Appropriations Recommendations

for Fiscal Year 2011

"Community-Based Mental Health Programs Improve Youth Performance and Save Millions In School Costs."

SAMHSA, May 7, 2009

MENTAL HEALTH LIAISON GROUP

National Organizations Representing

Consumers, Family Members, Advocates, Professionals and Providers

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 Dance Therapy Association
American Foundation for Suicide Prevention/SPAN USA
American Group Psychotherapy Association
American Hospital Association
American Mental Health Counselors Association
American Nurses Association
American Occupational Therapy Association
American Psychiatric Association
American Psychiatric Nurses Association
American Psychological Association
American Psychotherapy Association
Anxiety Disorders Association of America
Association for the Advancement of Psychology
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 Alcohol and Drug Abuse Directors
National Association of State Mental Health Program Directors
National Coalition of Mental Health Consumer/Survivor Organizations
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
National Foundation for Mental Health
School Social Work Association of America
Therapeutic Communities of America
Tourette Syndrome Association
United Jewish Communities
US Psychiatric Rehabilitation Association
Volunteers of America
Witness Justice

Table of Contents

Mental Health Liaison Group (MHLG) FY 2011 Appropriations Recommendations for the SAMHSA and Key NIH Institutions

(Dollars in Millions)

PROGRAMS	FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
CMHS				
CMHS TOTAL	$969.2m (+$58.3m)	$1,005.1m (+$35.9m)	$1,027.6m (+$22.5m)	$1,152.8m (+$147.7m)
Community Mental Health Services Performance Partnership Block Grant	$420.8m ($0.0m)	$420.8m ($0.0m)	$420.8m ($0.0m)	$482.7m (+$61.9m)
Children's Mental Health Services Program	$108.4m (+$6.1m)	$121.3m (+$12.9m)	$126.2m (+$4.9m)	$139.1m (+$17.8m)
PATH Homelessness Program	$59.7m (+$6.4m)	$65.0m (+$5.3m)	$70.0m (+$5.0m)	$74.6m (+$9.6m)
Protection and Advocacy (PAIMI)	$35.9m (+$1.0m)	$36.4m (+$0.5m)	$36.4m ($0.0m)	$41.8m (+$5.4m)
Programs of Regional and National Significance	$344.4m (+45.1m)	$361.5m (+$17.1m)	$374.2m (+12.7m)	$414.6m (+$53.1m)
Youth Violence Prevention Initiatives	$94.5m (+$1.0m)	$94.5m ($0.0m)	$94.5m ($0.0m)	$108.4m (+$13.9m)
Suicide Prevention for Children and Adolescents	$47.1m *(-$1.5m)*	$48.1m (+$1.0m)	$54.2m (+$6.1m)	$55.2m (+$7.1m)
Children and Adolescents with Traumatic Stress Disorder	$38.0m (+$4.9m)	$40.8m (+$2.8m)	$40.8m ($0.0m)	$46.8m (+$6.0m)
Mental Health Transformation State Incentive Grants	$26.0m ($0.0m)	$26.0m ($0.0m)	$26.0m ($0.0m)	$29.8m (+$3.8m)
Project LAUNCH	$20.0m (+$12.6m)	$25.0m (+$5.0m)	$27.0m (+$2.0m)	$28.7m (+$3.7m)
Grants for Primary and Behavioral Health Care Integration	$7.0m ($0.0m)	$14.0m (+$7.0m)	$14.0m ($0.0m)	$16.1m (+$2.1m)
Jail Diversion Program Grants	$6.7m ($0.0m)	$6.7m ($0.0m)	$6.7m ($0.0m)	$7.7m (+$1.0m)
Mental Health Outreach and Treatment to the Elderly	$4.8m ($0.0m)	$4.8m ($0.0m)	$4.8m ($0.0m)	$5.5m (+$0.7m)
Statewide Family Network Grants	$3.7m (+$0.36m)	$3.7m ($0.0m)	$3.8m (+$0.1m)	$4.3m (+$0.6m)
Minority Fellowship Workforce Training	$3.7m ($0.0m)	$3.7m ($0.0m)	$3.7m ($0.0m)	$4.3m (+$0.6m)
Rehabilitation Research and Training Centers	$3.6m (+$0.5m)	$3.6m ($0.0m)	$3.6m ($0.0m)	$4.1m (+$0.5m)
Mental Illnesses and Substance Abuse Disorder Grant	$3.61m ($0.0m)	$3.6m ($0.0m)	$3.6m ($0.0m)	$4.1m (+$0.5m)
Statewide Consumer Network Grants	$2.5m (+$1.03m)	$2.5m ($0.0m)	$2.6m (+$0.1m)	$2.9m (+$0.4m)
Consumer/Supporter Technical Assistance Centers	$1.95m ($0.0m)	$1.95m ($0.0m)	$1.95m ($0.0m)	$2.25m (+$0.3m)
NIH				
NIMH	$1,450.5m (+$46.0m)	$1,489.7m (+$39.2m)	$1,540.3m (+$50.6m)	$1,683.3m (+$193.6m)
NIDA	$1,032.8m (+$32.1m)	$1,059.5m (+$26.7m)	$1,094.1m (+$34.6m)	$1,197.2m (+$137.7m)
NIAAA	$450.2m (+$13.9m)	$462.1m (+$11.9m)	$474.6m (+$12.5m)	$522.2m (+$60.1m)

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

According to a March 2009 report by the Pew Center on the States, the first breakdown of spending in confinement and supervision in the past seven years, prison spending was the second fastest growing area in state budgets.

According to a Spring 2009 study by the RAND Corporation, some 300,000 service members are currently suffering from post-traumatic stress disorder or depression.

Treatment of mental disorders carries the highest cost of the top 5 most costly children's conditions, totaling $8.9 billion for U.S. children ages 0 to 17. It beats infectious diseases, trauma-related disorders, and asthma.
(AHRQ Medical Expenditure Panel Survey, April 2009)

Over a three-year period, school districts participating in the Safe Schools/Healthy Students grant program reported fewer students involved in violent incidents, decreased levels of experienced and witnessed violence, and improvements in overall school safety and violence prevention.
(SAMHSA, November 2009)

According to a December 2009 study published by the American Academy of Pediatrics, children of military parents deployed overseas have a "far greater number of emotional and behavioral problems than children of civilians."

The number of suicides reported by the Army has risen to the highest level since record-keeping began three decades ago. Last year, there were 192 among active-duty soldiers and soldiers on inactive reserve status, twice as many as in 2003, when the war began. (Five more suspected suicides are still being investigated.) This year's figure is likely to be even higher: from January to mid-July, 129 suicides were confirmed or suspected, **more than the number of American soldiers who died in combat during the same period** [our emphasis].
(New York Times, August 2, 2009)

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)

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)

[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)*

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)*

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 heath 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

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)*

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

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.***

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 – enactment of the parity law will expand access to mental health treatment and (2) the historical stigma surrounding mental illness and treatment.
- In the words of the Surgeon General's Report on Mental Health, we must "overcome the gaps in what is known and remove the barriers that keep people from ...obtaining...treatments."

Shift from Institutional Care to Community-Based Care

- Over the last several decades, the public mental health system has shifted its emphasis from institution-based care to community-based care – a more cost-efficient and effective way to promote recovery among many people with mental illnesses who can go on to lead productive lives in the community.
- Approximately two-thirds of state funding for mental health currently goes to provide community services. Similarly, most alcohol and drug treatment services are community-based.
- The 1999 U.S. Supreme Court decision in *Olmstead v. L.C. and E.W.* mandates that states develop adequate community services to move people with disabilities out of institutions – a blueprint for the President's New Freedom Initiative.
- Without adequate funding, however, efforts to transition people out of institutions and better serve those currently living in our communities will continue to fail.

- The transition from institutional care to community-based care has never been adequately funded, even though we know that community-based care is less expensive than institutional care.

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

Substance Abuse and Mental Health Services Administration (SAMHSA)

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

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

Substance Abuse and Mental Health Services Administration (SAMHSA)
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SAMHSA Legislative Contact: Joe Faha (240) 276-2000
Center for Mental Health Services (CMHS)
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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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$420.8m	$420.8m	$420.8m	$482.7m

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 2011 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.

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."

Comprehensive Community Mental Health Services for Children and Their Families Program

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$108.4m	$121.3m	$126.2m	$139.1m

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; coordination with needed residential treatment, primary health care and social services; 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 Reduced*** In FY 08, the average number of days spent in inpatient hospital care decreases from 2.02 days upon entry into system of care services to 0.87 days at 24 months after entry into services.

