects as they mature. Early diagnosis and treatment of mental disorders that may arise from maltreatment is important to prevent harmful, long-lasting effects on functioning. Unfortunately, treatment is not always accessible to traumatized children. NIMH-supported researchers reported in 2005 that half of all lifetime cases of mental illness begins by age 14, and that despite effective treatments that have been developed, there are long delays – sometimes decades – between first onset of symptoms and when treatment is obtained. The study also found that an untreated mental disorder can lead to more severe, more difficult to treat illness, and to the development of co-occurring mental illnesses. A pattern emerged in this study that suggested that the earlier in life the disorder begins, the greater the gap in time before treatment is obtained. This same study also reported that the majority of those with mental disorders received no treatment at all.

### **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. The NCTSN is working to integrate trauma-informed information, resources, and treatment into all child-serving systems, so that these resources become available to children, families, and providers wherever the need occurs.

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

Despite widespread exposure to trauma and violence and serious consequences for children and youth, recent national traumatic events (natural disasters, school shootings, terrorism) has led to a greater realization that we have failed to provide the resources necessary to strengthen research and services for these children. Expanding funding of the NCTSI 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 and trauma. 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 Network also disseminates these trauma-informed evidence-based treatments and services to all child-serving systems (schools, juvenile justice system, child welfare, foster care, etc.).

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 FY 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. Further decreases in FY 2006 and FY 2007 led to further reductions in the size of the Network (currently funded at 43 centers).

The FY 2008 budget included an increase of funding to \$33.1 million, and may restore some of these losses, but will still fall far short of meeting the national need.

The innovative program has developed a strong, collaborative network of committed community and treatment development centers that work together with child serving systems 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 1000 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 shelters).

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. The Network has served as this kind of national resource in response to many national and regional emergencies. With additional support for the NCTSI, hundreds of 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

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$26.0m	\$26.0m	\$26.0m	\$30.1m

### What Is the Mental Health Transformation State Incentive Grant Program?

The Mental Health Transformation State Incentive Grant program (T-SIG) supports five-year SAMHSA grants designed to help states and other grantees<sup>2</sup> create a more consumer and family driven system that works to strengthen mental health delivery infrastructure and reduce fragmentation. SAMHSA awarded seven T-SIGs in FY 2005 and two additional T-SIGs in 2006. Grantees were encouraged to use their funds to: 1) Expand service delivery; 2) Increase accountability, or 3) Increase the flexibility of resources by encouraging innovative uses of Federal funding.

### Why are the State Incentive Grants Important?

The New Freedom Commission released a groundbreaking report in 2003 that called for a “fundamental transformation” of the mental health system. This report observed that programs that serve persons with mental illnesses are fragmented across many levels of government and among many agencies. According to the Commission, a transformed system would have fewer gaps in mental health services, an improved coordinated system of care, no stigma associated with mental health disorders, a system that focuses on building the personal strengths of all individuals who seeks its services, and would promote recovery and resilience as treatment expectations.

Since their launch, the nine T-SIGs have made infrastructure changes that support the goals laid out by the New Freedom Commission for a transformed system. Specifically, the nine states have: 1) trained almost 50,000 providers; 2) made 150 significant organizational changes; 3) expanded data accountability systems across 139 organizations; 4) implemented over 1600 mental health programs, and

5) made over 200 significant policy changes, including many in the financing arena.

Specific state examples of positive transformation changes from the nine T-SIGs include:

- **Connecticut:** implementation of a statewide anti-stigma campaign.
- **Hawaii:** implementation of a Certified Peer Specialist Program.
- **Maryland and Missouri:** collaboration between both states for the refinement and implementation of Mental Health First Aid.
- **New Mexico:** introduction of a consumer survey to assess satisfaction with behavioral healthcare.
- **Ohio:** launch of a Network of Care website, an interactive site where individuals access mental health information.
- **Oklahoma:** creation of ten additional mental health courts.
- **Texas:** convening a Youth Summit that led to recommendations on mental health policies.
- **Washington:** passage of legislation that expedites Medicaid enrollment upon release from incarceration.

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

Federal funding for T-SIGs 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.

States have learned that the costs associated with activities, such as convening stakeholders and modernizing information systems, have proven to be among the most significant barriers they face. Federal spending for the T-SIG program would help to overcome these hurdles and give states the capacity needed to begin the arduous planning and implementation process.

<sup>2</sup> Territories, the District of Columbia, and/or federally recognized American Indian/Alaska Native Tribes or Tribal Organizations

## Project LAUNCH

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
N/A	\$7.4m	\$20.0m	\$23.1m

Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) is a new grant program designed to promote the wellness of young children ages birth to 8 years of age by addressing the physical, emotional, social, cognitive and behavioral aspects of their development.

Project LAUNCH grantees will implement a range of evidence-based public health strategies to support young child wellness. Participating states and tribes will work to improve coordination among child-serving systems, build infrastructure, and improve methods for providing services. The majority of the funds will be passed from the state and tribal level to an identified locality where the grant will support the enhancement and integration of services in addition to system coordination and development.

Local service enhancement efforts will include but not be limited to mental health consultation for childcare and early education providers, developmental assessments in a range of settings, family strengthening programs, integration of behavioral and primary health care, and home visitation.

Project LAUNCH grants will enhance and coordinate key child-serving systems in communities in order to promote child wellness in a more collaborative and efficient way. Project LAUNCH grantees also expand upon and enhance prevention and wellness-promotion services to ensure that all children will have the resources and skills they need to be healthy and ready for school, and that they will be raised in nurturing families within the context of safe and healthy communities.

In order to model the cooperation it requires from grantees, SAMHSA is working in partnership with other agencies in the U.S. Department of Health and Human Services to guide the development of the initiative and integrate Project LAUNCH with other federal programs. This partnership includes HHS’ Administration for Children and Families, Centers for Disease Control and Prevention and Health Resources and Services Administration.

The programs selected for LAUNCH grants will receive approximately \$900,000 each year, over the course of the next five years. The actual award amounts may vary, depending on the availability of funds and the progress achieved by the awardees. The program will be administered by SAMHSA’s Center for Mental Health Services.

The following is a list of the FY2008 grant awardees and their projected yearly grant amounts:

- The State of Maine’s Community Caring Collaborative -- \$916,000. The grant will help expand prevention programs for underserved communities in Washington County, including 2,000 Passamaquoddy tribal members.
- Arizona Department of Health Services’ TAPESTRY Project -- \$900,946. This grant will build programs to support the immediate and long term well being of children in Phoenix’s South Mountain community.
- State of Rhode Island’s RI LAUNCH Program -- \$915,922. This grant will enhance the RI Successful Start Initiative’s existing efforts to build the social-behavioral capacities of young children throughout the Providence, R.I., area.
- State of New Mexico’s New Mexico Project LAUNCH -- \$916,000. The State of New Mexico will use the grant to develop a demonstration project to promote the well being of young children in Santa Fe County.
- Washington State Department of Health’s Project LAUNCH Washington -- \$916,000. Grant monies will be directed toward expanding child wellness services in Yakima County, building on existing family service, healthcare and legal service systems.
- Red Cliff Band of Lake Superior Chippewas’ Red Cliff Project LAUNCH -- \$915,200. This project will build a supportive, family-driven system of child services by blending traditional tribal values and evidenced-based practices.

