CONCEPT PAPER

for

A National Forum on Creating Jail Mental Health Services for Tomorrow's Health Care Systems

San Francisco, CA
November 9-10, 1994

sponsored by:

National Institute of Corrections
Jails Division
1960 Industrial Circle, Suite A
Longmont, CO 80501

and

Center for Mental Health Services
Division of Program Development and Special Populations
5600 Fishers Lane
Rockville, MD 20857

Introduction

The legislation that established the Center for Mental Health Services (CMHS) on October 1, 1992, required that CMHS provide a report to Congress within 18 months of that date on the ..."most effective methods for providing mental health services to individuals who come into contact with the criminal justice system, including those individuals incarcerated in correctional facilities (including local jails and detention facilities), and the obstacles to providing such services." This report, "Double Jeopardy: Persons with Mental Illnesses in the Criminal Justice System," is currently under internal review by SAMHSA staff. The report will synthesize the research and state of knowledge on mental health services and systems interactions with police, jails, prisons, probation and parole to address the issues presented in the CMHS legislation.

The following paper presents some ideas and principles that have been drawn together as a result of this effort. The content reflects many of the issues discussed during the development of the CMHS Report to Congress and represents what may be many of the core elements of that document. While this National Forum focusses on jail settings. the content of the Congressional Report and this paper reflects all criminal justice settings, including law enforcement activities, jails. prisons and community corrections.

Background

In 1991, there were approximately 3,353 jails in the U.S. From 1980 to 1992, the number of persons in jail on any given day in the United States increased from 158,394 to 444,584 (United States Department of Justice, 1993). Further, U.S. currently process approximately 10.1 million admissions per year. In 1990. U.S. jails were functioning at 111 percent capacity overall. Fully 142 jurisdictions (28% of all jurisdictions containing jails with 100 or more capacity) had at least one jail under court order to reduce inmate population (United States Department of Justice. 1992).

Jail overcrowding is at epidemic proportions throughout the U.S. Not only are large numbers of jails antiquated and barely able to meet minimal standards of care, but also jail populations are exploding.

Among the burgeoning populations in U.S. jails are increasing numbers of persons with mental illnesses. A recent survey of male jail admissions in Cook County, IL. found that 6.1 percent had a current psychotic illness and were in need of treatment services (Teplin. 1994). Among female Cook County detainees, the estimates of mental illness were even higher. Fully 14 percent of the female detainees had a current mental illness of schizophrenia or affective disorder (Teplin. unpublished).   In the same study, Abrams and Teplin (1991) found that 58.3 percent of the persons with major mental illnesses were currently alcohol abusing/dependent, while 33.3 percent had current co-occurring drug abuse/dependence.

On a national level, this would indicate that nearly 700,000 admissions to U.S. jails in 1990 were individuals with acute and severe mental illnesses, and a significant proportion of these requires specialized substance abuse services.

In addition, there were 1.239 prisons in the U.S. in 1990. The Bureau of Justice Statistics reported that on June 2, 1994. there were nearly 945.000 inmates in U.S. prisons; a 300 percent increase since 1980. Despite the increase in expenditures and the expansion of physical plants. at the end of 1990, state prisons were operating at 18 to 29 percent over capacity. while Federal institutions were 51 percent over capacity.

Clearly, the prison population is different from the jail population in terms of seriousness of offense and length of confinement. However, like jails. a sizeable portion of prison inmates have mental illnesses. Estimates of severe mental disorders among prison inmates generally range from 6 to 15 percent (Monahan and Steadman. 1983; Steadman and Cocozza. 1993). In addition, co-morbidity is an important factor in the management of persons with mental illnesses in prison. While

arrests for all crimes have increased by 27.7 percent over the past decade. arrests for drug related crimes have increased by 125.9 percent (United States Department of Justice, 1991). Further, 79 percent stated that they had used drugs, excluding alcohol, in the past, and 62 percent said they used drugs on a regular basis.

Of the more than 4 million Americans under correctional supervision in 1990, 3.2 million were in the community. Based on jail and prison estimates, a significant number of persons under community corrections are mentally ill and in need of ongoing mental health treatment services in the community.

Correctional populations represent one of the most underserved populations of persons with mental illnesses in the U.S. And it is one of the fastest growing.

Important Distinctions and Concepts

A diverse group. People come into contact with the criminal justice system for many reasons. Only a portion of them have acute mental disorders, but this group demands disproportionate attention. both because of their special needs and because of the problems they pose for criminal justice system personnel and for the proper administration of the criminal justice system.

Persons with mental disorders are a heterogenous group. The effects of their mental illnesses range from psychosis, to severe disruptions in emotions. to functional impairments in the ability to relate to others or sustain work. They represent different ages. cultural and ethnic backgrounds. and sexual preferences. They include a disproportionate number of males. but also a significant and growing number of women. They have a wide range of experiences and abilities, and they live in metropolitan, suburban and rural areas. A few have been violent; most have not. All of these factors must be considered when developing mental health programs in the community and in the criminal justice system.

Most persons with mental illnesses are not violent. One of the most prevalent myths about persons with mental disorders is that most of them are prone to violence. Typically, this fear is based on the fact that an individual has a psychiatric diagnosis. has received treatment or has been hospitalized for a mental illness. These fears persist despite the facts that persons with mental illnesses are no more likely than the general population to commit violent acts. In fact, persons with mental illnesses are more likely to be held without criminal charges and are more likely to be charged with minor crimes.

Persons with special needs. Persons with mental illnesses who come into contact with the criminal justice system have special needs. Further, within this group there are subgroups that warrant particular attention. These include persons with co-occurring substance use disorders. women. ethnic and racial minorities, homeless persons, persons with HIV/AIDS, and youth.

Diversity of **points of contact.** Just as persons with mental illnesses have diverse needs. those needs will vary depending on the point at which they are in the criminal justice system. A person whose acute psychiatric crisis brings him or her to the attention of the police may need immediate stabilization, while a prison inmate with severe mental illness may require long-term treatment and support.

Clearly. the responsibilities of the criminal justice system for persons with mental illnesses will differ at each stage. as well. An individual may be detained in jail for a short period of time, so that jail staff may focus primarily on maintaining continuity of any community-based services the person is receiving. Personnel responsible for individuals with mental illnesses on probation or parole in the community may act as case managers to broker a full range of health, mental health, housing. and social services for their clients.

Key Issues at Various Points of Contact

Police. Effective police response to citizens with mental illnesses requires cooperation and the exchange of knowledge, resources, and services between law enforcement, mental health, and social service agencies. Without such cooperation, police may resort to the inappropriate use of arrest or of emergency psychiatric hospitalization.

In particular. the efforts of local police are bolstered when:

- 24-hour mobile mental health crisis response is available.

- Police training programs emphasize learning to identify symptoms of mental illnesses and knowing the operation of the local mental health system.

- Mechanisms sensitive to both client privacy and service system information needs are developed.

These approaches to effective police/mental health collaboration usually can be accomplished with little or no additional funding.

Jails/Lockups. Because jails have a constitutional duty to provide mental health treatment to individuals who require it, and a responsibility to provide a safe and secure environment for both staff and inmates. it is in the best interest of all concerned to stabilize persons who have mental illnesses. Effective mental health services can reduce security risks by helping persons with mental illnesses control their psychiatric symptoms and by educating staff to interact in a more positive way with these individuals.

Jail mental health services can be most effective when:

- The jail. as a community-based facility, functions as an integral part of the social and health services systems.

- Diversion programs arc developed to avoid inappropriate detention of persons with mental illnesses.

- The essential mental health services of screening, evaluation. crisis intervention, and discharge planning are available to persons who are not appropriate for diversion.

- Mental health professionals are encouraged to spend a specific amount of time in on-site training in jails.

Prisons. Consistent with the concept of a "community mental health system." prisons should provide a full array of mental health services, beginning with screening and evaluation and crisis intervention at the "front door," through psychotropic medication and monitoring, individual and group therapy, case management, and specialized housing in prison, to discharge planning and referral at the "back door."   In non-prison communities, the use of outpatient services can significantly enhance an individual's ability to live and function in the community. With similar help. inmates with mental illnesses can learn to function in the prison general population.

Prison mental health services are most effective when:

- States encourage continuity of mental health services both upon entry into the prison from jail and upon release from prison via either parole or direct discharge.

- Case-finding in prisons is continued throughout an inmate's stay to detect the possible onset of mental disorders that may occur at any time.

- Crisis beds and beds in special Residential Treatment Units are available to avoid unnecessary inmate transfers to psychiatric facilities and to promote integration of inmates with mental illnesses in the prison.

- Collaboration is promoted between State department of corrections and State mental health agencies.

Probation and Parole. Individuals with mental illnesses on probation and parole, like other community members with similar problems, require the availability of a full range of mental health services that are accessible, appropriate, and relevant to their needs. Mental health treatment may be a condition of probation or parole for some individuals; for others, participation in such services is voluntary.

Effective strategies for dealing with persons with mental illnesses on probation and parole include:

- Intensive case management that focuses on connecting the individual to community-based services.

- Development of general policies of progressive sanctions that decrease the probability that technical violations of the conditions of probation/parole will result in a return to jail/prison and increase the likelihood of continued community living.