- ***Cost Savings Resulted From Decreases In Inpatient Hospitalizations*** The estimated number of children served by funded system of care communities in FY 2008 was 13,051, and the estimated total cost savings due to decreases in utilization of inpatient hospitalization were $31,022,880. This translates to a cost savings of $2,377 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 2008 was 13,051, and estimated total cost savings due to decreases in number of arrests were $5,081,740. This translates to a cost savings of nearly $622 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 family-driven, youth-guided 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 808 or nearly 26 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. Key outcomes for children and families in comprehensive community mental health systems of care in 2008 include:

- ***Clinical Symptoms Improved Or Remained Stable*** Almost 93% of children improved or remained stable in their clinical symptoms from entry into system of care services to 24 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*** Child/youth suicide attempts were reduced by one-third within 6 months after entering systems of care, and were further reduced by more than two thirds after 24 months.

- ***Children And Youth Depression and Anxiety Symptoms Improved*** Twelve months after beginning system of care services 16% of youth reported significantly lower levels of depression and 21% reported significantly lower levels of anxiety than when they entered 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 Attendance Improved*** Within one year after entering system of care services, the percentage of youth attending school regularly (at least 80% of the time during the previous 6 months) increased from 75% to 81%. This improvement means that school attendance for youth with mental health needs in systems of care approached the national school attendance average of 83%.

- ***School Grades Improved*** The percentage of youth receiving passing grades (a grade of "C" or better) increased from 55% upon entry into services to 66% after 12 months of services. This change represents a 20% increase in the proportion of youth who received passing grades.

- ***School Expulsions Decreased*** Expulsions from school decreased by two thirds (from 15% at intake to 5%) within 12 months. No youth were permanently expelled from school within 12 months after entering services.

- ***No Law Enforcement Contacts After Entering Systems Of Care*** In FY 08, 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 08 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*** 24% 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.

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.

At age 12, Austin appears to be a typical sixth grader—he likes to play basketball and video games, and is enrolled in an after-school horseback riding program. He is an honor roll student, and his mother describes him as compassionate, loyal, and a champion for the "underdog." Austin and his family also manage the challenges of bipolar disorder each day.

Austin was diagnosed in first grade with attention-deficit/hyperactivity disorder and separation anxiety disorder, but Austin's mother, Kim, recalls a series of incidents that led her to question whether her son's mental health needs were being met. At age 9, Austin set two fires within a week. The first time it happened, Kim thought it was an isolated incident that would not be repeated—Austin said he was lighting candles.

The second time Austin set a fire, however, the situation was very different. While bringing groceries into the house, Austin set a small fire in the car. When Kim discovered signs of the fire the next morning, she says, "I immediately got on the phone and started calling his physician. Thoughts were flashing through my mind about what could have happened."

After Kim received a referral from Austin's physician for diagnostic testing and other mental health services, she learned that her son had been experiencing hallucinations, which were causing him to set the fires. She also learned that his extreme mood swings, as well as his unusual sleep patterns, were signs of bipolar disorder. As a result, Austin was hospitalized for 20 days and diagnosed with bipolar disorder. During this time, Austin was accepted into a system of care through a referral from his school guidance counselor.

Kim says the system of care played an important role in helping Austin make the transition from the hospital to his home—even providing transportation, as Kim's car was being repaired at the time. System of care staff helped Kim learn more about her son's disorder. They also helped her locate services and supports tailored to Austin's needs, including counseling, health care, specialized schooling, after-school programs, transportation, and child care.

The system of care also empowered Kim to be a more effective advocate for Austin's needs. Before joining the system of care, she says, "I tried to fit the service to the need, rather than fit the need to the service. That was a mistake."

Kim also assumed that professionals were best able to determine how to meet her child's needs. After working in partnership with the system of care, Kim now knows that services and supports should be responsive to Austin's needs and that her and her son's input into the services and supports is crucial.

Despite the successes her family has had, Kim emphasizes that the journey to wellness is not over. In addition to coping with the symptoms of bipolar disorder, she and Austin also must overcome the stigma associated with mental illnesses. Together, Kim and Austin counter this stigma by educating others that he, and others with mental illnesses, should be known for who they are rather than the disorders they happen to have. Despite the ongoing challenges of stigma and bipolar disorder, Kim believes that the system of care has made a huge difference in terms of helping her family move forward.

Projects for Assistance in Transition from Homelessness (PATH)

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$59.7m	$65.0m	$70.0m	$74.6m

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 2008, 483 PATH-funded local agencies provided outreach to more than 135,000 and enrolled more than 65,000 individuals with serious mental illness in services. 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.

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.

What Justifies Federal Spending for PATH?

For FY 2010, Congress boosted PATH funding by $5 million, to $68 million. This is projected to allow PATH to reach an additional 11,000 homeless individuals with serious mental illness. 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 2011 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 back in 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

Years of reliable data and research demonstrate that the most successful intervention for chronic homelessness is linking housing to appropriate support services. From 2005 – 2007, the number of chronically homelessness individuals has decreased by 28 percent nationwide. Current SAMHSA investments have played a role in this decrease. SAMHSA homeless programs are highly effective, cost efficient, and perhaps most importantly, fill a gap created by a preference *for funding housing capital needs over critically important services* that are necessary for programs to be effective.

One of the largest obstacles to ending homelessness for individuals and families is obtaining supportive services. In 2008, as part of a competition for $10 million in homeless services grants, SAMSHA received over 250 qualified applications, of which the agency was only able to fund 23 grants. The interest and capacity of providers to put these federal dollars to work and end homelessness for thousands of homeless individuals should demonstrate to Congress a clear mandate to significantly increase funding for SAMHSA's homeless programs. FY 2010 funding level of SAMHSA homeless programs is $75 million. This is divided by two accounts: $32.25 million within the Center for Mental Health Services and $42.75 within the Center for Substance Abuse Treatment.

Homelessness and the Need for Services Funding

Federally required surveys indicate that 18% of homeless individuals and families meet the definition of being chronically homeless, meaning that they have a disability and have been homeless repeatedly or continuously for 12 months. Permanent supportive housing successfully and cost effectively ends homelessness for this group. These programs couple a home with intensive supportive services such as access to health care, mental health services, addiction treatment and case management. SAMHSA's financial support of services in these environments is critical. Through their 10 year plans to end homelessness, state and local communities have identified a need of over 90,000 units of permanent supportive housing.

There are also successful housing programs linked with services models that are proving to be effective for all homeless populations, including those at-risk of homelessness. The services, based on clients' need, are usually less intensive than in permanent supportive housing but still essential for these families, individuals and youth. For example, substance use treatment programs that have taken a comprehensive approach to family treatment are finding that as they address a family's housing need they increase the family's odds of success. In addition, access to outpatient or in home mental health treatment can give people experiencing homelessness the tools they need to stabilize and reduce trauma, especially for families with children.

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 2011 Labor, Health and Human Services and Education appropriations bill.

Protection and Advocacy for Individuals with Mental Illness (PAIMI)

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$35.9m	$36.4m	$36.4m	$41.8m

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

In FY 2004, PAIMI was funded at $35 million, and after years of struggle and small cuts to the program, in FY 2010 funding has increased slightly to $36.38 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, 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 2008, the PAIMI program:

- Successfully closed over 17,600 cases of which over 4,000 were related to abuse, 2,800 to neglect, and 7,600 to a violation of individual rights;
- Conducted investigations into the deaths of 358 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 nearly 6,100 children and young adults and nearly 11,300 adults and elderly individuals with mental illness; and
- Provided information and referral services to almost 46,000 individuals. In addition, the PAIMI program provided training to over 83,000 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 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 **Arkansas** P&A conducted a primary investigation of allegations that staff of a community mental health center violated the rights of 5 clients with mental illness to visit with and retain the legal services of a personal injury attorney subsequent to an automobile accident involving a center vehicle, staff driver, and the clients. P&A staff confirmed that the 5 clients injured in the automobile accident were denied the right to seek legal representation for their injuries. The investigation led to additional allegations that the center misused the clients' Social Security funds, took the clients' food stamp cards away, confiscated Pell grant funds and student loans of a client, and overcharged a client for rent and refused to issue a refund. The work of the P&A substantiated all allegations and the center was required to pay restitution and make changes.