**Grants for Primary and Behavioral Health Care Integration**

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
N/A	\$7.0m	\$7.0m	\$7.9m

**What will Co-locating Primary Care in CMHCs Do?**

Beginning in FY 2002, Health Resources and Services Administration (HRSA) allocated over \$25 million to co-locate mental health services in Federally Qualified Health Centers (FQHCs). Similarly, MHLG is seeking additional funds to expand a new program that co-locates primary care and specialty medical services in Community Mental Health Centers (CMHCs) and other community-based mental health and substance abuse provider agencies. This funding would directly assist CMHCs in addressing the co-occurring chronic illnesses of people with serious mental illnesses on-site. In addition, prior to the FY 2009 omnibus, CMHCs received no funding to engage in preventive interventions that would improve the overall health condition of people with serious mental illnesses including smoking cessation, weight management, and encouraging medication adherence; it should be noted that this consumer population typically accounts for fully 50% of the average caseload of CMHCs nationwide. In short, the new appropriation acknowledges CMHCs are the “medical homes” for low-income persons experiencing mental and addictive disorders, and that integrating services at the provider level is key to reducing morbidity and mortality.

**Why are the Co-locating Primary Care Grants Important?**

There is a history of discrimination against adults with serious mental disorders in chronic care management programs at the federal and state levels. For example, these consumers are excluded from the Health Disparities Collaboratives administered by HRSA because the agency has failed to designate them as a health disparities population (despite a standing congressional directive to do so). Furthermore, individuals with conditions like schizophrenia, bipolar disorder and major clinical depression are rarely included in Medicare and Medicaid disease management programs or other

chronic care initiatives – due to their high cost and related clinical challenges. Therefore, the new federal funding at SAMHSA appears to be the only serious attempt – in all of DHHS– to improve the overall health of consumers served in the public mental health system.

**What Justifies Federal Spending for Co-Locating Primary Care Grants?**

A 2006 survey financed by SAMHSA entitled, *Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States*, looked at mortality rates among individuals served by public mental health systems in Arizona, Missouri, Oklahoma, Rhode Island, Texas, Utah, Vermont, and Virginia between 1997 and 2000. It concluded that these clients **died – on average – 25 years sooner** than their comparative state general populations. The causes of death were co-occurring chronic conditions including heart disease, cancer, and cerebrovascular, respiratory and lung diseases. [Preventing Chronic Disease, Public Health Research, Practice and Policy, Colton and Manderscheid, Vol. 3, No. 2, April 2006]. Mortality rates of this magnitude appear to be the worst among ANY population served by ANY agency of the United States Public Health Service.

On the care delivery side, several factors converge to produce these horrific data. Persons with serious mental disorders have poor diets, and experience both heavy co-occurring substance abuse and an extremely high incidence of smoking (85%) – all of which contribute to poor overall health status. Because schizophrenia and bipolar disorder produce pronounced cognitive impairments, it is often difficult to successfully refer consumers to outside providers of primary care and specialty medical services. These factors combine into a single harsh reality: persons with serious mental illnesses die much sooner than other Americans because their co-occurring chronic illnesses are either inadequately treated or, more likely, not treated at all.

### Jail Diversion Program Grants

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$6.93m	\$6.80m	\$6.7m	\$7.8m

#### Why are Jail Diversion Program Grants Important?

Each year, 11.4 million people are booked into U.S. jails. An estimated seven percent of jail inmates have current symptoms of serious mental illness. Of these 800,000 people approximately three-quarters have co-occurring substance use disorders. Approximately 63 percent of State prisoners with mental health problems used drugs the month before their arrest, 14 percent higher than those without a mental health problem. 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 reported that likewise female inmates have demonstrated significantly higher rates of mental health problems than male inmates (State prisons: 73 percent of females and 55 percent of males; local jails: 75 percent of females and 63 percent of males. A U.S. Department of Justice study reported that 16 percent of the population in prison or jail has a mental illness. Additionally, inmates with mental health problems also demonstrated significantly higher rates of homelessness and sexual abuse history. 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
- Nearly a quarter of both State prisoners and jail inmates with a mental health problem, compared to a fifth of those without, had served 3 or more prior incarcerations

#### 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. Currently, only 1 in 3 State prisoners and 1 in 6 jail inmates with mental health problems had received treatment since admission. 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; (overall, the mean time state prisoners who had a mental health problem expected to serve was 4 months longer than State prisoners without a mental health problem.
- 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.”

- At midyear 2005 more than half of all prison and jail inmates had a mental health problem, including 705,600 inmates in State prisons, 70,200 in Federal Prisons, and 479,900 in local jails.
- Jail diversion does not increase public safety risk; and
- Jail diversion programs successfully link those diverted to community-based services.

An estimated 70 percent of State prisoners, who had a mental health problem compared to 76 percent without, said they were employed in the month before their arrest. Among Federal prisoners, 68 percent of those who had a mental health problem

were employed, compared to 76 percent of those who did not have a mental problem.

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 on the need for people inappropriately warehoused in jails to receive appropriate and effective community-based treatment.

## Mental Health Outreach and Treatment to the Elderly

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$4.95m	\$4.86m	\$4.8m	\$5.6m

### 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. It should be noted that normal aging is not characterized by mental or cognitive disorders.

Although \$4,860,000 was allocated for evidence-based mental health outreach and treatment to the elderly in FY 2009, 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 program, at its inception in FY 2002, was funded at \$5 million, so current funding has fallen behind in both real and constant dollars.

### 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

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$3.40m	\$3.34m	\$3.7m	\$4.3m

### What Do the Statewide Family Networks Do?

The Statewide Family Networks Grants 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 primary decision makers in the transformation of the child-serving systems in their State. Grantees accomplish this by supporting families and youth to use their experiential expertise and informing other 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, resources, and child serving agencies;

*Providing outreach to families* through toll-free telephone numbers and through information and referral networks prepares youth and family members

to participate as effective and primary decision makers able to obtain needed services and supports;

*Serving as a liaison* with various human service agencies and educating states and communities about effective ways to improve children's services, include families and youth in decisions that impact their lives, 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.

### Why Are Statewide Family Network Grants Important?

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

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

**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 2006-2007, the Statewide Family Network grantees reported providing at least one service to 391,782 unduplicated family members and youth. In the same period, 38 grantees reported that family members and youth held 4,921 seats on numerous policy, planning and service delivery decision-making groups.

**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* is demonstrating positive outcomes of youth and family peer-to-peer services while scientifically documenting the same.
- **MD** *The Maryland Coalition* developed four new curricula to train families to be effective partners in Maryland’s systems of care for children with mental health needs.
- **NV** *Nevada Collaborating for Children* participated in training first responders with Crisis Intervention (CIT) Training, including juvenile justice staff, law enforcement officers, and emergency medical teams serving children with mental health issues and their families.
- **NY** *Families Together* increased their outreach through 10 Regional Chapters, resulting in involvement in policy making, research, program design and implementation, and service delivery to families and youth with special emotional, behavioral, and social needs.
- **WI** *Wisconsin Family Ties* has partnered with a rap group and developed a video with music to address stigma and build public understanding regarding issues facing youth with mental health care needs.
- **WY** *UPLIFT* has successfully developed statewide partnerships integrating mental health services into some of the country’s most remote areas and reaching children, youth and families that would not otherwise have received help.

**Minority Fellowship Workforce Program**

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$3.8m	\$3.7m	\$3.7m	\$4.3m

**What is the Minority Fellowship Workforce Program?**

The Minority Fellowship Program of the SAMHSA Center for Mental Health Services (CMHS) helps to reduce racial and ethnic disparities in mental health status and to improve the quality of mental health services for minority populations. It provides training minority mental health professionals to offer culturally competent, accessible mental health and substance abuse services for diverse populations.

**Why is the Minority Fellowship Workforce 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* documented 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 percent of our nation’s population and are projected to account for 40 percent in 2025. To ensure that minorities have access to culturally sensitive and effective mental health services, federal support for programs that train all eligible 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 does not answer the pressing needs of those being served. At its inception in the 1970’s, the National Institute of Mental Health (NIMH) Minority Fellowship Program (MFP) was 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 SAMHSA/CMHS Minority Fellowship Workforce Program has succeeded in educating many ethnic minority mental health professionals and in producing leaders in mental health field. 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 populations.

The CMHS Minority Fellowship Workforce Program is a cost effective way to address some of the nation’s most serious public health challenges and should be continued and expanded.