- The development of policies that respect an individual's right to privacy and freedom when community supervision involves forced treatment.

Diversion Programs. While some persons with mental illnesses who commit serious offenses and/or have previous histories of non-appearance for court dates warrant correctional detention, other individuals clearly do not belong in jail. When persons with mental illnesses can be appropriately diverted from the criminal justice system, it helps reduce jail overcrowding and promote the smooth operation of jail programs. The best diversion programs recognize that without assistance to overcome the barriers created by fragmented services. the nature of mental illnesses, and the lack of social supports and other resources, many individuals with mental illnesses may return to jail.

In particular, diversion programs are most effective when:

- Services are integrated at the community level, and involve corrections, local courts and probation, mental health, substance abuse services and social services, such as housing and entitlements with a high level of cooperation among all parties.

- Regular meetings of all the key players occur to encourage coordination of services and sharing of information.

- Boundary-spanners are selected for the program who can directly manage the interactions between the jail, court and mental health staff.

- Strong leadership exists that is able to involve all key players and put all of the necessary pieces into place.

- There is early identification of detainees with mental health treatment needs who meet the diversion program's criteria.

- Case managers are culturally and racially diverse and familiar with both the criminal justice and mental health systems.

Special Populations. Persons with mental illnesses who come into contact with the criminal justice system have special needs, as compared to other detainees. Yet even within this group of persons with mental illnesses. there arc subgroups that warrant particular attention. These include persons with co-occurring substance use disorders, women. ethnic and racial minorities. homeless persons. persons with HIV/AIDS. and youth.

The needs of these special groups can best be addressed when:

- Specialized services are available to all persons with mental illnesses who have special needs when they come into contact with the criminal justice system.

- Cultural competence training is available to all mental health and criminal justice staff.

- Specialized training for the management of persons with mental illnesses who have co-occurring disorders, such as substance abuse, HIV/AIDS, and other special treatment conditions, is emphasized for both mental health and criminal justice staff.

Some Principles for Successful Mental Health Services in Criminal Justice Settings

Based on a series of meetings with diverse groups of stakeholders. review of the existing research and feedback on earlier ideas. we are suggesting six core principles to guide what needs to happen to significantly improve the lives of persons with mental illnesses who come into contact with the criminal justice system. They are:

- Access to targeted, appropriate, and flexible mental health services should be available to all persons with mental illnesses.

- Creative use of existing resources can accomplish many of the needed changes to the criminal justice and mental health systems without the need for a massive infusion of new resources.

- Mental health services targeting the co-morbidity of severe mental illnesses with alcohol and drug use disorders should be a priority.

- Cross-training of mental health. law enforcement, and corrections personnel is crucial.

- The identification of need and the provision of mental health services should take cultural differences into account.

- Developing more detailed mental health care standards and promoting existing ones is an effective change strategy.

Prospects for Federal (CMHS) Initiatives

Emerging from many discussions and meetings with CMHS staff and representatives from key constituencies are a number of ideas for how CMHS may be able to impact the primary issue of providing quality mental health services in the criminal justice system.

Federal Working Group on Persons with Mental Illnesses in the Criminal Justice System. The creation of a working group composed of representatives of Federal agencies, mental health service providers, correctional and law enforcement professionals. consumers, family members, and researchers who have responsibilities either directly or indirectly for the care of persons with mental illnesses who come into contact with the criminal justice system is a first step toward solving the multiple problems of this population. Such a group could build on existing efforts sponsored by the Center for Mental Health Services, the National Institute of Mental Health, and it could target and coordinate efforts between department to facilitate the improvement of mental health services. The activities of this group might include:

- Developing Memoranda of Understanding between key Federal agencies to create training, education, research, and resource partnerships.
- Encourage research demonstration projects at CMHS. NIMH. and NIJ to expand the current knowledge base of effective programs.

Promote Systems Integration. Adequate care for persons with mental illnesses who come into contact with the criminal justice system requires an integrated system of care. While jail, prison, and probation/parole mental health systems often do not interact at all with community-based mental

health providers, coordinated and integrated programs clearly increase the likelihood of uninterrupted care, better psychiatric outcomes and lower recidivism. Services integration might be encouraged by:

- Including mental health services to persons in the criminal justice system in the State comprehensive mental health planning process.

- Technical assistance to provide communities with information. such as how to convene interagency community planning teams. develop contracts or letters of agreement, or implement specific programs.

Generate and Disseminate Knowledge and Information. The establishment of a comprehensive information gathering and knowledge dissemination plan should be considered to provide necessary information and technical assistance to the people. agencies, and communities that can best use it. This plan may include:

- Integrating key information. including essential components of jail/prison mental health services, specific road maps for localities to implement these services within correctional facilities, and fact sheets and brochures describing how programs have been developed in other areas.

- Continuing to fund technical assistance centers and consultants to help States and localities implement service programs

Stimulate Advocacy for **Persons with Mental Illnesses in the Criminal Justice System.** Persons with mental illnesses who come into contact with the criminal justice system are doubly stigmatized. Of all persons with special needs, they are the ones most likely to be forgotten. They are usually shuffled between the mental health and criminal justice systems with few advocates speaking on their behalf. They are often considered to be responsible for their plight. Advocates, including family. consumer. and professional groups. must continue to work diligently in order to guarantee that appropriate mental health services remain a priority.

Advocacy groups should be encouraged to increase their focus on mental health/criminal justice issues. Federal agencies can help by:

- Requesting the participation of both consumers and family members in task forces and work groups related to issues of policy, program design, and research on persons with mental illnesses in the criminal justice system.

- Supporting the information needs of these groups.

CMHS
Center for Mental Health Services

Bernard S. Arons, M.D., Director

... national leadership for treatment and prevention of mental illnesses

Office of Consumer, Family and Public Information, Center for Mental Health Services, 5600 Fishers Lane, Room 13-103, Rockville, Maryland 20857   ■   (301) 443-2792
U.S. Department of Health and Human Services   ■   Public Health Service   ■   Substance Abuse and Mental Health Services Administration

**CMHS
MISSION**

- Congress authorized the establishment of the Center for Mental Health Services with the 1992 ADAMHA Reorganization Act (Public Law 102-321). The Center was created to bring new hope to those who experience serious mental or emotional disorders by leading Federal efforts to treat mental illnesses, promote mental health and prevent the development or worsening of mental illness when possible. It is a component of the Substance Abuse and Mental Health Services Administration, one of eight U.S. Public Health Service agencies within the Department of Health and Human Services.

- The Center pursues its mission by helping states improve and increase the quality and range of treatment and support services for people with mental illnesses, their families and their communities. Through the Center, Congress encourages a wide range of programs to respond to the increasing number of mental, emotional and behavioral problems among America's youth, and programs of outreach and case management for the hundreds of thousands of Americans who are homeless and severely mentally ill. In addition, the Center supports efforts to help states and communities expand their mental health rehabilitative services and encourages the creation and effectiveness of consumer-run and self-help alternatives.

- The Center works with other Federal agencies whose programs and policies affect the lives of people with mental illnesses to enhance mental health services delivery and advance policy development. The Departments of Education, Housing and Urban Development, and Justice and the Federal Emergency Management Agency are among the agencies with which the Center collaborates.

**CMHS
ORGANIZA-
TION**

- The Center is organized into three divisions and supporting offices:

  - *The Division of Program Development, Special Populations and Projects* identifies gaps in prevention and services delivery and designs, develops and implements programs for underserved and at-risk populations. Among its constituencies are people involved with the criminal justice system, minorities, women, older people and rural Americans.

- *The Division of Demonstration Programs* plans, implements and evaluates service demonstration programs to develop models of innovative care and service delivery. Target groups are adults with severe mental illnesses, children and adolescents with serious emotional disturbances and their families, and homeless people who are mentally ill. Demonstration programs help planners and policymakers figure out what works, with whom and at what cost, as well as what doesn't work and why.

- *The Division of State and Community Systems Development administers the* community mental health services block grant, manages the Center's data collection effort and helps translate knowledge into practice and, ultimately, into better state mental health services. The division monitors state implementation of planning requirements and provides technical assistance to states. Using the lessons learned through the Division of Demonstration Programs, it seeks to promote applications in states through the block grant program.

- *The Office of Consumer, Family and Public Information* plans and implements a knowledge exchange program, including an education program for the general public; people with mental illnesses and their families; mental health services providers and other health care workers; mass media; other local, state and Federal government agencies; service and advocacy organizations; and the business community. The office also plans to start a national clearinghouse to facilitate access to the latest research and most successful model service delivery programs and systems.

CMHS ISSUES

Adults with-Severe Mental Illnesses

Each year, 5.5 million Americans experience severe mental illnesses, such as schizophrenia, manic-depressive illness and severe depressive disorders, which are Potentially as debilitating as chronic heart disease or diabetes. Over a lifetime, more than 41 million adults - 22 Percent - experience a mental disorder.

Services for Children and Adolescents

At least 7.7 million children and adolescents - 12 percent of all children - experience mental and emotional disturbances, depression and attention deficit disorder. Only about one-third of these children receive mental health services and many do not get appropriate care for their condition. For example, of the 54,000 children who receive care in hospitals and residential treatment facilities, many would be better served in less restrictive community-based facilities.