- The **Delaware** P&A assisted a psychiatric center patient alleged that his landlord/joint bank account holder was taking all his funds. The client closed his joint direct deposit account for Social Security disability and opened a new account. However, when the next Social Security deposit arrived at the bank, the closed account was reactivated and the joint account holder took the funds again. The P&A negotiated with the bank and secured a reimbursement of approximately $1,400. With the restoration of his funds, the client had the financial resources to facilitate his discharge and secure housing.

- The **Florida** P&A after receiving a complaint from a prisoner that he could not get his psychotropic medication while housed in a county jail, investigated and determined that county jails were controlling whether or not prisoners would receive their medications upon transfer. P&A staff negotiated to develop a procedure and policy that would alert jails of an incoming prisoner's medication needs in advance, ensuring proper arrangements for psychotropic and other medication needs during a prisoner's stay in jail. Now, before a prisoner is transferred, the prison makes telephonic and fax contact with the receiving facility to send documentation of the prisoner's prescription needs, ensuring the availability of the requested medications in the facility.

- The **Illinois** P&A represented a young woman with multiple disabilities, including mental illness. The client's aunt and legal guardian filed a petition to have the client involuntarily sterilized. In 2008, after years of extensive litigation, P&A attorneys successfully represented the client through a trial before the Illinois appellate court. As a result, the appellate court ruled in favor of the client, upholding the trial court's denial of the petition for involuntary sterilization.

- The **Minnesota** P&A represented an 11 year old boy who was placed alone in the school's "lost and found" room more than ten times during the 2007-2008 school year for behaviors arising from his psychiatric disabilities. Despite the young client's increasingly negative behaviors, the school continued to isolate him in an inappropriate room and failed to respond by proposing additional evaluations or developing positive approaches to prevent such behaviors. The P&A staff helped the client's family challenge the school's misuse of the "lost and found" room and its failure to proactively develop a positive plan. As a result of PAIMI involvement, the client successfully moved to a positive school environment.

- The **Rhode Island** P&A investigated the deaths of three individuals with mental illness who died during encounters with municipal police officers (from three different municipalities). After the first death, P&A staff successfully advocated for the municipal police academy to incorporate disability issues into its training curriculum. They also participated as part of a coalition that advocated for appropriate training for municipal police officers; participated in training new police officers; and served on a panel to train members of the state judiciary on the issues of individuals with mental illness in the criminal justice system.

Programs of Regional and National Significance (PRNS)

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$344.4m	$361.5m	$374.2m	$414.6m

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:

Youth Violence Prevention Initiatives

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$94.5m	$94.5m	$94.5m	$108.4m

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, 365 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 2009, this initiative funded a total of 365 communities and approximately 8.7 million students. In FY 2009, 29 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. In FY 2009 funding was available for only 7% of all qualified applicants. With additional funds in FY 2011, 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, initiated in 2005, 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.

The National Cross-Site Evaluation has documented significant improvements among grantees for selected youth outcomes since 2005, in contrast to national trends. Initial analyses of evaluation data showed significant decreases in violence from Year 1 to Year 3 of the grant, with fewer students reporting that they had experienced violence (12% decrease) or witnessed violence (15% decrease). Data for the same period from sources such as the Youth Risk Behavior Survey showed no significant changes in the number of students who reported either experiencing or perceiving violence.

The National Evaluation also examined data from the annual School Level Survey to determine how teachers and other school staff felt about the grant's impact on safety and violence at their school. From Year 1 to Year 3, perceptions of improved school safety grew by 59%, while perceptions of reduced violence on campus and in the community grew by 61% and 46%, respectively.

Suicide Prevention for Children and Adolescents

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$47.1m	$48.1m	$54.2m	$55.2m

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 2006, 33,300 individuals died by suicide in the U.S. Of these suicides, approximately 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).

According to the 2008 National Survey on Drug Use and Health (NSDUH), an annual SAMHSA survey that is the first to establish a national baseline on suicidality, an estimated 8.3 million adults aged 18 or older (3.7 percent of the adult population) had serious thoughts of suicide in the past year, 2.3 million (1.0 percent) made a suicide plan, and 1.1 million (0.5 percent) attempted suicide. Young adults aged 18 to 25 were more likely than adults aged 26 to 49 and those aged 50 or older to have had serious thoughts of suicide (6.7 vs. 3.9 and 2.3 percent, respectively), to have made any plans for suicide (1.9 vs. 1.1 and 0.7 percent), and to have attempted suicide (1.2 vs. 0.4 and 0.3 percent). Of the adults who attempted suicide in the past year, 62.3 percent received medical attention for their suicide attempts, and 46.0 percent stayed overnight or longer in a hospital for their suicide attempts

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 33,000 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 144 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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$38.0m	$40.8m	$40.8m	$46.8m

How Does Exposure to Trauma and 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 childhood 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 794,000 children were confirmed victims of child abuse and neglect as reported in 2007.

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. Even more significantly, recent findings from the ACE Study (2009) showed that exposure to adverse childhood experiences resulted in an increased risk of premature death.

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 begin 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 and 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. More recently, a 2009 NIMH report revealed that only half of adults with major depression receive any treatment.

The 2009 Interim Report of the National Commission on Children and Disasters, an independent Federal Advisory Committee established by Congress to advise on the needs of children in relation to exposure to disasters and other hazards, underscored the unique needs of children and the gaps in services that occur in times of crisis. The Commission characterized the "benign neglect" of children in such situations as having the potential for long-term health and mental health consequences. It is fair to say that such consequences can also occur when exposure to all forms of trauma (e.g., domestic violence, child abuse, traumatic bereavement, etc.) is not appropriately addressed in a child's life.

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 and manage a comprehensive data set documenting the impact of trauma and treatment on the children served. 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, exposure to war-related trauma) 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 and reduce the cost of potential long-lasting consequences in adult life related to health and productivity. The NCTSN also disseminates these trauma-informed evidence-based treatments and services to all child-serving systems (military family services, schools, juvenile justice system, child welfare, foster care, etc.).

The Children's Health Act of 2000 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). Subsequent appropriations provided small increases to reach the current FY 2010 level of $40.8 million, funding 59 Centers and the NCCTS, but still falls far short of meeting the national need.

The innovative NCTSI 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 are being trained in trauma-informed interventions. Over 1000 external partnerships have been established by NCTSN 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 programs serving military families).

As part of its mission, the NCTSI immediately mobilizes in the aftermath of national crises, including the terrorist attacks in 2001, and Hurricanes Katrina and Rita in 2005, deploying staff and disseminating resources, training, and materials throughout the country, and serving as a major national resource to the interagency federal response. The NCTSN has served as this kind of national resource in response to many regional emergencies as well. With additional support for the NCTSI, hundreds of thousands more children and families would 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), the NCTSN, and its partners. The ongoing federal evaluation of this program has repeatedly determined that it is "exceeding expectations" in its efforts to improve clinical outcomes for children affected by trauma.

Mental Health Transformation State Incentive Grant Program

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$26.0m	$26.0m	$26.0m	$29.8m

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[1] 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.

[1] Territories, the District of Columbia, and/or federally recognized American Indian/Alaska Native Tribes or Tribal Organizations

Project LAUNCH

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$20.0m	$25.0m	$27.0m	$28.7m

What is Project LAUNCH?

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) is a grant program designed to promote the wellness of young children ages birth to 8 by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. The long-term goal of Project LAUNCH is to ensure that all children enter school ready to learn and able to experience success in school and beyond. Project LAUNCH was first funded in FY2008 with an initial cohort of 6 grantees (5 states and one tribal nation). In FY2009, Project LAUNCH funded a second cohort of 12 grantees, bringing the total number to 18.

Project LAUNCH awards five year grants to states and tribes to improve coordination across child-serving systems, build infrastructure, and improve methods for providing services. At the state and tribal level, Councils on Young Child Wellness develop comprehensive plans for promoting healthy child development which include improvements to policies, data sharing, and funding strategies that better integrate and coordinate across programs.

Why is Project LAUNCH important?

The majority of Project LAUNCH funds are passed from the state and tribal level to an identified locality which serves as a "pilot site" for system coordination, infrastructure improvement, and service expansion and enhancement. A local Child Wellness Council in each community brings together families and public and private partners to identify unmet needs and set priorities for ensuring the healthy development of all young children. A strategic plan is developed which includes the use of five key prevention and promotion strategies: developmental assessments in a range of child-serving settings; integration of behavioral health into primary care settings; mental health consultation; home visiting; and family strengthening and parent skills training. Project LAUNCH sites implement evidence-based practices and programs in these 5 areas, as well as conducting workforce development and public education activities to increase awareness and knowledge of healthy child development and healthy parenting practices among the public, parents and providers from a wide range of disciplines.