## Rehabilitation Research and Training Centers

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$3.65m	\$3.07m	\$3.6m	\$4.1m

### What are the Rehabilitation Research and Training Centers?

The Rehabilitation Research and Training Centers conduct evaluations of evidence-based and promising practices in psychiatric rehabilitation (adults) and system-of-care service delivery (children). They also disseminate information and provide training and technical assistance regarding effective interventions that promote recovery and self-determination (adults) and illness prevention and enhancement of resilience (children). Information is directed to multiple constituencies including individuals with mental illness, families, community-based organizations, federal and state agencies, advocates, educators, and researchers. The RRTCs are in a unique position to conduct comparative effectiveness research due to their long history of rigorous evaluations of innovative community-based models. Their extensive experience with policy-relevant implementation studies also makes them well-positioned to engage in translational research with the potential for rapid adoption of effective practices in the public sector. Thus, they bridge the gap between science and service and have done so, by design, since the program's inception. There are four RRTCs, two focused on children and two on adults, co-funded by CMHS/SAMHSA and the U.S. Department of Education's (USDOE) National Institute on Disability and Rehabilitation Research.

### Why are the Rehabilitation Research and Training Centers Important?

The RRTCs are the only academic centers of excellence designed to focus on both psychiatric rehabilitation and system-of-care research, and on the translation of that knowledge into practice through training, dissemination, and technical assistance. They are one of the few centers of

excellence designed not only to produce new knowledge, but also to fully include people with disabilities in all phases of inquiry and knowledge utilization. They play a major role in the development and evaluation of many of the country's leading models of community-based care including: supported employment, supported education, self-

directed care, self-help and peer support, wrap-around services, and school-based mental health care. They respond to the call of the President's New Freedom Commission for greater availability and access to individualized care planning; peer support and self-help; vocational rehabilitation; family and person-centered services; service system integration; culturally competent care; and integration of health and mental health.

### What Justifies Federal Spending on this Program

In operation since 1978, the RRTC program is one of the federal government's longest running inter-agency agreements (IAG). As such, it makes excellent use of fiscal resources by sharing them between federal agencies. The Inter-agency Committee on Disability Research (ICDR) has called for increased coordination of research efforts across federal departments; the RRTC IAG between USDOE and CMHS/SAMHSA is a best-practice model for future inter-agency coordination efforts. This joint funding structure also ensures that the perspectives of mental health and rehabilitation/resiliency are fully integrated. The RRTCs' training and education mission responds directly to the critical need for workforce development in frontline care, using evidence-based and promising practices. An investment in research at multiple levels allows the Centers to address prevention at primary, secondary, and tertiary levels. This is particularly evident in the child RRTCs' focus on improving and expanding school-based mental health programs, and addressing the needs of transition-aged youth with severe emotional disorders. It also is evident in the adult RRTCs' emphasis on promotion of health and wellness, and focus on illness self-management models that prevent relapse and promote symptom management.

### Examples of Effectiveness

- Millions of people with severe mental illnesses have entered the labor force after receiving vocational services through models evaluated and disseminated by the RRTCs, such as supported employment and

transition to work services for school-aged youth.

- Millions of children, youth, and adults have benefited from the RRTC's focus on innovative education models such as supported post-secondary education and school-based mental health services.
- The RRTCs have a history of working directly with states to enhance and integrate service systems, while simultaneously conducting rigorous evaluations that advance knowledge and encourage adoption of best practices by other states.

- The RRTCs are one of the few academic research centers conducting comparative effectiveness research and randomized controlled trial studies on models widely used in community-based public mental health treatment, including evidence-based practices and peer-led services.
- The RRTCs have led the way in developing and studying novel behavioral health care financing strategies such as money follows the person (i.e., self-directed care), braided funding, comprehensive benefit design, and wraparound funding.

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

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$7.53m	\$3.61m	\$3.61m	\$3.95m

### 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 for co-occurring disorders. It is necessary to use clinical staff who are cross-trained in the treatment of both kinds of disorder.

For several decades, individuals with mental health and substance abuse disorders have suffered from services plagued with separate regulations, financing, provider education, licensing and credentialing, and eligibility. For this reason, these individuals have often been mistreated and shuffled between services, and have seldom received the comprehensive screening and assessment necessary. Collaborative treatment planning has proven much more productive for individuals with mental health and substance abuse treatment systems.

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 illness 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 (state partnership performance) programs.

### Statewide Consumer Network Grants

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$1.50m	\$1.47m	\$2.5m	\$2.9m

**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 grass-roots development. They give consumers hope by reaching out to this disenfranchised population. The funding helps people find their voice and feel empowered to bring about systemic mental health transformation in line with the recommendations from the President's New Freedom Commission on Mental Health.

Grantees use these resources to address stigma, reduce mental health disparities, prevent criminalization, promote self-care and peer-support, develop statewide infrastructure to promote positive changes in the state's public mental health system, encourage business and management skill development and help address gaps in services.

These grants help consumers promote the development of systems of care that help consumers live independently and productively in the community so they can rely less on the traditional mental health provider, move out of institutions and into the community (in line with the Supreme Courts' Olmstead decision), and avoid inappropriate use of inpatient services.

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 FY 2009.** 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

**Examples of Effectiveness**

Consumer Statewide Networks have contributed to the enhancement of capacity and infrastructure development by supporting consumer organizations in many ways. **Some examples are:**

**VT** -Vermont Psychiatric Survivors – builds innovative recovery programs which has lead to in peers developing as leaders, getting employed, becoming more independent of the system, pursuing educational opportunities, which has resulted in decreased hospitalizations and retainment of housing in the community.

**MD** – On Our Own of Maryland – held a statewide leadership summit which resulted in the

through self-help models.

establishment of Consumer Satisfaction Teams and a pilot project on self-directed mental health care.

**Oklahoma** - brought empowerment and leadership academy training to consumers statewide. This has resulted in people becoming self sufficient and off the Medicaid rolls, and becoming active partners in building new programs and assisting others.

**Ohio**- has successfully developed peer training programs and held regional and statewide meetings of peer groups, developed a statewide mentoring program to build relationships between more established groups and emerging groups, and published a state directory of mental health peer services.

**Consumer and Consumer-Support Technical Assistance Centers**

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$1.98m	\$1.95m	\$1.95m	\$2.3m

**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, avoid psychiatric hospitalization, and live meaningful lives in the community. This technical assistance is directed both to individuals and to community-based organizations run by people recovering from psychiatric disabilities and/or their supporters:

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

**Why are Consumer and Consumer-Supporter Technical Assistance Centers Important?**

Despite the fact that the importance of supporting and promoting mental health consumer-run services was recognized in the report of the President’s New Freedom Commission on Mental Health, the Administration proposes to eliminate funding for this program in FY 2009. The 2003 report of the President’s New Freedom Commission on Mental Health 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, and peer support services

in general, provide services that improve outcomes for people with mental illnesses.

Furthermore, a recently published report by the Center for Mental Health Services (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-run services, the CMHS report found that consumer-run program sites had technical assistance needs:

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

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

A CMHS-funded evaluation in 2001 found that the centers serve an impressive number of consumers, consumer-supporters, and organizations. 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.

## **Mental Health Research**

### **Fiscal Year 2010 Funding Recommendations**

for the

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

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

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

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

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

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

Acting Director: Raynard Kington, MD, Ph.D. (301) 496-4000

**Fiscal Year 2010  
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 transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. Mental illnesses are now understood and studied as brain disorders, specifically as disorders of brain circuits. Left untreated, a mental disorder can become more severe and more difficult to treat, and can lead to the development of co-occurring illnesses. Building on new discoveries from genetics, neuroscience, and behavioral science, NIMH-funded researchers have made extraordinary progress in understanding how biology, behavior, experience and the environment interact to lead to mental disorders. NIMH research is also demonstrating that medications and behavioral therapies can relieve suffering and improve daily functioning for many people. Analyses of the human genome have transformed our understanding of how individuals genetically vary from each other and how these variations can put some people at increased risk for certain illnesses. Neuroimaging studies and investigations of cognition and behavior have laid the vital groundwork needed to make unprecedented progress toward preventing and treating mental illnesses.