Services for Homeless Adults with Serious Mental Illnesses
Even by conservative estimates, up to 600,000 people are homeless throughout the country on any given night. About one-third are adults who have serious mental illnesses. More than half also have an alcohol or drug problem.

Emergency Services and Disaster Relief
Virtually all individuals who live and work in **a disaster** area are candidates for direct crisis counseling services. CMHS works with the Federal Emergency Management Agency and the Public Health Service to provide counseling and education to "normal people responding normally to an abnormal situation."

Jail and Prison Population
Congress is particularly interested in more effective ways to provide mental health services to individuals who come into contact with the criminal justice system. According to recent estimates, nearly 54,000 inmates - 7 percent of all prison inmates - have serious mental illnesses, and 95,000 inmates - 12.5 percent - have significant psychiatric problems requiring intermittent care.

Human Resource Planning
Over 40 million adult Americans have mental disorders sometime during their lives, but only one in four receives treatment There are 157,000 mental health professionals, one for every 304 people with mental illnesses.

Data Collection and Reporting
The Center collects and reports national statistical information on mental health services and consumers for use by other Federal agencies, legislators, state mental health agencies, national mental health organizations, researchers, academic leaders and national media.

Protection and Advocacy
Congress established the Protection & Advocacy program to protect the rights of people with mental illnesses, who are vulnerable to abuse and serious injury and subject to neglect, including lack of treatment, appropriate nutrition, clothing, health care and discharge planning. In FY 1992, the 56 P&A systems served almost 21,000 clients to address over 30,000 complaints about abuse, neglect and rights violations.

HIV/AIDS Mental Health Care
Up to 1.5 million people in the U.S. are infected with HIV, and more than 300,000 have been diagnosed with AIDS. The Center is developing programs to provide mental health services for individuals, their families and others who experience severe psychological distress as a result of positive HIV antibody testing, and to identify models of effective mental health services for people with HIV/AIDS. In addition, the Center trains mental health providers to identify and treat people with mental illnesses who may be at increased risk for

HIV/AIDS and trams primary health care and support services providers to recognize, refer and treat people with emotional trauma, depression, anxiety, severe mental disorders and dementia associated with HIV/AIDS.

Refugee Mental Health Care
CMHS is the focal point for mental health Services for thousands of refugees and detainees, including former political prisoners from Vietnam and their families, Pentecostal refugees from the former Soviet Union, and Marie1 Cubans. The Center provides consultation and technical assistance to a variety of Federal and state agencies, local services providers and academic researchers regarding refugee mental health issues.

Stigma
Although some progress has been made to counteract the myths, misperceptions and stereotypes surrounding mental illnesses, stigma still prevents many people from seeking treatment and causes countless others to keep their conditions secret for fear of losing their jobs, health insurance or homes.

Mental Health Information and Education
Information on many aspects of mental health and mental illnesses is gathered and disseminated to the many constituencies interested in these subjects. CMHS informs and motivates the public through health communication materials and presentations. Special events and media presentations can increase public awareness of specific mental health issues, reinforce certain knowledge or behavior and encourage action. CMHS-supported consumer advocacy programs encourage se&help efforts across the country.

CMHS
Center for Mental Health Services

... national leadership for the treatment and prevention of mental illnesses

U.S.Department of Health and Human Services • Public Health Service • Substance Abuse and Mental Health Services Administration

*T*he worn face of neglect of a mother's mental illness, the empty gaze of a child who is seriously disturbed and unserved, the emotional scars of a victim of domestic violence and sexual abuse, the nagging sight of people with a mental disorder who are homeless..

These are among the images that led Congress to create the Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration.

The Center's mission is to bring new hope to those who live with a serious mental or emotional disorder by leading Federal efforts to treat mental illness, promote mental health and prevent the development or worsening of mental illness when possible.

Public Law 102-321 mandates the Center's leadership role in mental health services delivery and policy development. Toward that end, Center activities involve facilitating the application of scientifically established findings and practice-based knowledge to prevent and treat mental disorders. and improving access. reducing barriers and promoting high quality, effective programs and services for people with -- or at risk for -- these disorders.

Center programs and staff help states increase and improve the quality and range of treatment and support services to people with mental illnesses, their families and their communities. They administer a wide range of programs to respond to the

increasing number of mental. emotional and behavioral problems among America's youngsters. and programs of outreach and case management for the thousands of Americans who are homeless and severely mentally ill. They support efforts to help states and communities expand their rehabilitation services and they encourage the creation and effectiveness of consumer self-help alternatives. They sponsor policy studies. evaluations and assessments that will help policymakers at every level of government organize and finance systems of care.

In addition to working with state and local governments to assure on-going. integrated services and improved access to comprehensive systems of care, the Center collaborates with other Federal agencies and departments whose programs affect the lives of people with mental illnesses to enhance mental health services delivery and policy development.

**THE PEOPLE
WE SERVE**

*Alissa is three years old and already in serious trouble. She is overly
active and disobedient at home, demanding and clingy with adults, bites
her nails, cannot sleep, and wets her bed nightly. At her child care
center, she is aggressive and uncontrollable. She actually injured
several children, and parents are insisting she be dismissed.*

*Joey, at age 14, is an African American child who is seriously disturbed.
His grandmother is his anguished parent. At age five. Joey was . . . a
cheerful child, devoted to his mother, but was learning disabled with a
low IQ. At seven, he watched as his mother was brutally killed. He
began to stutter, refused to pay attention to adults and stopped making
eye contact with anyone. A psychiatric evaluation called for intensive
treatment. But Joey didn't get services, as his grandmother unsuccess-
fully searched for help. Joey has now been rejected by a state facility
for the retarded because his problems are emotional, by 10 other public
and private facilities, including a good residential treatment center, and
by the state psychiatric hospital for children. His grandmother, now
quite elderly, is frightened. She fears she will die before Joey gets help.*

- At least 7.7 million children, 12 percent of all children. experience
  mental and emotional disturbances, depression and attention deficit
  disorder.

- Only about one third of these children receive mental health care, and
  many do not get appropriate care for their condition. For example, of
  the 54,000 children who receive care in hospitals and residential
  treatment facilities, many might be better served in less restrictive
  community-based facilities.

- **The Child and Adolescent Service System Program (CASSP) was**
  established in 1984 to help states and communities develop the
  infrastructure to provide comprehensive (addressing physical, emo-
  tional, social and educational needs) coordinated, community-based
  services to children and adolescents with serious emotional distur-
  bances. The goal is an organized network of caring and responsible
  people committed to assisting children meet their needs and poten-
  tials without being unnecessarily isolated or excluded from the
  community.

- CASSP works with state mental health administrators to ensure that CASSP principles are incorporated into state mental health plans.

- **The Child Mental Health Services Initiative** (Comprehensive Community Mental Health Services for Children Program), established in 1992, funds treatment services where there is an infrastructure to support coordinated and comprehensive service delivery for children and adolescents and for their families.

- Funded service systems must include: diagnosis and evaluation, outpatient, emergency, intensive home-based and day-treatment services, therapeutic foster care and group home services, wrap around services, transitional and case management services and respite care. Family involvement is encouraged in the development of local services and treatment plans.

MANDATE

- The Child and Adolescent Service System Program is authorized by Section 520A(e) of the Public Health Service Act. The Comprehensive Community Mental Health Services for Children Program is authorized by Section 565(f) of the Public Health Service Act.

FUNDING

FY '94 Appropriation

CSP/CASSP Demonstration Program:
$ 24,402,000*

- *These funds are divided in halfbetween the Community Support Program, also authorized under 52OA(e) of the Public Health Service Act, and the Child and Adolescent Service System Program.*

Comprehensive Community Mental Health Services for Children Program:
$35,000,000

STATUS

- There are three CASSP grant programs related to children's services: one to develop statewide family networks; one to develop service infrastructure at state and local levels; and one to evaluate the effectiveness of innovative models of organizing and providing services for children with serious emotional disturbances.

- Grant awards for FY '93 included: 28 for family networks, 8 for demonstration evaluation projects, and 29 for systems development. Four awards were made through the Child Mental Health Services Initiative.

- Linkages -- interagency collaborations with parent/child involvement and shared responsibilities to prevent children from falling through the service system cracks -- are supported through a technical assistance center funded with the Health Resources and Services Administration's Bureau of Maternal and Child Health and through joint funding of two research and training centers with the Department of Education's National Institute on Disability and Rehabilitation Research.

- The technical assistance centers focus on development of systems of care, community-based services approaches, cultural competence and services for high risk youth. One research and training center focuses on epidemiologic and service system research, and the other on family support and multicultural issues.

- CASSP has had a positive impact that far exceeds its appropriation, particularly when the overall costs of mental health care are considered.

  - Therapeutic options available to treat specific emotional disturbances in children and adolescents have become more numerous, more specific and more effective.

  - Systems of care that provide a full range of services for children and adolescents are cost effective and more satisfactory to families. For example, systems of care developed in Vermont, Kentucky, North Carolina, Virginia and California have demonstrated:

      . reduced use of inpatient services;
      . reduced placements in out-of-state facilities;
      . improved functioning;

. improved school attendance;
. reduced violations of the law and fewer contacts with law
    enforcement agencies; and
. increased parent satisfaction with services.