An important component of the Project LAUNCH model is the ongoing collaboration between the state/tribal and local leadership. Barriers encountered at the local level are brought to the state/tribal Council to be analyzed and addressed. Lessons learned and successful strategies implemented locally are shared with the state/tribal Council and can be disseminated statewide. State or tribal-level changes in policy, funding and data can be tested locally with ongoing feedback and communication.

What Justifies Investing In Project LAUNCH?

In order to model the collaboration it requires from grantees, SAMHSA works in close 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 states/tribes selected for LAUNCH grants receive between $850,000 and $916,000 each year, over the course of five years. The actual award amounts may vary, depending on the availability of funds and the progress achieved by the awardees. The program is administered by SAMHSA's Center for Mental Health Services.

The following is a list of the FY2008 and FY2009 grantees for Project LAUNCH:

FY2008:

- Arizona Department of Health Services
- Maine State Department of Health and Human Services
- Red Cliff Band of Lake Superior Chippewa
- State of Rhode Island and Providence Plantations Department of Health
- State of New Mexico Department of Health
- Washington State Department of Health

FY2009:

- California Maternal, Child and Adolescent Health Program
- District of Columbia Department of Health
- Illinois Department of Human Services
- Iowa Department of Public Health
- Kansas Department of Health and Environment
- Oregon Department of Health and Human Services
- Massachusetts Department of Public Health
- Michigan Department of Community Health
- New York State Council on Children and Families
- North Carolina Department of Health and Human Services
- State of Ohio Department of Health
- Wisconsin Department of Health Service

Grants for Primary and Behavioral Health Care Integration

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$7.0m	$14.0m	$14.0m	$16.1m

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 cession, weight management, and encouraging medication adherence; it should 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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$6.7m	$6.7m	$6.7m	$7.7m

Why are Jail Diversion Program Grants Important?

Each year, 13 million people are booked into U.S. jails. An estimated 17% of jail inmates have current symptoms of serious mental illness. Of these two million 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 (31 percent vs. 14.5 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 CMHS National GAINS Center lists over 550 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?

Seven years of program data from SAMHSA funded Jail Diversion grants have found that:

- Jail diversion does not increase public safety risk; and
- Jail diversion programs "work" by successfully linking those diverted to community-based services.
- Alcohol and drug use was reduced by more than 50% between the time of diversion and 12 months
- Symptoms and functioning difficulties reduced by one-third to half between the time of diversion and 12 months
- Arrests were reduced 40% in the 12 months following diversion compared with the prior 12 months.

- There is a high prevalence of trauma among people with mental illness involved in the justice system. Approximately 90% of divertees had experienced physical abuse and nearly 60% had experienced sexual abuse in their lifetime. Female and male participants experienced similar rates of abuse.

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. Based on results from program evaluation, Jail Diversion grants awarded in 2008 and 2009 have required grantees to address trauma related disorders and to prioritize veterans for diversion. 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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$4.8m	$4.8m	$4.8m	$5.5m

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 2010, this allocation falls short because the aging of the baby boomer generation will result in an increase in the proportion of persons over age 65 from 12.7% currently to 20% in 2030, with the fastest growing segment of the population consisting of individuals age 85 and older. During the same period, the number of older adults with major psychiatric illnesses will more than double, from an estimate 7 million to 15 million individuals, meeting or exceeding the number of consumers of consumers in discrete, younger age groups. 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.

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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$3.7m	$3.7m	$3.8m	$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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$3.7m	$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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$3.6m	$3.6m	$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 community integration (youth and young adults). They also disseminate information and provide training and technical assistance regarding effective interventions that promote recovery and self-determination (adults) and enhancement of resilience and transition-to adulthood (youth). 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 transition-aged youth and two on adults, co-funded through a long-standing inter-agency agreement between 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 psychiatric rehabilitation, community integration, and asset-building for people with serious mental health conditions, 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; strengths-based, 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. It also enables the Centers to make research-based recommendations not just for practice at the service delivery level, but also for implementation and policy at the organizational and systems levels. Additionally, the RRTCs' research agenda is consistent with a public health framework, with its 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 for adults, and transition to work services for school-aged youth and young adults.

- Millions of children, youth, and adults have benefited from the RRTCs' 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.
- The RRTCs are unique in their focus on pairing asset development, financial literacy, and economic security enhancement with models that promote employment for youth and adults with serious mental health conditions.

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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$3.6m	$3.6m	$3.6m	$4.1m

What does the Integrated Treatment Program Do?
The Children's Health Act of 2000 authorized Integrated Treatment grants to support the implementation of critically important and innovative programs directed to the special needs of people with co-occurring serious mental and substance use disorders. Research clearly demonstrates that mental and addictions disorders are often inter-related and that integrated treatment is more effective than parallel and sequential treatment for persons with co-occurring disorders. To be successful, these programs must use clinical staff who are cross-trained in the treatment of both kinds of disorders.

The presence of co-occurring mental and substance abuse disorders is complex, as the illnesses interact with and exacerbate one another. Emerging research suggests that mental disorders often precede substance abuse. It is also the case that alcohol and drug abuse and withdrawal can cause or worsen symptoms of mental illnesses. Substance use also can mask symptoms of mental illness, particularly when alcohol or drugs of abuse are used to "medicate" the mental illness. One disorder may interfere with an individual's ability to benefit from and participate in treatment for the other disorder. Dysfunctional and maladaptive behaviors can be attributed to either disorder. Individuals with untreated mental disorders are at increased risk for substance use. Similarly, individuals who abuse alcohol and other drugs are at increased risk for experiencing mental disorders. Moreover, individuals with co-occurring disorders tend to be more symptomatic, have multiple health and social problems, and require more costly care, including inpatient hospitalization. Many are at increased risk of homelessness and incarceration.

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. Estimates from prevalence studies reveal that during a 12-month period, 22 to 23 percent of the U.S. adult population - 44 million people - have diagnosable mental disorders. About 15 percent (approximately 6.6 million) of adults with a diagnosable mental disorder have a co-occurring substance abuse disorder. Although evidence supports integrated treatment for co-occurring disorders, it is only available in a limited number of communities. More specific findings follow, along with some initial data from the National Comorbidity Survey Replication.

What Justifies Federal Spending for Integrated Treatment Grants?
Mental health and substance abuse treatment are funded through a patchwork of separate Federal, State, local, and private funding sources. The Substance Abuse Prevention and Treatment (SAPT) Block Grant is the single largest source of State expenditures for public substance use prevention and treatment services, representing 40 percent of such expenditures. The Community Mental Health Services (CMHS) Block Grant represents between 3 and 4 percent of State expenditures for community-based mental health care. The need to fund services for co-occurring disorders from these multiple, disparate programs may place the burden of aggregating funds on providers.

The insufficiency of service system dollars and trained professionals to provide care means there is also a significant gap in the ability of both systems to treat people in need. A new analysis of trends in health care spending reveals that expenditures for mental health services and substance abuse treatment represented 7.8 percent of the more than one trillion dollars in all U.S. health care expenditures in 1997, down from 8.8 percent of the total in 1987 (SAMHSA, 2000).

This decline occurred despite the persistent gap between the prevalence of substance abuse disorders and mental disorders and treatment use. Estimates suggest that while about 20 percent of the U.S. population is affected by mental disorders in any given year, only one-third of people in need of mental health treatment receive it (U.S. DHHS, 1999b). When it comes to substance abuse disorders, between 13 million and 16 million people need treatment for alcoholism and/or drug abuse in any given year, but only 3 million (20 percent) receive care (SAMHSA, 2000).

In 2000, Congress, recognizing the need to reach this difficult to serve population with the best treatment, authorized funding for integrated treatment for co-occurring mental health and substance abuse disorders. It is therefore critically important that Congress provide funding for integrated treatment.

Statewide Consumer Network Grants

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$2.5m	$2.5m	$2.6m	$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, a wellness life style, 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 $2.5 million is provided to support 30 grantees at $70,000 each per year. This funding is essential n bringing about mental health transformation, making services more accountable and better able to meet the real needs of consumers, and promote grass-roots systems change.

Why are the Statewide Consumer Networks Important?