The burden of mental disorders on society is enormous. Mental disorders are the leading cause of disability in the United States and Canada, accounting for 24 percent of all years of life lost to disability and premature mortality (Disability Adjusted Life Years or DALYs). Moreover, suicide is the 11th leading cause of death in the United States, accounting for the deaths of approximately 33,000 Americans each year. In a given year, an estimated 13 million American adults (approximately 1 in 17) have a seriously debilitating mental illness. The economic burden of serious mental illness, excluding incarceration, homelessness, comorbid conditions and early mortality is \$317.6 billion annually.

To inspire and support research that will continue to make a difference for those living with mental illnesses, and ultimately, promote recovery, NIMH has developed a Strategic Plan to guide future research efforts. The overarching objectives of the Strategic Plan are to: (1) promote discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders; (2) chart mental illness trajectories to determine when, where and how to intervene; (3) develop new and better interventions that incorporate the diverse needs and circumstances of people with mental illnesses; and (4) strengthen the public health impact of NIMH-supported research.

**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)**

FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$1,403.6m	\$1,404.5m	\$1,450.5m	\$1,552.0m

***Basic Scientific Research***

Innovative research and research training supported by NIMH have made great progress in revealing the complexities of mental disorders. Researchers are working to understand how genes give rise to basic biological functions, and how disruptions in function can lead to mental illnesses. 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 spectrum disorders (ASD), 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.

***Clinical Research***

NIMH has made great strides in moving the science from the laboratory and into clinical settings. For example, NIMH has supported several practical clinical trials, involving more than 10,000 patients at over 200 sites, which examined treatment effectiveness for mental disorders such as schizophrenia, bipolar disorder, and depression. To continue the collaborations forged through the trials, the Institute established the NIMH Clinical Trials Networks. These networks of clinical sites continue to serve as an extensive resource for more rapid initiation of research aimed at answering the real world questions involved in treating mental disorders, such as better ways to determine the likelihood of an individual patient developing adverse side effects from specific medications. The NIMH Clinical Trials Network consists of three individual networks - The Schizophrenia Trials Network, the Bipolar Trials Network, and the Depression Trials Network. NIMH is committed to translating the discoveries made in basic and behavioral 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.

***Autism Spectrum Disorders***

ASD share a diverse combination of core clinical characteristics of impairment in verbal and nonverbal communication skills and social interactions, and restricted, repetitive, and stereotyped patterns of behavior. The national prevalence rate of ASD is estimated to be as high as 6.6 children per 1,000 (or about 1 in 150 children) The rate varies significantly between states. The emerging picture of the genetics of autism is quite surprising. NIMH-supported research has found that many of the seemingly disparate genetic mutations recently discovered in autism may share common underlying mechanisms. The mutations may disrupt specific genes that are vital to the developing brain, and which are turned on and off by experience-triggered neuronal activity. There appear to be many separate mutations involved. Such research is among the wide array of studies that will be coordinated and accelerated by the Strategic Plan for ASD Research. This plan, and its annual updating, is required by the Combating Autism Act (CAA) of 2006 (P.L. 109-416), which established the Federal Interagency Autism Coordinating Committee (IACC). NIMH leads the IACC, with NIMH Director, Thomas Insel, M.D., as its Chair.

***PTSD and Suicide***

Post-traumatic Stress Disorder (PTSD) is an anxiety disorder that can develop following exposure to an overwhelming traumatic event, such as violent personal assault, war, or natural disaster. The aftermath of national traumas, such as the 9/11/2001 terrorist attacks, military actions in Afghanistan and Iraq, and Hurricanes such as Katrina have highlighted the toll that such traumas may take on mental health. Over the past several years, researchers have made rapid progress in understanding the mental and biological foundations of PTSD, including the brain’s fear circuitry, making the prediction and prevention of PTSD a realistic goal. NIMH is currently investigating how to differentiate between trauma

survivors who require early preemptive interventions and those who are likely to recover without assistance. NIMH is also interested in studying the impact of existing national, state, and/or local community-based programs addressing the adjustment and mental health needs of recent combat veterans, including returning National Guard, Army Reserve, and newly separated active duty personnel. These research projects will produce new information concerning effective strategies for fostering successful transition from combat to civilian roles for returning service members.

NIMH has issued a request for applications (RFA) for a Collaborative Study of Suicidality and Mental Health in the U.S. Army. The funding opportunity will be in the form of a cooperative agreement with

NIMH, and allows for up to five years or \$50 million in total costs. The RFA is an outgrowth of a recently signed memorandum of agreement between NIMH and the U.S. Army in which the Army will fund the multi-year study on suicide and suicidal behavior among soldiers, across all phases of Army service. It will be the largest single study on the subject of suicide that NIMH has ever undertaken. The project aims to strengthen the Army's efforts to reduce suicide among its soldiers by identifying risk and protective factors for suicidal thinking and behavior. The study's findings will also inform our understanding of suicide in the U.S. population overall, and may lead to more effective interventions for both soldiers and civilians.

**Fiscal Year 2010  
Funding Recommendations**

for the

National Institute on Drug Abuse (NIDA)

Drug abuse and addiction are a major burden to society; economic costs alone are estimated to exceed half a trillion dollars annually in the United States—including health, crime-related costs, and losses in productivity. However, as staggering as these numbers are, they provide a limited perspective of the devastating consequences of this disease.

Like other mental illnesses, such as depression, bipolar disorder, and schizophrenia, addiction is a chronic disease that can last a lifetime absent proper treatment. Moreover, addiction and other mental illnesses often co-occur and should be treated together. Ignorance of or failure to treat one disorder can jeopardize the chances of a successful intervention for the other(s). Scientists still do not know enough to prove a connection or causality, or how to prevent comorbidity, but the research does show that certain mental disorders are established risk factors for subsequent drug abuse—and vice versa. Correct diagnosis is critical for optimizing treatment effectiveness for both. New studies examining this issue aim to develop interventions for people with comorbidities, including 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 the associated adverse individual, social, health, and economic consequences. As the world’s foremost 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.

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

APPROPRIATIONS FY 2007	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$1,000.3m	\$1,000.7m	\$1,032.8m	\$1,105.1m

**Background**

In 2007, an estimated 19.9 million Americans or 8.0 percent of the population aged 12 or older were current (past month) illicit drug users (72007 National Survey on Drug Use and Health, SAMHSA). This rate has remained relatively unchanged since 2002, signifying that work needs to be done.

NIDA-supported scientific advances over the past three decades have revolutionized our understanding of drug abuse and addiction, informing the development of more effective prevention and treatment approaches. NIDA is committed to the principle that addiction is a preventable and treatable disease. Close collaborations with other stakeholders help to bring this message—backed by science—to communities across the country. These efforts educate and inform diverse populations, changing people’s perceptions and replacing stigma and shame with a new understanding of addiction as a treatable disease.

To confront the most pressing aspects of this complex disease and to tackle its underlying causes, NIDA relies on a multi-pronged approach that takes advantage of research programs in the basic, clinical, and translational sciences: genetics, functional neuroimaging, social neuroscience, medication and behavioral therapies, prevention, and health services. 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.