▪ Most states now place a higher priority on the needs of children and adoles-
cents with serious emotional and mental disorders than they used to.

● The Child Mental Health Services Initiative provides direct services. It is
estimated that for each million dollars in grants, an estimated 300 children
with serious emotional disturbances will receive services.

CMHS

Center for Mental Health Services

COMMUNITY SUPPORT PROGRAM

Division of Demonstration Programs

THE PEOPLE WE SERVE

- Each year 5.5 million Americans are disabled by severe mental illnesses such as schizophrenia, manic-depressive illness and severe depression disorders, which are potentially as debilitating as chronic heart disease or diabetes. Over their lifetimes, more than 22 percent (41 million) of adults have a mental disorder.

- Mental health treatment costs for 1990 are estimated at $67 billion. or 10 percent of total U.S. health care costs. A 1989 Rand study estimated that $27 billion a year is spent on depression alone, with $17 billion lost due to time away from work. Major depression accounts for more lost work than any other disorder except cardiovascular disease.

- Untreated, mental disorders can fog thoughts, sap motivation, and turn emotions into terror, rage or despair. Life-long or recurrent mental illnesses can be costly and disabling, affecting people's work, finances, education, independence and relationships with families -- and friends.

- Most symptoms of severe mental illnesses can be managed successfully with treatment and community-based assistance in meeting basic needs such as housing, jobs, education, social services, transportation, and medical and nursing care.

- The Community Support Program (CSP), established in 1977, funds states to develop these services, essential to the mental health and quality of life of the approximately 5.5 million individuals, age 18 years and older, whose lives are seriously impaired by severe and persistent mental disorders.

MANDATE

- CMHS is authorized by Section 52OA(e) of the Public Health Service Act to administer the Community Support Program to facilitate the development of services for seriously ill persons, and to fund state services demonstration projects on comprehensive delivery systems for community-based care.

FUNDING

FY '94 Appropriation

CSP/CASSP Demonstrations:
$ 24,402,000*

- *These funds are divided in half between the Community Support Program and the Child and Adolescent Service System Program.*

STATUS

- In FY '93, CSP awarded close to $12 million to states. communities, and provider, family and consumer organizations to improve services for individuals with severe mental illnesses and to support rigorous program evaluations. An estimated 350,000 people are enrolled in community support programs.

- CSP promotes comprehensive, coordinated services that include outreach, assistance in meeting basic human needs, mental health care, 24 hour crisis assistance, psychosocial and vocational services, supportive housing, consultation and education, natural support systems, protection of client rights and case management.

- CSP has worked extensively with state mental health administrators to ensure that CSP principles are incorporated into State Mental Health Plans.

- Since 1979, **The Statewide Service System Improvement Projects Program** has funded 3-year grants to all states, the District of Columbia, the Virgin Islands and Puerto Rico to demonstrate and evaluate service system improvement strategies. Since FY 1990, this nationwide program also has focused on integrating consumers and family members into the planning and provision of mental health and support services at state and local levels.

- **The Research/Demonstration Grant Project Program** supports research on innovative approaches to organizing, delivering, and financing systems of care for adults with severe mental illnesses. Thirty research projects are funded to evaluate various models of organizing and providing services: 12 for case management, 11 for rehabilitation and 7 for crisis services. Studies include consumer case managers; community treatment for "what the client needs, when and where the client needs it"; a crisis respite care alternative to psychiatric inpatient care; and companionship programs to facilitate community integration and reduce the need for emergency services.

- Through joint funding with the National Institute on Disability and Rehabilitation Research (Department of Education), two national rehabilitation research and training centers are supported. CSP also supports three national technical assistance centers: one focused on housing and supports and two on self-help.

- This modestly-funded Federal program has had a positive impact far exceeding its appropriation. particularly when the overall costs of mental health care are considered:

- Each dollar of CSP grant funds has leveraged approximately $18 (in 1986 dollars) of state, local, private. or other funding for persons with severe mental disorders.

- In **every** state, a state level focal point (usually a special office) for services has been identified.

- In **almost all** states, persons with long-term mental illness now are a priority for mental health services. Day treatment and partial hospitalization programs have moved from traditional to psychosocial rehabilitation oriented programs, resulting in decreases in rehospitalization and increases in independent living and working. Family support and consumer self-help groups have been established and strengthened in almost every state.

- In **approximately half** the states, state funding now supports CSP services. Social clubs and client self-help groups have been started with CSP funds and continued with state and local funds, and case management services have increased significantly.

- In **a number of** states, interagency agreements, e.g., between mental health and vocational rehabilitation agencies, have been signed for additional, non-mental health resources for persons with long-term mental illness.

- Approximately 60 local community support programs have received **CSP** seed funding, which has been replaced by state and local funds.

THE PEOPLE WE SERVE

Gladys didn't like the shelters (and she had tried them all over the years), but one bitter cold night a few years ago. she tried out a new shelter a young street worker had recommended. After a few weeks there, Gladys started a fight with the woman in the next cot, who, she believed. was sending her messages through the television. Most shelters simply sent Gladys back on the streets when she got into fights. but this one was different: she was sent to a mental health center where she was assessed and treated as an inpatient for a while.

The medications silenced the voices, and she started to feel better After a few weeks, when she was ready to leave the hospital, her case manager arranged for her to move temporarily to the center's specialized residence for homeless mentally ill people. By now, Gladys, working with her case manager, was able to start attending to the rest of her life--what she called "the gettings ": getting someplace decent to live, getting good medical care (including surgery to make her hand more usable), getting off alcohol and other drugs, and getting some education and training so she could get a paid job instead of living on welfare, She also talked about the "givings": using her considerable street wisdom and native intelligence to help other people.

- It is difficult to know exactly how many Americans are both homeless and severely mentally ill--this includes people on the streets, in jails and in emergency shelters.

- On any given night throughout the country, even by conservative estimates, up to 600,000 people are homeless. An estimated one third have serious mental illness. Over half also have an alcohol and/or drug problem.

- Minorities, especially African Americans, are over-represented among homeless persons with mental illness.

- The complex needs they present are extraordinary. Often, they resist shelter and mental health treatment because of negative experiences. In addition, they need primary health care, substance abuse treatment, legal assistance, help accessing entitlements, and other supports while they learn to abandon skills that helped them survive on the streets. Few providers can address this range of needs.

- CMHS was the lead Federal agency on the **Federal Task Force on Homelessness and Severe Mental Illnesses,** and provides coordination and oversight for the implementation of 58 action steps to promotesystems integration, outreach, access, housing options and alternative services.

- The Homeless Services Program works extensively with state mental health administrators to ensure adequate, appropriate services through the Projects for Assistance in Transition from Homelessness (PATH), a formula grant program.

- The Center supports a program to test alternative approaches to integrated systems of care for homeless persons with severe mental illness through the Access to Community Care and Effective Services and Supports (ACCESS) demonstration program.

MANDATE

The Homeless Demonstration Programs for homeless mentally ill and dually diagnosed individuals are authorized by Sections 506 and 520 A (e) of the Public Health Service Act. The PATH program is authorized by Section 535 (a) of the Public Health Service Act, as well as by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (Public Law 101-645, Title V, Subtitle B).

FUNDING

FY '94 Appropriation

Homeless
Demonstrations: $21,419,000

PATH: $29,462,000

STATUS

- Access to Community Care and Effective Services and Supports (ACCESS) is a new five-year national demonstration program for cooperative agreements involving nine states and two communities within each state to care for homeless persons with severe mental illnesses, including those who also have alcohol and/or other substance abuse disorders. ACCESS will test new integrated systems models to improve and evaluate the availability, quality and comprehensiveness of services. The Departments of Health and Human Services and Housing and Urban Development worked with the Departments of Labor, Education, Agriculture and Veterans Affairs to establish the ACCESS program.

- The **PATH** formula grant program funds states. the District of Columbia, Puerto Rico and the U.S. Territories to support services for persons with severe mental illness, as well as those who also have substance abuse disorders, who are or may become homeless. Services include: outreach, screening and diagnosis, habilitation and rehabilitation, community mental health services, alcohol or drug treatment (for mentally ill individuals with co-occurring substance abuse disorders), staff training, case management, supportive and supervisory services in residential settings. and referral for primary health services, job training and education. In addition, to improve coordination of services and housing for the target population, a limited set of housing services may be funded.

- The Center is collaborating with the Center for Substance Abuse Treatment (CSAT) to develop specific treatment protocols for individuals with co-occurring mental illness and substance abuse problems. Approximately $3 million will be awarded via cooperative agreements to 16 organizations for this project.

Total CMHS contribution in FY 93:	$1,583,662
Total CSAT:	$ 998,862
Total FY '93 CMHS and CSAT:	$2,582,524

COMMUNITY MENTAL HEALTH CENTERS CONSTRUCTION MONITORING PROGRAM

CMHS
Center for Mental Health Services

Division of Program Development, Special Populations and Projects

**THE PEOPLE
WE SERVE**

- Community mental health centers provide five essential mental health services: inpatient, outpatient, partial hospitalization, emergency, and consultation and education services through 1,500 catchment (service) areas nationwide. CMHCs also offer a range of community support services to people with serious mental illnesses and their families.

- A small percentage of patients have private health insurance or can afford to pay fees for services. However, most CMHC clients are low income people without insurance.