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

For example, the SCNGs:

- **Educate the public that mental health care is essential to overall health** by conducting education campaigns that increase knowledge and consciousness about mental health care, and convening Leadership Academies, BRIDGES Programs, Consumer Support Specialists and Peer Support Activity that promote and sustain leadership skills;
- **Promote consumer and family driven care** through the development of position papers and/or impact statements to courts, local mental health councils and state administrators on systems needs and creative funding and providing outcomes based training that strengthens organizational relationships, promotes consumer leadership and develops local consumer councils throughout states;
- **Demonstrate interest in the elimination of disparities in mental health services** by developing regional partnerships that overlap with existing service needs and developing media and training materials that are culturally appropriate to consumers of various ethnic groups;
- **Promote recovery and resilience through self-help models** by incorporating the Wellness Recovery Action Plan (WRAP), leadership academies and self-help models into training programs and partnering with academic institutions to assist in the development and evaluation of self-help models, vocational training and innovative

ways to promote mental health recovery; and

- **Promote the use of technology to access mental health care and information** by implementing technological advances to disseminate information statewide and nationally, and creating interactive websites that allow consumers to exchange information, learn about recovery, and sustain recovery through self-help models.

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 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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$1.95m	$1.95m	$1.95m	$2.25m

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 diagnosed with serious 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 access and utilize community resources, recover from the disabling effects of mental health problems, and enhance self-determination; and
- Organizations receive assistance that enhances their capacity to meet operational and programmatic needs. Program support focuses on enhancing peer-support approaches, recovery models, and employment programs.

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

The 2003 report of the President's New Freedom Commission on Mental Health recognized the importance of supporting and promoting mental health consumer-run services 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 2011
Funding Recommendations

for the

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

National Institutes of Health (NIH)

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

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

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

National Institutes of Health (NIH)
Director: Francis Collins, M.D., Ph.D. (301) 496-4000

Fiscal Year 2011
Funding Recommendations

for the

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 as brain disorders, specifically as disorders of brain circuits. This has changed how we diagnose them, how we treat them, and how we train people to help with mental illnesses. 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, analyses of the human genome have transformed our understanding of how individual 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 earlier diagnosis, prevention and successful treatments for mental illnesses.

The burden of mental illness is enormous. In a given year, an estimated 13 million American adults (approximately 1 in 17) suffer from a seriously debilitating mental illness.[2, 3] 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).[4] Moreover, suicide is the 11th leading cause of death in the United States, accounting for the loss of approximately 33,000 American lives each year.[5] Schizophrenia, bipolar disorder, depression, autism, post-traumatic stress disorder, eating disorders, and other disorders are serious, life-threatening illnesses for which we need reliable diagnostic tests, new treatments, and effective strategies for prevention.

National Institute of Mental Health (NIMH)
Director: Thomas Insel, MD (301) 443-3675
Constituency Relations and Public Liaison
Director: Gemma Weiblinger (301) 443-3673

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[2] Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). Archives of General Psychiatry, 2005 Jun;62(6):617-27. PMID: 15939839

[3] U.S. Census Bureau Population Estimates by Demographic Characteristics. Table 2: Annual Estimates of the Population by Selected Age Groups and Sex for the United States: April 1, 2000 to July 1, 2004 (NC-EST2004-02) Source: Population Division, U.S. Census Bureau Release Date: June 9, 2005.

[4] The World Health Organization. The global burden of disease: 2004 update, Table A2: Burden of disease in DALYs by cause, sex and income group in WHO regions, estimates for 2004. Geneva, Switzerland: WHO, 2008.

[5] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS). (www.cdc.gov/ncipc/wisqars)

National Institute of Mental Health (NIMH)

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$1,450.5m	$1,489.7m	$1,540.3m	$1,683.3m

NIMH Strategic Plan

To inspire and support research that will continue to make a difference for those living with mental illnesses, and ultimately, promote recovery, NIMH developed a Strategic Plan in 2009 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.

Translating Research Advances into New Treatments

Discoveries in basic science are exciting not only for the knowledge they generate, but for the opportunities they present for developing new treatments, and improving existing ones, that can enhance the quality of life for people living with mental illness. NIMH supports a broad range of translational research, from improving and personalizing preventive interventions to validating potential medication targets and undertaking medication safety and efficacy research.

For example, a recent NIMH study has linked panic disorder to a wayward hormone in a brain circuit that regulates vigilance. While too little of the hormone, called orexin, is known to underlie narcolepsy, the new study suggests that too much of it may lead to panic attacks that afflict 6 million American adults.

They showed that blocking orexin gene expression or its receptor prevented panic attack-like responses in rats. The study also revealed that panic disorder patients have excess levels of the hormone. Targeting the brain's orexin system may hold promise for a new generation of anti-anxiety treatments

In FY 2011, NIMH will support an initiative to leverage and link large existing healthcare networks so that they can be used to conduct treatment effectiveness trials. When completed, this infrastructure will be able to more efficiently identify, recruit, and enroll participants, saving taxpayers millions of dollars and allowing for more rapid translation from bench to bedside.

Toward Meaningful Improvements in Mental Healthcare

One of the key goals of the NIMH Strategic Plan is to increase the public health impact of the Institute's research. One avenue for accomplishing this is through the broad portfolio of NIMH services research, which is aimed at making meaningful improvements in mental healthcare. In FY 2011 and beyond, NIMH will be funding a series of grants that pair state agencies with researchers to analyze existing state and national administrative datasets and track the impact of state-level policy initiatives, such as the State Children's Health Insurance Program. These research teams will be studying the effects of changes in mental health policies, financial policies, delivery systems, and other policies that affect the cost, quality of care, and outcomes for persons with mental disorders. NIMH will also be supporting a national mental health tracking system to provide timely data on the prevalence, severity and age of onset of mental disorders, and allow for the assessment of mental health service use, the quality and outcomes of care, and disparities among people from diverse populations.

Suicide Prevention

A new NIMH-funded grant aims to increase suicide detection and prevention efforts among patients who present with suicide risk factors in hospital emergency departments. The Emergency Department Safety Assessment and Follow-up Evaluation (EDSAFE) trial will be coordinated by the Emergency Medicine Network (EMNet), which is based at Massachusetts General Hospital.

EDSAFE will be conducted in three phases. The first phase will assess treatment as usual (TAU) for patients. TAU typically consists of evaluating suicidal risk only among those emergency department patients who have psychiatric risk factors such as depression, suicidal thinking or behavior (ideation), or substance abuse. Often these patients are put under observation while at the hospital and are evaluated by a mental health provider. They also may be referred to a mental health professional outside the hospital, but few receive adequate follow-up care after they are discharged. During the second phase, a universal screening process will be tested in which all patients, regardless of whether they exhibit typical risk factors for suicide, will be screened for suicidal ideation. The researchers will compare universal screening with TAU to determine how well each detects suicidal patients.

During the third phase, a more intensive intervention that includes screening, brief counseling, an evaluation by a mental health provider, referral to outpatient care and other components will be implemented. Patients will then receive follow-up phone counseling. The intensive intervention will be compared to TAU and to universal screening. The study will be conducted at eight sites throughout the nation and is set to begin in June 2010.

Genomics and Other High Throughput Technologies Can Lead to Breakthroughs in Autism

Over the past several years, the technology used in genomics research has progressed at an amazing pace, and has been matched with equally impressive reductions in cost. Recognizing the opportunities that these advances and cost savings present, NIMH supports research that uses these new approaches to study the brain and mental disorders in ways that are truly comprehensive. For example, in FY2010 and FY2011, NIMH will support several innovative genomics studies of autism spectrum disorder (ASD), utilizing data from thousands of samples from the NIMH Center for Collaborative Genetic Studies. In the first study of its kind, researchers will sequence the entire genomes of individuals with ASD. This work will help to identify specific subtypes of ASD based on genomics; provide the first molecular targets for treatment development; and yield a robust strategy for the study of environmental factors (which interact with genetic risk).

Military

Beginning in 2002, the suicide rate among soldiers rose significantly, reaching record levels in 2007 and again in 2008 despite the Army's major prevention and intervention efforts. In response, the Army and NIMH partnered to develop and implement STARRS, with Army funding.

The Army Study to Assess Risk and Resilience in Service Members (Army STARRS) is the largest study of suicide and mental health among military personnel ever undertaken. Army STARRS will identify – as rapidly as possible – modifiable risk and protective factors related to mental health and suicide. It also will support the Army's ongoing efforts to prevent suicide and improve soldiers' overall wellbeing.

The length and scope of the study will provide vast amounts of data and allow investigators to focus on periods in a military career that are known to be high-risk for psychological problems. The information gathered throughout the study will help researchers identify not only potentially relevant risk factors but potential protective factors as well. Study investigators will move quickly to provide information that the Army can use immediately in its suicide prevention efforts and use to address psychological health issues.