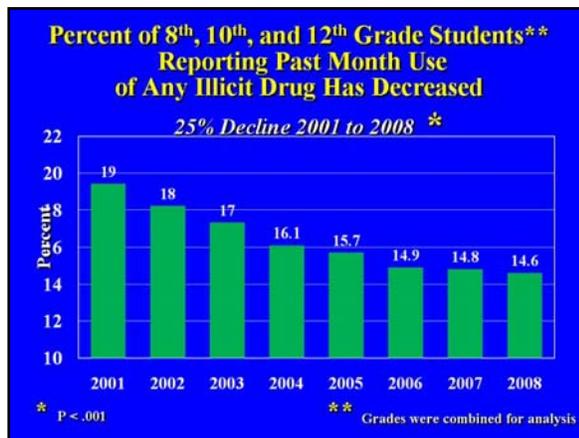
Decades of research progress have positioned NIDA to take advantage of accumulated research findings by applying new tools, techniques, and knowledge that are helping to change the way we address drug addiction in this country. Innovative use of new genetics tools are providing insights into who is most

vulnerable and who could optimally benefit from particular therapies—i.e., a new era of personalized medicine. Applications of brain imaging technologies allow scientists to literally see in “real-time” how drugs affect the brain and influence decision-making. Particularly relevant to substance abuse is the social environment, as genetic and imaging studies continue to reveal how the interplay of biological (i.e., genes, developmental stage) and social influences (i.e., family, peers, culture) affect individual choices and decisions about drugs. Related to this is an emerging area of research and an important focus for NIDA—epigenetics. Epigenetics refers to changes in DNA structure caused by environmental events that can influence gene expression and function. These changes are triggered not only by drug exposure, but also by social stressors and parenting style, for example. Understanding the causes and effects of epigenetic changes offers a real opportunity for developing interventions to counter, prevent, or take advantage of them. Such knowledge is crucial to ultimately be able to tailor prevention and treatment interventions to address the risk areas of a given individual.

NIDA’s portfolio includes a significant investment in effectiveness and cost-effectiveness research that encompasses community treatment programs as well as criminal justice settings, where drug abuse problems are widespread. NIDA’s Drug Abuse Treatment Clinical Trials Network (CTN) plays a key role in testing evidence-based treatments in community settings, optimizing their utility and cost-effectiveness and fostering their adoption. This requires alliances that NIDA has catalyzed between practitioners from community-based drug treatment programs and university-based research centers, in addition to SAMHSA and Single State Authorities. 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) network, an inter-agency collaboration aimed at bringing proven treatment models into the criminal justice system to help stop the vicious cycle of drug abuse and crime. These programs allow NIDA to

learn how to modify treatments to make them more practical and community/justice system friendly. Testing treatments in the settings where they will be deployed, and training providers to implement them, promotes their acceptance and identifies potential obstacles to their adoption.

NIDA also monitors drug use patterns and trends to stay on top of emerging threats. A long-standing tool in this regard is the annual Monitoring the Future Survey (MTF) of 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> graders. Recent survey results show a 25-percent decline among the three grades combined in past month abuse of “any illicit drug” between 2001 and 2008 (see figure). In addition, cigarette smoking is at the lowest rate in the survey’s history.



But the news is not all good. For while marijuana use across the three grades has shown a consistent decline since the mid-1990s, it appears to have leveled off. In addition, nonmedical use of prescription drugs remains at unacceptably high levels.

- Abuse of prescription drugs has been on the rise in teens and young adults over the last decade, and now they are among the most commonly abused by high school seniors. Marijuana is still number 1, however, behind alcohol and tobacco.
- In 2008, 15.4% of 12<sup>th</sup> graders reported using a prescription drug nonmedically within the past year<sup>3</sup>, with nearly 1 in 10 reporting abuse of the prescription painkiller vicodin.

<sup>3</sup> This category includes amphetamines, sedatives/barbiturates, tranquilizers, and opiates other than heroin.

- Also commonly abused are stimulants, such as methylphenidate and amphetamines, and cough medicines containing dextromethorphan (DXM).

### Priority Research Areas

**Learning more about the adolescent brain.** Because adolescence is typically when drug abuse and addiction take hold, NIDA continues to focus research on this vulnerable period of development. Given that the brains of adolescents have not fully developed, including the connections between brain areas involved with emotions and areas involved with judgment and decision-making, adolescents are less able to exert inhibitory control over emotions and desires and are hence more likely to engage in risky behaviors, including drug experimentation. However, the brain at this stage is also inherently more plastic, which offers opportunities for prevention interventions that could lead to greater resilience.

**In search of promising new targets for anti-addiction medications.** Medications development is an important focus for NIDA and offers exciting opportunities even while it presents challenges. A major one is the limited pharmaceutical industry involvement in developing and testing potential addiction medications. This makes it critical for NIDA to be able to pursue and test newly defined targets for different drugs of abuse. Indeed, NIDA supports multiple trials of promising medications to counter addiction to both licit and illicit drugs.

Capitalizing on breakthrough discoveries showing the involvement of different brain systems in drug abuse and addiction—beyond the dopamine/reward system—NIDA’s medications development program is pursuing a variety of emerging targets and treatment approaches. Examples include medications to diminish conditioned responses, promote new learning, and inhibit stress-induced relapse. Another innovative strategy in which NIDA is investing is immunotherapy, or “vaccines,” for methamphetamine, cocaine, and nicotine dependence, the latter in Stage III efficacy trials. Immunotherapy causes the body to generate antibodies that bind to specific drugs while they are still in the bloodstream, blocking their entry into the brain. Such approaches have great potential to help people remain abstinent and avoid relapse once they are in treatment.

### Comorbidity: Addiction and Other Mental Illnesses

For the past 20 years, national surveys have documented the high prevalence of drug abuse among individuals diagnosed with other mental illnesses and vice versa. To collectively report on

these and other findings, NIDA recently released a research report titled *Comorbidity: Addiction and Other Mental Illnesses*, summarizing the state of the science regarding the complex relationship between substance abuse and other mental disorders. The research report also describes common factors that can lead to comorbidity, including genetic and gender vulnerabilities, involvement of similar brain regions, and the influence of developmental factors; it also discusses how comorbidity can be diagnosed and treated. Several examples of behavioral therapies tested in patients with comorbid conditions--as well as potential medications--are outlined in the research report.

In addition, because chronic pain and drug addiction also co-occur, and share behaviors and symptoms related to psychological states like depression or stress, NIDA has issued a new call for studies to explore how brain changes associated with these states may resemble those caused by chronic pain and drug addiction, and to better understand the cause and effect involved.

***Military Personnel and Substance Abuse***

There is growing concern that military personnel, including those returning from Iraq and Afghanistan as well as other combat veterans, are experiencing a range of medical problems, such as traumatic brain injury, post traumatic stress disorder (PTSD), depression, anxiety, and tobacco, alcohol, and other drug abuse. To respond to these urgent needs, NIDA convened a two-day meeting in January 2009 to address the issue of substance abuse and associated mental and physical health problems among military personnel and their families. The meeting was a highly collaborative one, eliciting involvement and support from the U.S. Army Medical Research and Materiel Command, the Department of Defense Health Affairs, the Army Center for Substance Abuse Programs, the Department of Veteran Affairs, the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, the National Heart, Lung, and Blood Institute, and the National Cancer Institute. An upcoming report will issue resulting recommendations for new research directions and priorities. NIDA will also be issuing a

call for studies on trauma, stress and substance use and abuse among U.S. military personnel, veterans, and their families. These efforts will be coordinated with other NIH Institutes, as well as military-focused federal agencies. NIDA's Clinical Trials Network will also serve a key role in this collaborative effort to help U.S. military personnel, veterans, and their families.

***Screening, Brief Intervention, and Referral to Treatment***

A large majority of individuals with substance use disorders often go undetected and untreated. Screening and brief intervention tools have tremendous potential to help identify early on individuals at risk for and already experiencing drug use disorders. Physicians can use these tools to assess their patients' involvement with substance abuse and refer them to treatment if necessary. Such efforts encourage and support the medicalization of addiction, which in turn creates an environment where people can get the help they need to get off drugs and reclaim their lives. NIDA has recently launched a new initiative to develop and promote the use of these vital tools, in collaboration with other federal agencies. It is expected that a screening instrument will be ready for distribution by the Spring of 2009.