- About 86 percent of all CMHC patient care episodes are outpatient. Inpatient (inclusive of emergency) hospitalization care comprises about 5 percent of total patient care episodes; partial hospitalization care comprises 9 percent.

- The CMHC Act, Public Law 88-164, passed 30 years ago, authorized support for several types of grants for building and operating CMHCs. Grantees accepted a 20-year obligation to provide the five essential mental health services and continuity of care along with a reasonable amount of free and reduced cost care in return for Federal funding. From 1965 to 1975, 575 CMHC construction grants were awarded.

- Although the CMHC Act was repealed by the Omnibus Budget Reconciliation Act of 1981 (OBRA - P.L. 97-135), the recovery and monitoring provision related to construction grants was retained, allowing the Federal Government to recover funds from grantees or subsequent owners in instances where the facility failed to provide the program and services stipulated, or failed to use the facility as approved. The law also authorizes the release of a grantee or subsequent owner from the obligation to repay the Federal interest under certain circumstances.

- The CMHC Construction Grant monitoring program received national media attention in March 1990, with allegations of substantial mismanagement on the part of NIMH, which was overseeing the CMHC program. NIMH developed a remedial management improvement plan to address the problems by June 1990. The plan, which was

approved by the Assistant Secretary for Health, included an accelerated three-year site visit schedule to cover ail active grantees not visited since 1983.

MANDATE

- The program is authorized by Public Law 88-164, The Community Mental Health Centers Act, as amended by Public Law 97-135.

FUNDING

- This program is funded entirely from program management appropriations of CMHS, including $377,000 in FY '94 to complete the three-year site visit schedule of the CMHCs.

STATUS

- In accordance with the Assistant Secretary for Health's directive, program staff are visiting the CMHCs not previously visited: A total of 109 site visits were made in FY'91; 121 site visits were completed in FY '92. By the end of FY '93, 110 site visits will have been completed.

- Results conclude that nearly 80 percent of the grantees are in compliance and about 20 percent are not. The program emphasizes problem resolution through technical assistance and negotiations to maintain adequate services in the community, rather than recovering a portion of the value of the building.

- Still, about $6.4 million has been recovered from 15 noncompliant CMHCs in the 30-year history of the program. In the last 3 years, CMHS has recovered $2.4 million from 4 grantees.

- By approving program changes and responding to shifts in community needs, CMHCs have helped grantees establish mental health services that are more appropriate than those approved years ago. For example, CMHS has allowed grantees to relocate services to newly built facilities or focus programs and resources on substance abusers, older people, children and other especially needy populations.

CMHS
Center for Mental Health Services

EMERGENCY SERVICES AND DISASTER RELIEF PROGRAM

Division of Program Development. Special Populations and Projects

THE PEOPLE WE SERVE

When the flood of 1993 swept through the Midwest. it washed away the carefully-laid plans of an ambitious high school senior named Brett. Last June, Brett was looking forward to serving as his school's 1993-94 football captain and senior class president, making top grades, getting into a selective college, and leaving behind a legacy of excellence. By summer's end, his school under water, Brett faced the depressing prospect of becoming "a nobody in somebody else's school."

Alarmed by his own distress and that of several friends. Brett called on the mental health services agency that had worked on campus before the flood helping students with the normal problems of adolescence. Within a few days, a team of teen counselors was organized to work one-on-one with the displaced teenagers and their families as they returned to their devastated homes. Their job: make friends, listen to the stories while they helped clean up, watch for signs of stress and fatigue, encourage the family to take breaks, and be nurturing to the parents and younger siblings as well.

- The Emergency Services and Disaster Relief program is a cooperative effort of CMHS, the Federal Emergency Management Agency (FEMA) and PHS.

- The crisis counseling program is designed to serve all individuals who live or work in a disaster area. While elements of the program are directed to populations at particular risk, the overall thrust is to provide counseling and education to "normal people, responding normally, to abnormal situations." The program is based on *mental health* models as opposed to *mental illness* models.

- CMHS staff coordinate support for direct crisis counseling services to the victims of major disasters, such as the Flood of '93, the bombing of the World Trade Center, Hurricane Andrew, Hurricane Hugo, the Loma Prieta earthquake, and the riots in Los Angeles.

- PHS is the lead Federal unit responsible for implementing Emergency Support Function 8 (ESF-8), the Health and Medical portion of the Federal Disaster Response Plan. SAMHSA, through CMHS, is tasked with addressing the mental health needs of survivors and

responders. CMHS staff work closely with the staff of the Office of Emergency Preparedness in OASH and participate in training exercises to hone responses to a variety of disaster scenarios.

- The Center also provides training in disaster crisis counseling for direct services staff. Training and education efforts are directed to program administrators and designers, health and mental health professionals, and others who provide assistance and comfort following disasters (e.g., school personnel and clergy).

- CMHS works closely with FEMA in the annual presentation of a course at the National Training Center in Emmitsburg. Md. The course trains state staff (mental health and emergency preparedness) to deal with a variety of disaster mental health concerns.

MANDATE

- The Robert T. Stafford Disaster Relief and Recovery Act (P.L. 93-288) is the enabling legislation.

- The services activities are primarily funded through an annual Interagency Agreement with FEMA. It provides for the obligation of funds to CMHS to award grants to states and territories for crisis counseling services following Presidentially-declared disasters.

- With CMHS consultation and supervision, **Immediate Services** funds are provided directly from FEMA to the state to support services for 60 days from the date of the declaration of disaster.

- The **Regular Services** grant program supports nine-month grants that require site visits, quarterly and final reports, and consultation. Increasingly, these grants are being extended (with or without additional funds) to 12 months.

FUNDING

FY '93	FY '94 Estimates

$ 23,000,000* $ 20,000,000 - $ 25,000,000
                                 exclusively for the mid-west
                                 flooding

* Funds come through FEMA following Presidentially-declared disasters

- Funding for this program varies from year to year. The trend is toward more programs and more complex programs. In FY '93, 21 states received funds through the Immediate Services and Regular Services programs.

STATUS

- The program has generated positive exposure for the PHS. The program's success is based largely on effective working relationships with external people and groups. For example, CMHS is working with the American Red Cross to develop mental health capacities in their state and local chapters.

- In addition, FEMA has asked the program for guidance in reducing work related stress among their disaster workers. Acknowledging this issue has not come easily to FEMA; indeed. their request underscores the trust between CMHS staff and theirs.

THE PEOPLE WE SERVE

The Prevention and Program Development Branch addresses the mental health services needs of a variety of underserved populations, including people with mental illnesses in jails and prisons, minorities, women, and rural and older Americans.

For example. according to recent estimates, nearly 54,000 inmates have serious mental illnesses (7 percent of all prison inmates) and 95,000 inmates (12.5 percent) have significant psychiatric problems requiring intermittent care. In addition, 7.1 percent of jail detainees have serious mental illnesses, while another 3.1 percent have at least one episode of mental illness at some point in their lives.

MANDATE

Public Law 102-321 (The ADAMHA Reorganization Act) mandates a vigorous Federal leadership role in mental health services and policy development for the special populations mentioned above and a Report to Congress on the most effective ways to provide mental health services to individuals who come into contact with the criminal justice system.

FUNDING

The division's four focus areas -- Persons with Mental Illnesses in Jails and Prisions, Prevention Services, Women's Mental Health and Minority Issues -- are funded through management and program fund sources.

STATUS

Persons with Mental Illnesses in Jails and Prisons

- CMHS, the National Institute of Justice and the National Institute of Corrections (both of the Department of Justice) have signed a Memorandum of Understanding to improve services for offenders with mental illnesses and divert persons with emotional and mental disorders from inappropriate placement in jails.

**STATUS
continued**

- An agenda for joint training, technical assistance and data coordination has been developed through the MOU. This includes training for administrators of mental health and criminal justice systems on existing jails, using the best features of jail-linked community mental health services as "model" technical assistance sites, and joint planning of specific data collection projects on the availability of mental health services in jails across the country.

- Information from this effort will be used in a Report to Congress on the most effective ways to provide mental health services to individuals who come into contact with the criminal justice system.

Prevention Services

- During the last 10 years, there have been major advances in developing preventive interventions regarding mental disorders in children and adolescents, suicide attempts in adolescents and adults, and the negative impacts of stress in adults.

- CMHS convened a work group to help draft a policy statement on the concept of prevention and recommend program priorities and strategies in the mental health prevention services area.

- Two special work groups are being created: one will address the relationship of prevention services in mental health care reform to primary health care service delivery. The other, a collaborative effort with the National Institute of Occupational Safety and Health and the American Psychological Association, will address the state of the art of prevention services relative to mental health in the workplace.

- Collaborative efforts are being explored with the American Counseling Association, National Mental Health Association, American Association of Retired Persons, the Department of the Navy and the Center for Substance Abuse Prevention.

Women's Mental Health

- CMHS has established a Workgroup to address mental health issues affecting women with severe and persistent mental illness and girls with serious emotional disturbances who are at least 12 years old. Priority issues are physical and sexual abuse, mothering/caregiving and aging.