Mental Health Research for the 21st Century

In FY 2011 NIMH will support several significant grants to fuel the next generation of mental health researchers. The new Biobehavioral Research Awards for Innovative New Scientists (BRAINS) initiative is based on the successful NIH Pioneer Award program. This program is intended to support the research and career development of outstanding scientists who are in the early stages of their careers, and who are making a long term career commitment to mental health research. NIMH seeks to expand opportunities for students from diverse backgrounds and in FY 2011will continue to support mentoring programs for underrepresented minority graduate students in high priority fields for the Institute.

Fiscal Year 2011
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 $600 billion dollars annually in the United States—including health, crime-related costs, and losses in productivity.[6] However, as staggering as these numbers are, they provide a limited perspective of the devastating consequences of this disease.

Like other mental disorders, 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 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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[6] Office of National Drug Control Policy (2004). The Economic Costs of Drug Abuse in the United States, 1992-2002. Washington, DC: Executive Office of the President (Publication No. 207303). http://www.google.com/search?hl=en&source=hp&q=Economic+Costs+of+Drug+Abuse+in+the+United+States%2C+1992-2002&btnG=Google+Search&cts=1256315608181&aq=f&oq=&aqi=

Rehm J, Mathers C, Popova S, Thavorncharoensap M, Teerawattananon Y, Patra J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. Lancet. 2009 Jun 27;373(9682):2223-33. [Table 4]

Centers for Disease Control and Prevention. *Best Practices for Comprehensive Tobacco Control Programs—2007. Atlanta: U.S.* Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health; October 2007. http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/best_practices/

National Institute on Drug Abuse (NIDA)

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$1,032.8m	$1,059.5m	$1,094.1m	$1,197.2m

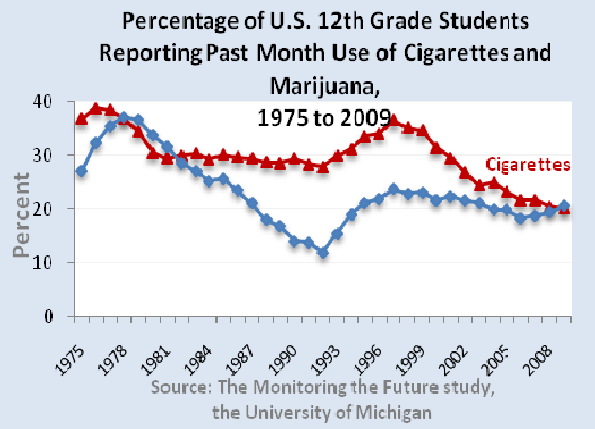
Background

In 2008, an estimated 20.1 million Americans or 8.0 percent of the population aged 12 or older were current (past month) illicit drug users (2008 National Survey on Drug Use and Health, SAMHSA). This rate has remained relatively unchanged since 2002, signifying that work needs to be done.

More than three decades of research supported by NIDA has proven addiction to be a complex brain disease characterized by compulsive, at times uncontrollable, drug craving, seeking, and use that persist despite potentially devastating consequences. The overall risk for addiction, which varies from person to person, is influenced by the biological makeup of the individual, his or her developmental stage, and the surrounding social environment (e.g., conditions at home, at school, and in the neighborhood), among others. Scientists estimate that genetic factors account for about half of a person's vulnerability to addiction, including the effects of environment on gene expression and function.

Science has come far in helping us understand how addiction develops in individuals and how drugs of abuse change the brain. New knowledge is revealing an increasingly detailed picture of the molecular, cellular, and circuit level changes that can lead to compulsive drug use and addiction. Collaborative efforts that bring science-backed messages to communities nationwide educate and inform diverse populations, changing people's perceptions and replacing stigma and shame with a new understanding of addiction as a treatable disease. The need for this knowledge is urgent, as drug abuse and addiction cause enormous, yet preventable, morbidity and mortality.

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 in real-world settings 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.



NIDA's portfolio includes a significant investment in effectiveness and comparative-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.

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 8th, 10th, and 12th graders. The good news is that in 2009, cigarette smoking is at its lowest point in the history of the survey on all measures for 8th, 10th, and 12th graders. The not-so-good news is that from 2008 to 2009, lifetime, past month, and daily use of smokeless tobacco increased among 10th graders, who, along with 8th graders, also perceived less risk in regular use of marijuana. The trend with marijuana use—which had shown a consistent decline in all three grades since the mid-1990s—has stalled, with prevalence rates the same as they were 5 years ago.

In addition, nonmedical use of prescription drugs remains at unacceptably high levels.

- Past year non-medical use of Vicodin and OxyContin increased during the last 5 years among 10th graders and remained unchanged in 8th and 12th graders. Nearly 1 in 10 high school seniors reported non-medical use of Vicodin; 1 in 20 reported abuse of OxyContin.
- When asked how prescription narcotics were obtained for non-medical use, 52 percent of 12th graders said they were given to them by a friend or relative; 34 percent bought them from a friend or relative; and 30 percent received a prescription for them. The number of reports of obtaining them over the internet was negligible.Note that respondents were allowed to identify multiple sources.

Priority Research Areas

The adolescent brain and propensity toward risk-taking. Because the adolescent brain is still developing, teens are more likely to take risks, including experimenting with drugs. And since adolescence is typically when drug abuse and addiction begin, NIDA continues to focus research on this vulnerable period of development. The relative immaturity of certain brain regions in adolescents likely underlies their propensity toward risk-taking behavior. Specifically, the brain's reward circuitry matures faster than regions involved in exerting control over one's behavior, biasing the adolescent's action toward immediate gratification over long-term gains. 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. Breakthrough discoveries in the last decade have led to a profound transformation in the understanding of the mechanisms and consequences of drug abuse and addiction. The current picture offers unprecedented detail and a unique opportunity to translate the products of NIDA's combined research into new, effective pharmacotherapies that could, either by themselves or in tandem with validated behavioral therapies, help alleviate the personal and social impact of this complex disease. We are now poised to capitalize on our greater understanding of the neurobiology underlying addiction and of newly identified candidate systems and molecules to hone research on medications development. The development of new medications, will better position NIDA to involve the medical community in drug abuse treatment, helping to de-stigmatize the disease and widen the access and availability of therapeutic options.

Another innovative strategy in which NIDA is investing is immunotherapy, or "vaccines," for methamphetamine, cocaine, and nicotine dependence, the latter (NicVAX) in Stage III efficacy trials. NicVAX has shown significant improvement in smoking cessation rates and continuous long-term smoking abstinence. 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. Preliminary studies of an anti–cocaine vaccine have demonstrated decreased drug use in patients who produced high antibody levels. 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 shown that mental illnesses and drug problems frequently co-occur. In particular, data show that persons diagnosed with mood or anxiety disorders are about twice as likely to also suffer from a drug use disorder compared with respondents in general—with the reverse also true. Causality is more difficult to determine, with certain mental disorders being established risk factors for subsequent drug abuse, and vice versa, although the relationship can be a complex one. It may also be the case that both are caused by overlapping factors such as genetic vulnerabilities, early exposure to stress or trauma, or insults to common brain circuits. In fact, drug-induced changes in brain structure and function occur in some of the same brain areas that are disrupted in other mental disorders, such as depression, anxiety, or schizophrenia.

To collectively report on these and other findings, NIDA recently released a research report titled *Comorbidity: Addiction and Other Mental Illnesses*

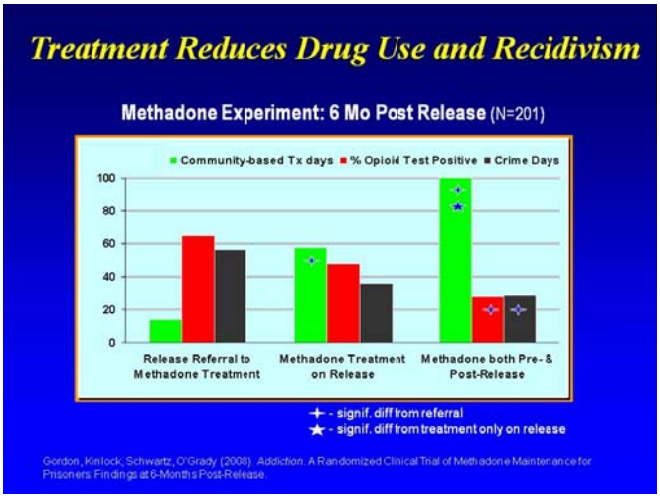
(http://www.nida.nih.gov/ResearchReports/comorbidity/), summarizing the state of the science regarding the complex relationship between substance abuse and other mental disorders. The research report also describes common factors that can lead to comorbidity, including vulnerabilities related to genes and gender, 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.