***The evolving HIV/AIDS epidemic***

Drug abuse continues to be a major vector for the spread of HIV/AIDS through its connection with other risky behaviors, such as needle sharing and unprotected sex. NIDA research has advanced the less acknowledged link between drug abuse and the resulting impaired judgment that can lead to risky sexual behavior and HIV transmission—highlighting the value of drug abuse treatment in preventing HIV spread. NIDA will continue to support primary prevention research to find the most effective HIV risk-reduction interventions for different populations. Young people are a major focus for these efforts, calling for strategies that start early and can adapt with age. NIDA is also supporting research to develop effective secondary prevention strategies designed to reduce HIV transmission.

**Fiscal Year 2010  
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.

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

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

APPROPRIATIONS FY 2007	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$436.3m	\$436.3m	\$450.2m	\$481.7m

**Background**

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is the lead Federal entity for biomedical and behavioral research focused on uncovering the causes and improving prevention and treatment of alcohol abuse, alcoholism and other health effects of alcohol. NIAAA funds 90 percent of all alcohol research in the United States. This research is designed to reduce the enormous health, social, and economic consequences caused by excessive drinking. Approximately 18 million Americans meet the criteria for a diagnosis of alcohol abuse or dependence (alcoholism), and 40 percent of Americans have direct family experience with alcohol abuse or dependence. Annually, 79,000 deaths are attributable to alcohol, and excessive alcohol consumption is the third leading preventable cause of death in the U.S.

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. More than 70 percent of the cost borne by society relates to the enormous losses to productivity due to alcohol related illnesses and the loss of earnings resulting from 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.

Injuries are the leading cause of death among people ages 1-44 in the U.S., and alcohol is the leading contributor to injury deaths - over 40,000 injury deaths annually are attributable to alcohol. Almost 30 percent of victims of violent crime report the offender had been drinking, and two-thirds of victims who suffered violence by an intimate (a current or former spouse, boyfriend, or girlfriend) reported that alcohol had been a factor. The severe impact of alcohol on juvenile populations has been well documented. Alcohol-related traffic crashes are the leading cause of teen deaths. Alcohol is also involved in homicides and suicides, the second and third leading causes of teen deaths, respectively. Because injury deaths most often occur among young people, alcohol attributable injury deaths account for twice the number of preventable years of

lost life as chronic disease alcohol attributable deaths, which by itself is substantial.

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

- 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.
- Longitudinal studies to: expand our understanding of alcohol effects on the developing adolescent brain; determine how alcohol use affects development of co-morbid disorders and how other disorders affect the emergence and progression of alcohol use disorders;
- Acceleration of medications development for treatment of alcoholism. More specifically, the development of promising compounds to treat alcohol dependence, including compounds that reduce the number or duration of heavy drinking occasions, and those that can be used for individuals who are not abstinent at the start of treatment;
- Expanding research to understand how individuals change their harmful drinking behaviors either in the presence or absence of treatment;
- 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;
- Understanding the neural basis for the transition from drinking to compulsive drinking.

**NIAAA ADVANCES**

**Gene identification informing medications development**

NIAAA has made significant progress in identifying genes that contribute to the development of alcohol dependence, and medications targeting molecules identified in these studies are now in preclinical and clinical testing. Moreover, pharmacogenetic studies have demonstrated that the effectiveness of medications varies among individuals, depending in part upon which variants of specific genes they carry. Information from these studies will enable health care providers to personalize the treatment they offer their patients.

**Gaining a better understanding of the full spectrum of alcohol dependence**

A recent study has given us new insight into the face of alcoholism in the U.S. While clinicians and researchers have long recognized the variation within the alcohol dependent population, the public perception of a ‘typical alcoholic’ remains that of a dysfunctional individual affected by the chronic relapsing subtype of the disorder. In fact, this subtype occurs in a relatively small percentage of the alcohol-dependent population. Recent analyses of data from NIAAA’s National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) have identified distinct subtypes of alcohol dependence. Because these analyses were performed on data representing the general population, and not specifically on data from people in alcohol treatment settings, they provide a much broader and more accurate picture of the range of individuals who suffer from alcohol dependence and the multi-faceted nature of their disorder.

Certain subtypes of alcoholics have emerged that were previously undetected, or at least significantly underestimated, because few individuals with these subtypes of alcohol disorder access treatment. For example, young adults rarely seek any kind of help for their drinking but comprise the largest group of alcoholics in this country. In addition, nearly 20 percent of alcoholics are highly functional and well-educated with good incomes and stable families; less than 1/5 of this group seeks treatment. Individuals in other subtypes, although variable in age and other characteristics, make up the more severe end of the spectrum. They are more likely to have other psychiatric disorders and other substance abuse problems, are more likely to seek treatment and therefore have been well characterized in treatment-focused studies. NIAAA is using this knowledge to

help all groups along the spectrum -- from harmful drinking to chronic, relapsing dependence -- access the care they need.

**Expanding screening and brief intervention into primary care and beyond**

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. Therefore, NIAAA-supported research is promoting screening and brief intervention in venues other than specialty treatment facilities. For example, despite the high burden of illness associated with alcohol abuse and dependence, screening and diagnosis of alcohol problems are not standard components of primary health care for most individuals. NIAAA’s Helping Patients Who Drink Too Much - A Clinician’s Guide is helping to change this by providing a user-friendly, research-based approach to screening, diagnosing and managing patients with heavy drinking and alcohol use disorders for both primary care and mental health providers. Alcohol screening is simplified to a single question about heavy drinking days. 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. The updated Guide offers several new resources including online training with CME/CE credits, support for medication-based therapy in non-specialty settings, a handout with strategies to help patients reduce or quit drinking, a dedicated Web page devoted to the Guide and supporting resources for clinicians and patients, and an updated PowerPoint presentation for educators and instructors.

To complement the Clinician’s Guide, NIAAA is releasing a consumer-oriented product called Rethinking Drinking which physicians can recommend to their patients as part of screening and brief intervention, and which is also available to the public at large. Rethinking Drinking takes an individual through the process of examining his/her drinking pattern, comparing it to drinking patterns in the general population and to recommended guidelines, and also assessing whether drinking is currently causing any symptoms or problems. Excessive drinkers are encouraged to examine the pros and cons of change, and then to develop a change plan and monitor their progress. Especially in the web version, many tools are provided that result in a highly individualized experience, with concrete change plans and advice

about how to cut down. Additional resources are identified for those requiring more intensive care. Rethinking Drinking offers a significant opportunity to disseminate widely guidelines about drinking and recommended limits. In addition to being disseminated in the health care system, it could be used in many other settings, such as social service agencies, schools and colleges, workplaces, criminal justice settings and pastoral counseling. Finally, it is available on the web thus offering universal access to state-of-the art change assistance.

**Addressing underage drinking on many fronts**

Underage drinking is 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. NIAAA is continuing to emphasize research, evaluation, and out reach efforts regarding underage drinking, using a developmental approach. Employing such a framework will make us more effective in preventing and reducing underage alcohol use and its associated problems.

In response to NIAAA findings of the high prevalence of alcohol dependence in young adults, the extensive

binge drinking among adolescents, and the serious consequences that result, the Surgeon General issued a Call to Action To Prevent and Reduce Underage Drinking. This concise report offers a comprehensive view of underage drinking and its consequences within a developmental framework. NIAAA provided the scientific foundation for the Call to Action, a collaborative effort of the Office of the Surgeon General, NIAAA, and the Substance Abuse and Mental Health Services Administration.

Given the high rates of drinking (especially binge drinking) among adolescents, coincident with significant developmental changes in the brain and nervous system, it is critical to better understand the impact of alcohol exposure on the developing brain. NIAAA recently funded 2 research initiatives to address this issue. One initiative is aimed at increasing our understanding about the short- and long-term effects of child and adolescent alcohol consumption on the developing brain. Another initiative is focused on understanding the effects of alcohol and pubertal hormones on brain development and on differences in drinking patterns and vulnerabilities between boys and girls. In addition, NIAAA is currently focusing on developing guidelines for screening children and adolescents for risk for alcohol use and alcohol use disorders.