- The majority of women with diagnoses of serious mental illnesses have histories of physical and/or sexual abuse. In addition, caregiving is difficult for women with diagnosed mental illnesses: they face barriers to providing child care and receiving treatment. An estimated two-thirds of these women lose their children to some form of alternative care. And many older women face depression, abuse/misuse of prescription and over-the- counter drugs, abuse, caregiver "burnout," and other mental health problems that may occur following the death of a spouse.

  CMHS plans to sponsor a Women's Mental Health Forum on physical and sexual abuse issues in 1994. Activities are planned with other SAMHSA Centers and FDA to address the problems of depression and substance abuse in older women.

Minority Issues

- To enhance the delivery of culturally competent treatment for ethnic minority populations, CMHS meets with representatives of consumer, advocacy, professional and provider organizations serving African American, Asian, Pacific Island, Hispanic and Native American populations. CMHS also assists state and local governments in this area.

- CMHS facilitates consumer involvement in program development activities to improve access to, and quality of, community based treatment. For example, the Center met with the American Association of People of Color Mental Health Consumers to refine CMHS program development activities.

- Collaborations with professional organizations improve culturally competent training opportunities for professionals. CMHS co-sponsored a meeting with a multi-ethnic group of psychologists with the Public Interest Directorate of the American Psychological Association to address professional training and service delivery to ethnic communities.

- A 1993 conference with Asian and Pacific Island mental health service providers addressed access and quality of care in the Pacific Islands. CMHS will provide technical assistance to local authorities for advancing mental health care.

- A conference with Hispanic mental health providers in 1993 examined strategies for improving treatment effectiveness for Latino populations.

Rural Programs

- Rural areas have far fewer mental health services than urban centers. CMHS serves as a catalyst to ensure that the mental health needs of rural populations are not neglected by various components of the public and private sectors.

Older Americans

- Older people are vulnerable to gaps in systems of care. CMHS brings the mental health needs of the aging population to the forefront of discussion. For example, in testimony before the Senate Committee on Aging, CMHS highlighted the need to develop comprehensive and coordinated services to older people.

REFUGEE MENTAL HEALTH CARE PROGRAM

CMHS

Center for Mental Health Services

Division of Program Development. Special Populations and Projects

THE PEOPLE WE SERVE

The "Freedom Flotilla" began in April 1980. It endedjive months later with the closing of Mariel Harbor. During that period, nearly 121.000 Cubans arrived in Florida. Many had criminal backgrounds and pre-existing psychiatric problems. At the same time, thousands of Haitians arrived on U.S. shores. In response to the massive need for mental health services, the Refugee Mental Health Branch (RMHB), originally called the Cuban/Haitian Mental Health Unit of the National Institute of Mental Health, began operations in October 1980.

- Since then, the RMHB has broadened its mandate to include Amerasian and Russian Jewish refugees, among others. An estimated 51,000 Amerasians and their families live in the U.S.; 33,000 more are waiting in Vietnam to be processed and 7,000 are at the Philippine Refugee Processing Center awaiting resettlement.

- The RHMB offers consultation and technical assistance on general refugee mental health issues and for Cuban/Haitian entrant and refugee mental health issues. This includes liaison with other Federal agencies and developing, implementing and overseeing mental health inpatient and outplacement programs for Cuban entrants.

MANDATE

- The RMHB is funded by the Department of Justice (DOJ) through inter- and intra-agency agreements with the PHS Office of Refugee Health and CMHS.

- The applicable statutory authorities are: Sections 322 and 325 of the Public Health Service Act, Section 234 of the Immigration and Nationality Act of 1952, Section 501 (c) of the Refugee Education Assistance Act of 1980 (P.L. 96-422) and Section 601 of the Economy Act of 1932 as amended.

- In addition, there are many DOJ tasking orders, memoranda and Executive Order 12341 (January 1982). Supplemental funding for refugee assistance support is provided by the Office of Refugee Resettlement and CMHS.

REFUGEE MENTAL HEALTH
CARE PROGRAM

FUNDING

FY '93 Appropriation		FY '94 Estimates	
DOJ:	$ 12,874,000	DOJ:	$ 10,775,000
ORR:	$ 100,000		

STATUS

- The RMHB is the focal point for refugee mental and psychosocial adjustment issues within the Federal government.

- The RMHB provided mental health services to the Marie1 population through contracts and grants for inpatient psychiatric services (110 beds), halfway house programs (122 beds), and out-patient mental health evaluation services (approximately 800 clients) in FY '93.

- Technical assistance is provided to many refugee resettlement programs and other Federal agencies concerned with Russian refugees. Vietnamese re-education camp political prisoners, Amerasian youth Haitian boat people and people injured in the war in Bosnia. Programs in 26 states received assistance this year.

- The RMHB sponsors and participates in workshops, conferences and conventions that address refugee issues. The branch also has published a resource directory for Southeast Asian refugees.

- Among the constituent groups or organizations that follow RMHB activities and offer support and consultation are the American Red Cross, Physicians for Human Rights, World Federation for Mental Health, Indochinese Refugee Information Center, Health Service for Migrants, Population Council, Spunk Fund, Inc., The Pew Charitable Trusts, American Medical Association, Lutheran Immigration and Refugee Services, Hogg Foundation for Mental Health, Jewish Federation of Chicago, Jewish Vocational Services (Baltimore), Harvard Program on Refugee Trauma, Center for Victims of Torture, and Refugee Women in Development.

CMHS
Center for Mental Health Services

COMMUNITY
MENTAL HEALTH SERVICES
BLOCK GRANT PROGRAM

Division of State and Community Systems Development

THE PEOPLE WE SERVE

- More than 40 million adults. 22 percent of all adults, have mental disorders some time during their lives.

- More than 7.5 million children. 12 percent of all children. experience mental and emotional disturbances. including depression and attention deficit disorder.

- The **Community Mental Health Services Block Grant** provides funds to support comprehensive. community-based services for adults with a serious mental illness and children with serious emotional disturbances. In general, persons with serious mental illnesses quickly exhaust insurance benefits and are likely to require public mental health services. Sufficient support for these services does not now exist through insurance and other mechanisms.

- Among those most likely to be served through block grant funds are people with severe mental illnesses, such as schizophrenia. manic-depressive illness, and severe depression; these illnesses affect over 5 million Americans a year.

- State mental health planning councils mandated by block grant legislation must include consumers, family members, providers and state representatives. At the Federal level, consumers and family members contribute to Federal guidance to states, to the review of state plans and block grant applications, and to most other block grant program activities.

MANDATE

- The Community Mental Health Services Block Grant is authorized by Part B of Title XIX of the Public Health Service Act (42 U.S.C. 300x et seq.)

FUNDING

FY '93 Appropriation	FY '94 Appropriation
$ 277,918,720	$ 277,919,000

STATUS

- The block grant serves individuals with serious mental illnesses in 59 states and territories.

- FY 1993 awards, totaling $264,022,781, have been made to all 59 states and territories. The remainder of program funds are used by CMHS for technical assistance, data collection and program evaluation activities.

- State planning requirements within the Block Grant legislation encourage linkages among a broad variety of services, including primary and mental health care, case management, housing, education, and medical and dental care. The program also promotes linkages among Federal, state and local government agencies.

- Because states must now have acceptable plans in order to receive block grant funding, the state planning process has become a much more powerful lever on state systems of care. During this program's first year of operation in FY 1993, the grant approval process served to: establish separate mental health planning councils in a few states that had combined mental health/substance abuse councils; include in state plans objectives for criteria specified in the law; specify target numbers of adults and children to be served; and document state-expected prevalence rates for the target populations.

- SAMHSA, upon the recommendation of CMHS, may waive most block grant requirements for the smallest Pacific jurisdictions -- American Samoa, the Commonwealth of the Northern Mariana Islands, Palau, and the Marshall Islands. This waiver was used in FY 1993 to facilitate awards to these jurisdictions. In these territories the block grant awards are a major part of the mental health budget, and directly and significantly improve the availability of essential services where few or no mental health services currently exist.

THE PEOPLE WE SERVE

. More than 40 million adult Americans have mental disorders sometime during their lives; only one fourth receive treatment.

- There are only 157,000 mental health professionals -- one mental health professional per 304 persons with mental disorders.

- Ethnic minorities are particularly underserved. Although about one-fourth of the population, they constitute less than 10 percent of the mental health professionals, trainees or faculty.

- Other underserved populations include adults with severe mental illnesses. children with serious emotional disturbances, older people and individuals in rural areas who have mental disorders.

- To address these needs, the Center operates a human resources planning and development program with five core mental health disciplines: psychiatry, psychiatric nursing, psychology, social work, and marriage and family therapy.

MANDATE

The Center's Human Resources and Clinical Training programs are authorized by Section 303 of the Public Health Service Act.

FUNDING

| FY '94 Appropriation |

$ 2,500,000

STATUS

- In FY '93, 40 training grants were awarded to universities and 13 to states. Stipends supported 120 students.

- A series of national conferences and reports on training for professionals treating adults with severe mental illnesses and children with

serious disturbances have documented the state of the art training needed by future mental health care providers who expect to treat children and adults with the most serious mental illnesses. Capping off these conferences was last February's CMHS-sponsored meeting, "Building a Competent Mental Health Workforce for the 21st Century."

- In the last five years, CMHS/NIMH sponsored 150 clinical training programs linking academic programs to public needs.