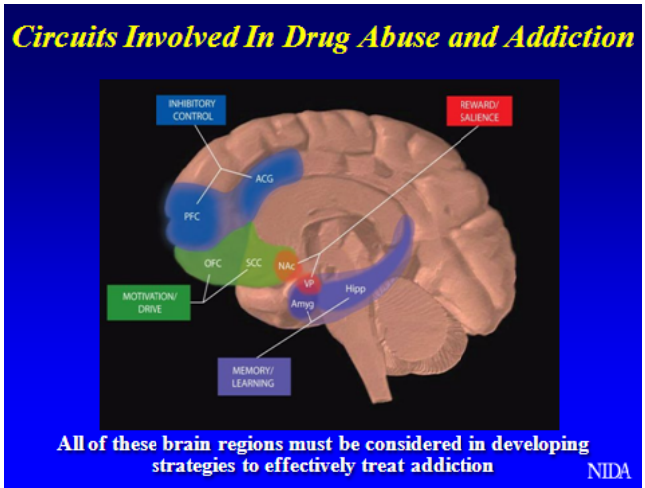
Military Personnel and Substance Abuse

A two-day meeting held in January 2009 to address the issue of substance abuse and associated mental and physical health problems among military personnel and their families elicited the support and involvement of multiple collaborators. These included 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. The meeting prompted the issuance of a new RFA to encourage studies on the associations between drug abuse, deployment stress, and combat trauma among U.S. military personnel and their families. Exposure to combat has been linked with increased substance abuse risk, as well as post traumatic stress and depressive disorders and disrupted social relationships.

Getting Proven Treatments into the Criminal Justice System

Collective findings clearly demonstrate the benefits of treatment, voluntary or court-ordered, and have reinforced NIDA's commitment to learn how to effectively integrate proven drug abuse treatments in criminal justice settings. Such settings offer good opportunities for providing treatment and for having considerable societal impact. To this end, in 2002, NIDA launched the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) initiative, a multi-site research collaborative aimed at more rapidly integrating substance abuse and addiction diagnosis, referral, and treatment into criminal justice settings. Research from CJ-DATS demonstrates the value of providing addiction treatment and linkage to aftercare in helping prison releasees stay drug- and arrest-free. For example, prisoners with pre-incarceration heroin addiction who received methadone treatment pre-release entered and remained in community-based treatment, were less likely to test positive for opioids, and reported significantly fewer days of heroin use and criminal activity than participants who received counseling and referral only. Research findings also categorically demonstrate that providing prison-based drug abuse treatment saves money—between $2 to $6 for every $1 spent on treatment, which in part reflects reductions in criminal behavior.





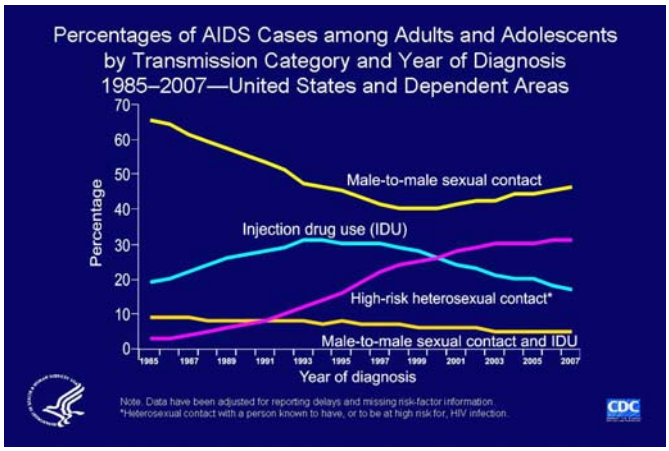
Screening, Brief Intervention, and Referral to Treatment

The vast majority of individuals with substance use disorders 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 serve as the "frontline" responders–they can assess their patients' involvement with substance use and refer them to treatment if necessary. Indeed, research shows that screening and brief intervention conducted in medical settings can significantly reduce tobacco and alcohol use; while emerging evidence is suggesting the utility of SBIRT for illicit drug use as well. For example, a recent large epidemiological study of SBIRT across a wide variety of medical settings in six states showed significant improvements at 6 months post-screening for both illicit drug use (67.7% reduction) and heavy alcohol use (38.6% reduction) among a diverse

patient population. Efforts to advance routine substance abuse screening among patients in traditional healthcare settings should lessen the stigma surrounding substance abuse and help create an environment where people can seek treatment or be persuaded to obtain the help they need.

The evolving HIV/AIDS epidemic

Over the past three decades, the proportion of new HIV/AIDS cases attributable to injection drug use has been substantially reduced, thanks in part to NIDA research that has led to improved treatments (e.g., methadone and buprenorphine) for injection drug users addicted to heroin.



However, drug abuse continues to be a major vector for the spread of HIV/AIDS through its connection with other risky behaviors, such as 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.

Fiscal Year 2011
Funding Recommendations

for the

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 alcohol use disorders, i.e., alcohol abuse and alcohol dependence (alcoholism) and other 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, behavioral research, medical consequences, medications development, prevention, and treatment through the award of grants and within the NIAAA's intramural research program;
- Supporting policy studies that have broad implications for prevention and treatment of alcohol-related problems;
- 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 research activities; and
- Disseminating research findings to health care providers, researchers, policymakers, and the public.

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

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$450.2m	$462.1m	$474.6m	$522.2m

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. In any given year, approximately 18 million Americans suffer from alcohol use disorders, and an estimated 40 percent have direct family experience with alcohol abuse or dependence. Annually, 79,000 deaths are attributable to alcohol, and alcohol 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 U.S. The financial burden from alcohol on our nation is estimated at $235 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 and/or enhance a number of key NIAAA initiatives including:

- Acquiring scientific knowledge in the area of biomarkers for alcohol consumption (especially during pregnancy), for the early detection of alcohol-induced organ damage (especially liver, pancreas, and heart), and for patients who respond to treatment for alcohol dependence and tissue injury;
- Studies aimed at early identification and diagnosis of harmful alcohol use, risk reduction, and personalized treatment;
- Research on pharmacotherapy for adolescents and young adults with severe alcohol use disorders and psychiatric comorbidities, as well as behavioral interventions that target young individuals along the continuum of mild to severe alcohol related problems;
- The continued development of effective pharmacological and behavioral treatments for individuals who have alcohol use disorders and co-existing other drug, psychiatric and/or physical disorders;
- Discovering clinically useful and reliable biomarkers of alcohol consumption and alcohol-induced tissue injury, as well as validating existing ones and advancing them to marker acceptance;
- Expanded understanding of the underlying mechanisms of alcohol-induced liver injury and the identification of biomarkers of alcohol-induced tissue injury (these studies are expected to reveal new therapeutic targets, inform strategies for preventing tissue injury, facilitate early diagnosis and improve the prognosis for alcohol-related liver disease);
- Longitudinal studies to: expand our understanding of alcohol's effects on the developing adolescent brain and;

determine how alcohol use affects development of co-morbid disorders and how other disorders affect the emergence and progression of alcohol use disorders;
- Expanding research to understand how individuals change their harmful drinking behaviors either in the presence or absence of formal treatment.

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 is enabling health care providers to personalize the treatment they offer their patients.

Genetics gives us the key to match therapeutic plans and patients. In the past, clinicians had to rely, to some degree, on trial and error in applying pharmacological and psychological interventions. Now, we know a great deal more about which medicines are likely to work for which patients—based on genetic profiles. For example, for many patients the drug naltrexone is not particularly effective. However, rather than abandoning its use, ongoing research is showing that this drug, when used in combination with psychotherapy, is very effective with alcoholics who have a particular genetic variation in one of their opioid receptors, roughly a quarter of all patients in treatment.

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. Whether the patient has an alcohol use disorder or is a heavy, at-risk drinker, the *Clinician's Guide* offers streamlined, step-by-step guidance for conducting brief interventions and managing patient care. The updated *Guide* offers additional resources including online training with continuing education credit programs, video case studies that demonstrate effective use of the *Guide*, support for medication-based therapy in non-specialty settings and supporting resources for clinicians and patients. Since its release in 2007, over 330,000 copies of the updated *Clinician's Guide* have been distributed. More than 24,000 clinicians (physicians, nurses, physician assistants, and other health professionals) have viewed the interactive video cases and almost 10,000 have completed the programs for continuing education credit.