**SAMHSA Substance Abuse Prevention and Treatment Block Grant (SAPT), and Centers for Substance Abuse Prevention (CSAP) and Treatment (CSAT)**

<b>CSAT Block Grant</b>			
FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$1,758.6m	\$1,758.7m	\$1,778.6m	\$1928.6m

<b>CSAT Programs of Regional and National Significance</b>			
FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$399.0m	\$399.8m	\$414.3m	\$489.3m

<b>CSAP Programs of Regional and National Significance</b>			
FY 2007 CR	FY 2008 OMNIBUS	FY 2009 OMNIBUS	MHLG RECOMMENDATION FY 2010
\$193.0m	\$194.1m	\$201.0m	\$276.0m

**SAMHSA Substance Abuse Prevention and Treatment (SAPT) Block Grant**

**What is the Substance Abuse Prevention and Treatment (SAPT) Block Grant?**

The Substance Abuse Prevention and Treatment (SAPT) Block Grant Program distributes funds to 60 eligible States, Territories, the District of Columbia and the Red Lake Indian Tribe of Minnesota through a formula, based upon specified economic and demographic factors. The SAPT Block Grant is the cornerstone of the nation’s drug and alcohol prevention and treatment system, providing roughly half of all public funding for treatment services. The current law includes specific provisions and funding set-asides, such as a 20 percent prevention set-aside; an HIV/AIDS early intervention set-aside; requirements and potential reduction of the Block Grant allotment with respect to sale of tobacco products to those under the age of 18; a maintenance of effort requirement; and provisions that limit fluctuations in allotments as the total appropriation changes from year to year.

**Why is the Block Grant Important?**

In 2004, the Block Grant accounted for approximately 40 percent of public funds expended by states for prevention and treatment. Twenty two States and Territories reported that greater than 50 percent of their substance abuse prevention and treatment programs came from the Federal Block Grant. Thirteen States and Territories reported Block

Grant funding at greater than 60 percent of the total spent, while seven States and Territories reported over 70 percent. Over 10,500 community-based organizations receive Block Grant funding from the States. In FY 2004, approximately 1.9 million individuals were served.

**What Justifies Federal Spending for the SAPT Block Grant?**

*The Costs of Untreated Addiction are Staggering:* According to the National Institute on Drug Abuse, misuse and addiction to alcohol, nicotine, and illegal substances cost Americans upwards of half a trillion dollars a year, considering their combined medical, economic, criminal, and social impact. Every year, abuse of illicit drugs and alcohol contributes to the death of more than 100,000 Americans, while tobacco is linked to an estimated 440,000 deaths per year. Substance abuse and addiction are the costliest and most prevalent of brain maladies, surpassing Alzheimer’s, depression, spinal cord injury, and other developmental disorders, according to a recent analysis in the Archives of General Psychiatry.

*People with substance use disorders rely on public sources of financing to a much greater extent than people with other diseases<sup>4</sup>.* Unfortunately, the overall amount of funding that is invested in

<sup>4</sup> National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001

addiction treatment pales in comparison to the costs; an estimated \$18 billion was devoted to treatment of substance use disorders in 2001, only 1.3 percent of all health care spending. The SAPT block grant, the main source of federal addiction prevention and treatment funding, is approximately \$1.8 billion and has been cut by approximately \$20 million over the last four years. Federal support is critical due in large part to the fact that over the last ten years public payers have taken on more responsibility for addiction treatment expenditures, increasing from 62 percent in 1991 to 76 percent in 2001.

*The current treatment gap is significant and can be explained, in part, by a shortage of affordable treatment services.* In 2006, 23.6 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.6 percent of the persons aged 12 or older) but only 2.5 million (10.8 percent) received treatment in a specialty facility. Thus, 21.1 million persons (8.6 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive it in the past year. Based on 2004-2006 combined data, among those individuals who made an effort to receive treatment the most often reported reason for not receiving treatment was not having health insurance and not being able to afford the cost (36.3 percent).

**SAMHSA’s Centers for Substance Abuse Prevention and Treatment**

In SAMHSA’s Centers for Substance Abuse Prevention and Treatment there are two program categories within the Programs for Regional and National Significance: Capacity and Science to Service. The first category supports SAMHSA’s Capacity goal, and includes services programs, which provide funding to implement a service improvement using proven evidence-based approaches, and infrastructure programs, which identify and implement needed systems changes. The second category supports SAMHSA’s Effectiveness goal, and includes programs that promote the identification and increase the availability of practices thought to have potential for broad service improvement.

**Center for Substance Abuse Prevention (CSAP)**  
Current research shows that evidence-based substance abuse prevention is effective in preventing youth from initiating substance use and in reducing the number of individuals who become dependent. The 2006 Monitoring the Future survey of eighth, tenth, and twelfth graders showed gradually declining

rates of students reporting use of any illicit drug in the past 12 months.

The mission of the Center for Substance Abuse Prevention (CSAP) is to bring effective substance abuse prevention to every community through the Strategic Prevention Framework, which incorporates SAMHSA’s goals of Accountability, Capacity, and Effectiveness. CSAP works with States and communities to develop comprehensive prevention systems that create healthy communities in which people enjoy a quality life. This includes supportive work and school environments, drug- and crime-free neighborhoods, and positive connections with friends and family.

CSAP administers two major programs: Programs of Regional and National Significance (PRNS), and the 20 percent Prevention Set-aside of the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

**Additional CSAP Prevention Activities**

*Preventing and Reducing Underage Drinking*

In collaboration with the Interagency Coordinating Committee on The Prevention of Underage Drinking (ICCPUD), established by the Sober Truth on Preventing (STOP) Underage Drinking Act, SAMHSA continues to coordinate efforts to address the problem of underage drinking through the use of evidence-based strategies.

*The Drug Free Communities (DFC) Program*

The Drug Free Communities (DFC) program now supports over 700 drug-free community coalitions across the United States. This anti-drug program provides grants of up to \$100,000 to community coalitions that mobilize their communities to prevent youth alcohol, tobacco, illicit drug, and inhalant abuse. The grants support coalitions of youth; parents; media; law enforcement; school officials; faith-based organizations; fraternal organizations; State, local, and tribal government agencies; healthcare professionals; and other community representatives.

**The Primary Prevention Component of the SAPT Block Grant**

As required by legislation, 20 percent of Block Grant funds allocated to States through the SAPT Block

Grant formula must be spent on substance abuse primary prevention services. Prevention service funding varies significantly from State to State. Some States rely solely on the Block Grant's 20 percent set-aside to fund their prevention systems; others use the funds to target gaps and enhance existing program efforts. CSAP requires under regulation that the States use their Block Grant funds to support a range of prevention services and activities in six key areas to ensure that each State offers a comprehensive system for preventing substance abuse. The six areas are information dissemination, community-based process, environmental strategies, alternative activities, education, and problem identification and referral.

**Center for Substance Abuse Treatment (CSAT)**

The mission of the Center for Substance Abuse Treatment (CSAT) is to improve the health of the nation by bringing effective alcohol and drug treatment to every community. CSAT's primary objectives are to increase the availability of clinical treatment and recovery support services; to improve and strengthen substance use disorder clinical treatment and recovery support organizations and systems; to transfer knowledge gained from research into evidence-based practices; and to provide regulatory monitoring and oversight of SAMHSA-certified Opioid Treatment Programs. CSAT works with States and community-based groups to improve and expand existing substance use disorder treatment services under the Substance Abuse Prevention and Treatment Block Grant Program. CSAT also supports SAMHSA's free treatment referral service to link people with the community-based substance use disorder treatment services they need.