- The Report to Congress on the service payback requirement of the Human Resource and Clinical Training Program provided data on the value of investing in the public mental health workforce:

  - More than 93 percent of trainees complete their payback service obligation;

    - Of these, 80 percent remain in the public or private nonprofit sector; and

  - The program costs only $11,000 per trainee per year.

CMHS
Center for Mental Health Services

MENTAL HEALTH STATISTICS IMPROVEMENT PROGRAM

Division of State and Community Systems Development

THE PEOPLE WE SERVE

- The Mental Health Statistics Improvement Program is designed to develop and implement minimum data standards for the mental health field.

- It represents a strong collaborative effort with state mental health agencies and other key groups including private psychiatric hospitals and mental health service consumers.

- MHSIP is the only program in the nation focusing on the need for and development of data standards for comparable. high quality statistical information on mental health services.

- The philosophy and collaborative nature of MHSIP have made it a model in the health care statistics field. It is being emulated by the statistical programs of the state alcohol and drug abuse agencies, the Indian Health Service for its mental health service programs, and the World Health Organization for developed and developing countries.

- Examples of results from MHSIP grants to states are:

  - an integrated electronic reporting system that includes all MHSIP data elements for organizational characteristics, human resources, finances, clients, and events in Oklahoma:

  - a regional research effort among Northeastern states to examine hospital utilization; and

  - the development of a case management reporting system by Nebraska.

MANDATE

- This program is authorized by Section 520 (b) (14) of the Public Health Service Act.

FUNDING

FY '94 Appropriation

$ 7,000,000*

This program is funded from the 5 percent set-aside from the Block Grant for Community Mental Health Services.

STATUS

- MHSIP now supports 53 grants. Awards are staged into 3 types: Implementation Grants - Stage I: For states/territories not previously funded; Implementation Grants - Stage II: For states/territories completing the implementation process; and Decision Application Grants: For states/territories to develop and demonstrate the application of MHSIP data to management and policy issues.

- MHSIP also supports the activities of four regional user groups comprised of staff from states in each region.

- MHSIP provides the basis for uniform. comparable statistical information about mental health services to enable broad based research on systems of care and models of care delivery.

NATIONAL REPORTING PROGRAM
FOR MENTAL HEALTH STATISTICS

Division of State and Community Systems Development

THE PEOPLE WE SERVE

- The National Reporting Program collects and reports national statistical information on mental health services and the people who receive them.

- The program provides information to state mental health agencies, national mental health organizations. researchers, academic leaders, other Federal agencies, national media and legislators.

- Examples of uses of data from this program are:

  - Parents seeking background information for a court hearing to place their child in a residential treatment facility.

  - Mental health providers setting up mental health services.

  - The President's Health Care Reform Task Force for formulating initial and projected mental health benefit packages.

  - The U.S. Supreme Court for decisions about continuing SSI benefits for patients in state mental hospitals.

- The program is the only national source of information that focuses on services and clients seen in mental health organizations. It is operated collaboratively with the states, national organizations (NASMHPD, NAPHS, AHA) and local mental health organizations.

MANDATE

This program is authorized by Section 520 (b) (13) of the Public Health Service Act.

FUNDING

FY '94 **Appropriation**

$ 922,000*

This program is funded from the 5 percent set-aside from the Block Grant for Community Mental Health Services.

STATUS

- The NRP is recognized in the mental health field as the authoritative data source on mental health organizations, their staff, finances and clients.

- NRP data are used widely by researchers and cited extensively in the scientific literature.

- Program staff respond directly to more than 2.000 requests for information each year and disseminate about 100,000 copies of publications a year to the mental health field. media, researchers, Federal agencies and others.

- The Center maintains linkages with the fields of alcohol and drug abuse, general health, rehabilitation and justice.

  - Epidemiological data on mental disorders are coordinated with the National Center for Health Statistics, the NIMH and the Office of Applied Studies within SAMHSA;

  - Projects are underway with the Rehabilitation Services Administration (Department of Education) to study rehabilitation data on people with mental disabilities;

  - An interagency agreement is in place with the Health Resources and Services Administration (Department of Education) to collect and analyze information on psychiatric nurses and nurse practitioners; and

  - Data items have been included in a Department of Justice survey on probationers. The NRP recently completed a survey of state prisons, and is conducting a survey of mental health services in local jails.

- NRP initiatives focus on modernizing the data collection system and expand-ing coverage to provide an even more comprehensive look at mental health services.

- The NRP is looking at interorganizational linkages among providers that comprise systems of care outside traditional mental health settings and at models of care within each of these systems.

- The NRP also is testing the feasibility of conducting surveys within the consumer self-help and juvenile justice systems.

CMHS
Center for Mental Health Services

PROTECTION AND ADVOCACY
PROGRAM FOR INDIVIDUALS
WITH MENTAL ILLNESSES

Division of State and Community Systems Development

THE PEOPLE WE SERVE

An elderly female state hospital resident, with a long history of mental illness, assaultive and aggressive behavior and multiple psychiatric hospitalizations contacted her state Protection and Advocacy (P&A) agency. She complained about her care and treatment and requested assistance in returning home. Prior to her hospitalization, she lived in a rural community as a ward of the public guardian. P&A contacted the guardian and explained the woman's needs and wishes.

A case manager was assigned and a discharge plan was formulated with the participation of the woman, her guardian and appropriate community services providers. Although she was granted a trial visit to a transitional community residential facility in her home community, the woman was denied placement because of the number of stairs she would have to climb. P&A intervened again and insisted on reasonable accommodations in her community. The woman was placed in the facility . . . on the groundfloor.

- Congress has found that people with mental illnesses are vulnerable to abuse and serious injury and subject to neglect, including lack of treatment, appropriate nutrition, clothing, health care and discharge planning. Congress also has found that state systems to monitor compliance with individuals' rights vary and often are inadequate.

- Congress established the P&A Program to protect the rights of people with mental illnesses and to investigate incidents of abuse or neglect. P&A programs do not provide care; they are required to be independent of any organization providing mental health care, treatment or services in the state.

- P&A programs are authorized to provide services to individuals who have a significant mental illness or emotional impairment as determined by a mental health professional and who are inpatients or residents in public or private residential facilities that provide care or treatment for people with mental illnesses. Residential facilities that discharge people without ensuring appropriate housing, follow-up treatment or support services may be subject to P&A actions.

- People who have been discharged from such facilities in he last 90 days also are eligible for P&A services.

- Most P&A program clients are residents of public psychiatric facilities.

MANDATE

- Public Law 99-319, the Protection and Advocacy For Individuals with Mental Illness (PAIMI) Act (42 U.S.C. 10801 et seq.) authorizes formula grant allotments to be awarded annually to P&A systems designated by the governor of each state to protect the rights of, and advocate for, people with disabilities.

FUNDING

FY '94 Appropriation

$21,957,000

STATUS

- P&As engage in administrative, legal (individual and class action), systemic and legislative activities. Each P&A system sets its own policies and priorities for the services it provides. These priorities are subject to annual public review.

- There are 56 P&A systems, one in each of the 50 states, and one in the District of Columbia, the Virgin Islands, Puerto Rico, Guam, American Samoa, and the Commonwealth of the Northern Mariana islands. Forty-three are private, not-for-profit organizations and the rest are state government agencies or special departments.

- In FY '92, PAIMI programs served 20,739 clients to address 30,552 complaints concerning abuse, neglect and rights violations; 35 class action suits were filed with 181,935 clients named; 49,175 information/referral requests were handled; and 83,699 mental health administrators, legislators, clients of the mental health system, their family members and other community groups benefitted from public education and training activities.

- PAIMI programs work cooperatively with public and private mental health care and service providers and administrators; legal, court and law enforcement personnel; state legislative bodies; mental health consumer/ex-patient, family and other mental health advocacy organizations; and state housing, health care, transportation, education, welfare and other social services providers.

CMHS

Center for Mental Health Services

Office of the Director

**THE PEOPLE
WE SERVE**

- Up to 1.5 million people in the U.S. are living with HIV infection. Based on Centers for Disease Control and Prevention criteria, more than 330,000 people have been diagnosed with AIDS. More than 194,000 have already died. In every one of these cases, there are mental health consequences for the patient, friends and families, and a stress on the health care and support systems.

- A special Center HIV/AIDS training program supports education for traditional mental health care providers -- psychiatrists, psychologists, nurses, social workers and marriage and family counselors; other first line providers of mental health services -- medical students and primary care physicians; and nontraditional providers such as members of the clergy and other spiritual providers, alternative health care workers and counselors.

- The Center also is supporting the development and expansion of programs to provide mental health services for individuals, their families and others who experience severe psychological distress as a result of positive HIV antibody testing, and to provide mental health services for people with HIV/AIDS.

MANDATE

- The Center's HIV/AIDS training program is authorized by Section 303 of the Public Health Service Act.