NIAAA recently launched an interactive website and supporting booklet, Rethinking Drinking (http://rethinkingdrinking.niaaa.nih.gov), to help individuals recognize and reduce their risk for alcohol problems. 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. The website also provides interactive, personalized on-line tools, such as a calculator to estimate the alcohol content in common cocktails. *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 is being used in many other settings, such as Employee Assistance Programs, 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. Since its release in 2009, nearly 200,000 copies of the *Rethinking Drinking* booklet have been distributed and almost 250,000 visitors have accessed the website.

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 individuals die from motor vehicle crashes, other unintentional injuries, and homicides and suicides that involve underage

drinking. NIAAA is continuing to emphasize research, evaluation, and outreach 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, NIAAA continues to promote and disseminate the Surgeon General issued a Call to Action to Prevent and Reduce Underage Drinking, a collaborative effort of the Office of the Surgeon General, NIAAA, and the Substance Abuse and Mental Health Services Administration. This concise report offers a comprehensive view of underage drinking and its consequences within a developmental framework. NIAAA is also developing a practitioner's guide for screening children and adolescents for alcohol consumption, binge drinking, and alcohol use disorders, as well as to identify those who have not initiated drinking but are at high risk for alcohol use. This new guide will be designed for use in multiple settings such as pediatrician's offices and schools.

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 has supported two research initiatives to address this issue. One initiative was aimed at increasing our understanding about the short- and long-term effects of child and adolescent alcohol consumption on the developing brain. Another initiative 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. Importantly, a recent prospective study of youth, which started before participants began drinking, suggests that teen drinkers may experience changes in their developing brains that result in sustained attention deficits among boys and visuospatial memory impairments among girls. While these results are preliminary, this study provides new evidence that teen drinking may negatively impact the structure and functioning of the developing adolescent brain.

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

CSAT Block Grant

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$1,778.6m	$1,798.6m	$1,798.6m	$2,008.5m

CSAT Programs of Regional and National Significance

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$414.3m	$452.6m	$486.7m	$529.6m

CSAP Programs of Regional and National Significance

FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
$201.0m	$202.2m	$223.1m	$277.2m

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. 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 state substance abuse agencies 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 Calendar Year 2007, the Block Grant supported treatment services for approximately 2 million client admissions.

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. *SAPT Block Grant-Funded Services help people get better:*

In Calendar Year 2007, the SAPT Block Grant supported treatment services for approximately 2 million client admissions. During the same year, at discharge from treatment, 73 percent of clients were abstinent from illicit drug use; 80 percent of clients were abstinent from alcohol use; 89 percent had no involvement with the criminal justice system and 49 percent were employed or in school.

People with substance use disorders rely on public sources of financing to a much greater extent than people with other diseases[7]. Unfortunately, the overall

[7] National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001

amount of funding that is invested in 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, a core source of federal addiction prevention and treatment funding, is approximately $1.8 billion. 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 2008, 23.1 million persons aged 12 or older needed treatment for a drug or alcohol use problem. During the same year, only 2.3 million persons received treatment at a specialty facility. As a result, 20.8 million persons needed but did not receive treatment for a drug or alcohol use problem in 2008. 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. Overall, SAPT Block Grant funding makes up 63.6 percent of State-territory funded primary prevention funding for States. 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. In FY 2010, the SBIRT program was funded at $29.1 million.

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. In FY 2010, the RCSP program was funded at $5.2 million.

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. In FY 2010, the total for the criminal justice portfolio was $67.6 million.

Addiction Technology Transfer Centers (ATTCs)

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

In FY 2010, the ATTCs were funded at $9.1 million.

Mental Health Liaison Group (MHLG) FY 2011 Appropriations Recommendations for the SAMHSA and Key NIH Institutions

(Dollars in Millions)

PROGRAMS	FY09 FINAL (Omnibus)	FY10 FINAL (Minibus)	FY11 ADMIN REQUEST	FY11 MHLG REQUEST
CMHS				
CMHS TOTAL	$969.2m (+$58.3m)	$1,005.1m (+$35.9m)	$1,027.6m (+$22.5m)	$1,152.8m (+$147.7m)
Community Mental Health Services Performance Partnership Block Grant	$420.8m ($0.0m)	$420.8m ($0.0m)	$420.8m ($0.0m)	$482.7m (+$61.9m)
Children's Mental Health Services Program	$108.4m (+$6.1m)	$121.3m (+$12.9m)	$126.2m (+$4.9m)	$139.1m (+$17.8m)
PATH Homelessness Program	$59.7m (+$6.4m)	$65.0m (+$5.3m)	$70.0m (+$5.0m)	$74.6m (+$9.6m)
Protection and Advocacy (PAIMI)	$35.9m (+$1.0m)	$36.4m (+$0.5m)	$36.4m ($0.0m)	$41.8m (+$5.4m)
Programs of Regional and National Significance	$344.4m (+45.1m)	$361.5m (+$17.1m)	$374.2m (+12.7m)	$414.6m (+$53.1m)
Youth Violence Prevention Initiatives	$94.5m (+$1.0m)	$94.5m ($0.0m)	$94.5m ($0.0m)	$108.4m (+$13.9m)
Suicide Prevention for Children and Adolescents	$47.1m *(-$1.5m)*	$48.1m (+$1.0m)	$54.2m (+$6.1m)	$55.2m (+$7.1m)
Children and Adolescents with Post Traumatic Stress Disorder	$38.0m (+$4.9m)	$40.8m (+$2.8m)	$40.8m ($0.0m)	$46.8m (+$6.0m)
Mental Health Transformation State Incentive Grant	$26.0m ($0.0m)	$26.0m ($0.0m)	$26.0m ($0.0m)	$29.8m (+$3.8m)
Project LAUNCH	$20.0m (+$12.6m)	$25.0m (+$5.0m)	$27.0m (+$2.0m)	$28.7m (+$3.7m)
Grants for Primary and Behavioral Healthcare and Services	$7.0m ($0.0m)	$14.0m (+$7.0m)	$14.0m ($0.0m)	$16.1m (+$2.1m)
Jail Diversion Program Grants	$6.7m ($0.0m)	$6.7m ($0.0m)	$6.7m ($0.0m)	$7.7m (+$1.0m)
Mental Health Outreach and Treatment to the Elderly	$4.8m ($0.0m)	$4.8m ($0.0m)	$4.8m ($0.0m)	$5.5m (+$0.7m)
Statewide Family Network Grants	$3.7m (+$0.36m)	$3.7m ($0.0m)	$3.8m (+$0.1m)	$4.3m (+$0.6m)
Minority Fellowship Workforce Training	$3.7m ($0.0m)	$3.7m ($0.0m)	$3.7m ($0.0m)	$4.3m (+$0.6m)
Rehabilitation Research and Training Centers	$3.6m (+$0.5m)	$3.6m ($0.0m)	$3.6m ($0.0m)	$4.1m (+$0.5m)
Mental Illnesses and Substance Abuse Disorder Grant	$3.61m ($0.0m)	$3.6m ($0.0m)	$3.6m ($0.0m)	$4.1m (+$0.5m)
Statewide Consumer Network Grants	$2.5m (+$1.03m)	$2.5m ($0.0m)	$2.6m (+$0.1m)	$2.9m (+$0.4m)
Consumer/Supporter Technical Assistance Centers	$1.95m ($0.0m)	$1.95m ($0.0m)	$1.95m ($0.0m)	$2.25m (+$0.3m)
CSAT				
Block Grant	$1,778.6m ($19.9m)	$1,798.6m (+$20.0m)	$1,798.6m ($0.0m)	$2,008.5m (+$210.0m)
Programs of Regional and National Significance	$414.3m (+$14.5m)	$452.6m (+$38.3m)	$486.7m (+$34.1m)	$529.6m (+$75.0m)
CSAP				
Programs of Regional and National Significance	$201.0m (+$6.9m)	$202.2m (+$1.2m)	$223.1m (+20.9m)	$277.2m (+$75.0m)
NIH				
NIMH	$1,450.5m (+$46.0m)	$1,489.7m (+$39.2m)	$1,540.3m (+$50.6m)	$1,683.3m (+$193.6m)
NIDA	$1,032.8m (+$32.1m)	$1,059.5m (+$26.7m)	$1,094.1m (+$34.6m)	$1,197.2m (+$137.7m)
NIAAA	$450.2m (+$13.9m)	$462.1m (+$11.9m)	$474.6m (+$12.5m)	$522.2m (+$60.1m)