**CSAT's Programs of Regional and National Significance:**

**Targeted Capacity Expansion (TCE) Program**

Introduced by CSAT in 1998 to help communities to bridge gaps in treatment services, in general, TCE funding supports grants to units of State and local governments and tribal entities to expand or enhance a community's ability to provide a rapid, strategic, comprehensive, integrated, creative, community-based response to a specific, well documented substance use disorder treatment capacity problem, including technical assistance. The TCE programs include:

*SBIRT: Screening, Brief Intervention, Referral and Treatment*

Initiated in 2003, SBIRT uses cooperative agreements to expand and enhance the State or tribal organization continuum of care by adding Screening, Brief Intervention, Referral and Treatment service within general medical settings and by providing consistent linkages with the specialty treatment system. The SBIRT Initiative targets those with nondependent substance use and provides effective strategies for intervention prior to the need for more extensive or specialized treatment. The Initiative involves implementation of a system within community and/or medical settings—including physician offices, hospitals, educational institutions, and mental health centers—that screens for and identifies individuals with or at-risk for substance use-related problems.

*Recovery Community Services Program (RCSP)*

RCSP grant projects design and deliver peer-to-peer recovery support services to help individuals in their communities initiate and sustain recovery and gain overall wellness. Peer support services are not treatment or post-treatment services provided by professionals, but rather support services from people who share the experiences of addiction and recovery. They are designed to promote a sense of self-worth, community connectedness, and quality of life—all important factors in sustaining recovery from alcohol and drug use disorders

*Criminal Justice Activities*

To help States break the pattern of incarceration and reduce the high rate of recidivism, SAMHSA's Criminal Justice Activities include grant programs which focus on diversion and reentry for adolescents, teens and adults with substance use and mental disorders.

*Addiction Technology Transfer Centers*

An accompanying regional technical assistance system including 14 Addiction Technology Transfer Centers (ATTC's) created to build capacity at the State and program level to provide the highest quality treatment services. The ATTC network focuses on six areas of emphasis to improve treatment services:

- Enhancing Cultural Appropriateness
- Developing & Disseminating Tools
- Building a Better Workforce
- Advancing Knowledge Adoption
- Ongoing Assessment & Improvement
- Forging Partnerships

**Mental Health Liaison Group (MHLG) FY 2010  
Appropriations Recommendations for the  
SAMHSA and Key NIH Institutions**

(Dollars in Millions)

PROGRAMS	FY 07 FINAL	FY08 CR FINAL	FY09 FINAL (Omnibus)	FY10 MHLG REQUEST <sup>5</sup>
<b>CMHS</b>				
<b>CMHS TOTAL</b>	\$883.9m (\$0.0m)	\$910.9m (+\$27.0m)	\$969.2m (+58.3m)	\$1,121.4m (+\$152.2m)
<b>Community Mental Health Services Performance Partnership Block Grant</b>	\$428.3m (\$0.0m)	\$421.0m (-\$7.3m)	\$420.8m (\$0.0m)	\$486.9m (+\$66.1m)
<b>Children’s Mental Health Services Program</b>	\$104.1m (\$0.0m)	\$102.3m (-\$1.8m)	\$108.4m (+\$6.1m)	\$125.4m (+\$17.0m)
<b>PATH Homelessness Program</b>	\$54.3m (\$0.0m)	\$53.3m (-\$1.0m)	\$59.7m (+\$6.4m)	\$69.1m (+\$9.4m)
<b>Protection and Advocacy (PAIMI)</b>	\$34.0m (\$0.0m)	\$34.9m (+\$0.9m)	\$35.9m (+\$1.0m)	\$41.5m (+\$15.6m)
<b>Programs of Regional and National Significance</b>	\$263.3m (\$0.0m)	\$299.3m (+\$36.0m)	\$344.4m (+45.1m)	\$398.5m (+\$54.1m)
Youth Violence Prevention Initiatives	\$93.3m (\$0.0m)	\$93.5m (+\$0.2m)	\$94.5m (+1.0m)	\$109.3m (+\$14.8m)
Suicide Prevention for Children and Adolescents	\$36.1m (+\$1.4m)	\$48.6m (+\$12.4m)	\$47.1m (\$0.0m)	\$54.5m (+\$7.4m)
Children and Adolescents with Post Traumatic Stress Disorder	\$29.5m (\$0.0m)	\$33.1m (+\$3.6m)	\$38.0m (+\$4.9m)	\$44.0m (+\$6.0m)
Mental Health Transformation State Incentive Grant	\$26.0m (\$0.0m)	\$26.0m (\$0.0m)	\$26.0m (\$0.0m)	\$30.1m (+\$4.1m)
Project LAUNCH	n/a	\$7.4m	\$20m (+\$12.6m)	\$23.1m (+\$3.1m)
Grants for Primary and Behavioral Healthcare and Services	n/a	\$7.0m (\$0.0m)	\$7.0m (\$0.0m)	\$7.9m (+\$0.9m)
Jail Diversion Program Grants	\$6.93m (\$0.0m)	\$6.80m (-\$0.13m)	\$6.7m (\$0.0m)	\$7.8m (+\$1.1m)
Mental Health Outreach and Treatment to the Elderly	\$4.95m (\$0.0m)	\$4.86m (-\$0.09m)	\$4.8m (\$0.0m)	\$5.60m (+\$0.8m)
Statewide Family Network Grants	\$3.40m (\$0.0m)	\$3.34m (-\$0.06m)	\$3.7m (-\$0.36m)	\$4.3m (+\$0.6m)
Minority Fellowship Workforce Training	\$3.8m (\$0.0m)	\$3.7m (-\$0.1m)	\$3.7m (\$0.0m)	\$4.3m (+\$0.6m)
Rehabilitation Research and Training Centers	\$3.7m (\$0.0m)	\$3.1m (-\$0.6m)	\$3.6m (+\$0.5m)	\$4.1m (+\$0.5m)
Mental Illnesses and Substance Abuse Disorder Grant	\$7.53m (\$0.0m)	\$3.61m (-\$3.92m)	\$3.61m (\$0.0m)	\$3.95m (+\$0.34m)
Statewide Consumer Network Grants	\$1.50m (\$0.0m)	\$1.47m (-\$0.03m)	\$2.5m (+\$1.03m)	\$2.9m (+\$0.4m)
Consumer/Supporter Technical Assistance Centers	\$1.98m (\$0.0m)	\$1.95m (-\$0.03m)	\$1.95m (\$0.0m)	\$2.3m (+\$0.35m)
<b>CSAT</b>				
<b>Block Grant</b>	\$1,758.6m (\$0.0m)	\$1,758.7m (+\$0.1m)	\$1,778.6m (+\$19.9m)	\$1,928.6m (+\$150.0m)
<b>Programs of Regional and National Significance</b>	\$399.0m (-\$0.1m)	\$399.8m (+\$0.8m)	\$414.3m (+\$14.5m)	\$489.3m (+\$75.0m)
<b>CSAP</b>				
<b>Programs of Regional and National Significance</b>	\$193.0m (+\$0.1m)	\$194.1m (+\$1.1m)	\$201.0m (+6.9m)	\$276.0m (+\$75.0m)
<b>NIH</b>				
<b>NIMH</b>	\$1,403.6m (+\$0.1m)	\$1,404.5m (+\$0.9m)	\$1,450.5m (+\$46.0m)	\$1552.0m (+\$101.5m)
<b>NIDA</b>	\$1,000.3m (+\$0.3m)	\$1,000.7m (+\$0.4m)	\$1,032.8m (+\$32.1m)	\$1,105.1m (+\$72.3m)
<b>NIAAA</b>	\$436.3m (+\$0.4m)	\$436.3m (0.0m)	\$450.2m (+\$13.9m)	\$481.7m (+\$31.5m)

<sup>5</sup> Administration request figures were unavailable as of the date this document went to press.