- The Center's AIDS Demonstration Program is authorized under Sections 520B and 501 of the Public Health Service Act.
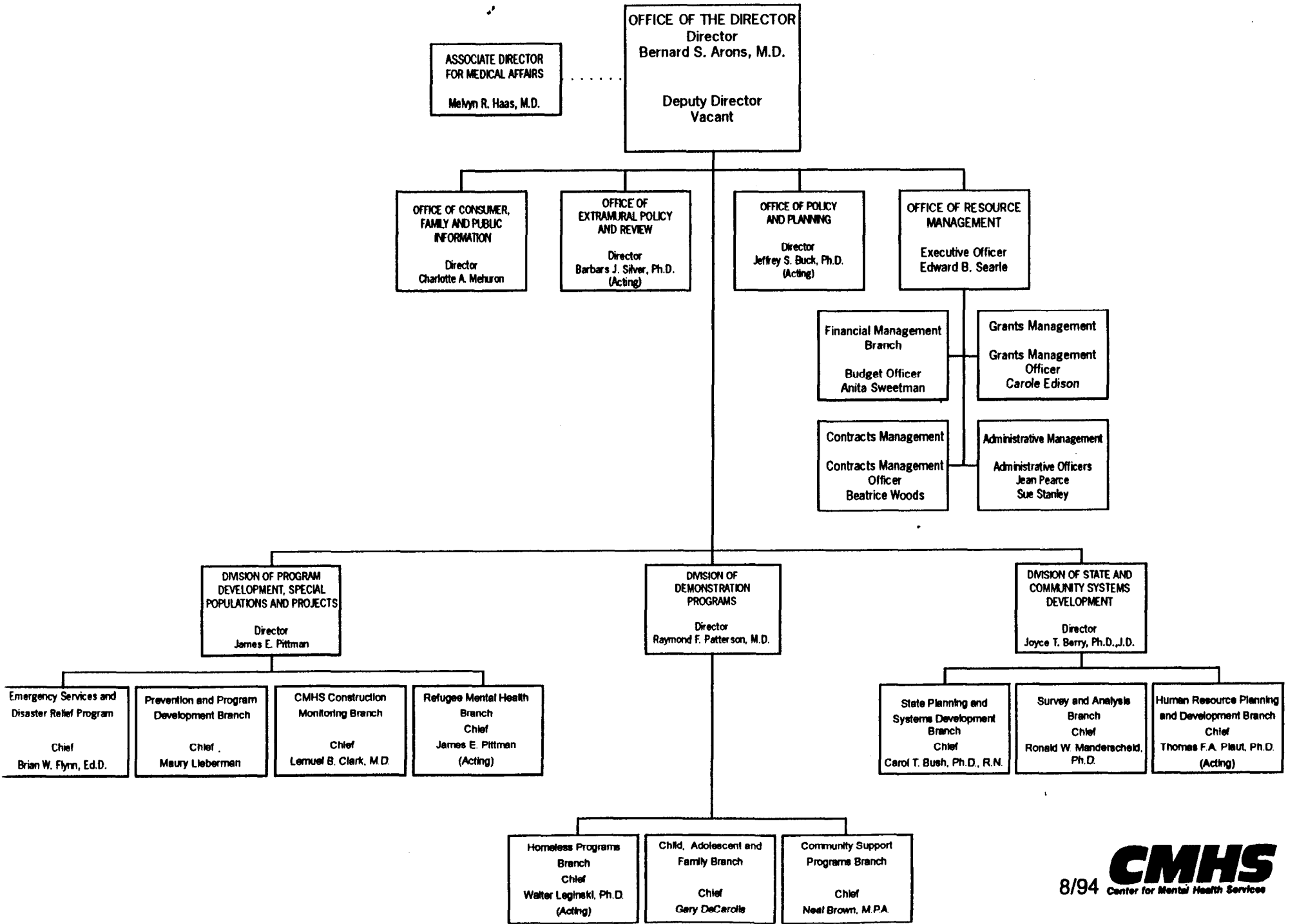
FUNDING

FY '94 Appropriation	
Mental Health Care Provider Education in HIV/AIDS	$2,943,000
HIV/AIDS Mental Health Services Demonstration Program	$1,500,000

STATUS

- Since 1986 more than 98,000 psychiatrists, psychiatric nurses, psychiatric social workers, psychologists, marriage and family counselors, medical students and residents, and support services groups, such as clergy, police and alternative health care providers, have been trained.

- In FY '93 CMHS funded 12 grants and two contracts to provide education and training for more than 14,000 mental health care, primary health care and support services providers.

- Twice a year, CMHS holds a grantees' meeting to update information and techniques.

CMHS
Center for Mental Health Services

OFFICE OF THE DIRECTOR
Director
Bernard S. Arons, M.D.

Deputy Director
Vacant

ASSOCIATE DIRECTOR FOR MEDICAL AFFAIRS
Melvyn R. Haas, M.D.

OFFICE OF CONSUMER, FAMILY AND PUBLIC INFORMATION
Director
Charlotte A. Mehuron

OFFICE OF EXTRAMURAL POLICY AND REVIEW
Director
Barbara J. Silver, Ph.D.
(Acting)

OFFICE OF POLICY AND PLANNING
Director
Jeffrey S. Buck, Ph.D.
(Acting)

OFFICE OF RESOURCE MANAGEMENT
Executive Officer
Edward B. Searle

- Financial Management Branch
  Budget Officer
  Anita Sweetman

- Grants Management
  Grants Management Officer
  Carole Edison

- Contracts Management
  Contracts Management Officer
  Beatrice Woods

- Administrative Management
  Administrative Officers
  Jean Pearce
  Sue Stanley

DIVISION OF PROGRAM DEVELOPMENT, SPECIAL POPULATIONS AND PROJECTS
Director
James E. Pittman

- Emergency Services and Disaster Relief Program
  Chief
  Brian W. Flynn, Ed.D.

- Prevention and Program Development Branch
  Chief
  Maury Lieberman

- CMHS Construction Monitoring Branch
  Chief
  Lemuel B. Clark, M.D.

- Refugee Mental Health Branch
  Chief
  James E. Pittman
  (Acting)

DIVISION OF DEMONSTRATION PROGRAMS
Director
Raymond F. Patterson, M.D.

- Homeless Programs Branch
  Chief
  Walter Leginski, Ph.D.
  (Acting)

- Child, Adolescent and Family Branch
  Chief
  Gary DeCarolis

- Community Support Programs Branch
  Chief
  Neal Brown, M.P.A.

DIVISION OF STATE AND COMMUNITY SYSTEMS DEVELOPMENT
Director
Joyce T. Berry, Ph.D., J.D.

- State Planning and Systems Development Branch
  Chief
  Carol T. Bush, Ph.D., R.N.

- Survey and Analysis Branch
  Chief
  Ronald W. Manderscheid, Ph.D.

- Human Resource Planning and Development Branch
  Chief
  Thomas F.A. Plaut, Ph.D.
  (Acting)

8/94 **CMHS**
Center for Mental Health Services

	FY 1995 President's Budget	FY 1995 Amended Budget	FY 1995 House Mark	FY 1995 Senate Mark
Mental Health Services				
Mental Health Demonstrations	—	—	—	—
Community Support Program (CSP)	24,402	24,050	24,184	24,184
Homeless Demonstrations	21,419	21,109	21,227	21,227
AIDS Demonstrations	1,500	1,478	1,487	—
Subtotal Demonstrations	47,321	46,637	46,898	45,411
Children's Mental Health Services	35,000	34,492	60,000	35,000
Protection and Advocacy	21,957	21,685	21,760	21,957
PATH Formula	29,462	29,096	29,197	29,462
Clinical Training and AIDS Training	—	—	—	—
Clinical Training	2,500	2,454	2,451	2,451
AIDS Training	2,943	2,889	2,943	2,943
Subtotal, Training	5,443	5,343	5,394	5,394
Mental Health Block Grant	277,919	274,573	275,420	275,420
TOTAL CMHS	417,102	411,826	438,669	412,644

8/94

The Center for Mental Health Services supports and encourages the involvement of consumers and family members in the design, implementation and evaluation of care. Consumers of mental health services and their families offer a unique perspective on what must be done, how well it is being done and how services can be improved.

The Center has a broad legislative mandate. With respect to consumers, the Center is directed to:

- Develop improved methods of treating individuals with mental health problems and assisting their families;

- Promote policies and programs at Federal, State, and local levels and in the private sector that foster independence and protect the legal rights of persons with mental illnesses;

- Conduct services-related assessments, including evaluations of self-help and consumer-run programs and rural mental health care; and

- Establish a clearinghouse for mental health information to assure the widespread dissemination of information to a variety of audiences, including the general public concerning the practical application of research that is applicable to improving the delivery of services.

The Center has a range of activities to address these legislative mandates and facilitate consumer and family involvement in the mental health system.

ADULTS

CMHS supports projects and activities to foster the development of consumer self-help and family support groups and enhance their involvement in planning, providing and evaluating mental health and support services.

Demonstration Projects

- The Center funded 13 three-year service demonstration projects to implement and evaluate a variety of consumer-run programs, including offices of consumer affairs at the state level; clubhouses; drop-in centers; "model" testing; transition/linkage services between state hospitals and

communities; and consumer-run service programs and consumer-controlled non-profit corporations that began client-operated businesses.

- Three research demonstration projects -- in California, New York and Pennsylvania -- *are* testing ways to use consumers on case management teams to provide peer and other supports. Preliminary findings indicate that consumers can serve successfully on these teams and provide hopeful models for others.

- Two research demonstration projects -- in Kentucky and Pennsylvania -- are testing approaches for using consumers as providers. The Kentucky project is testing consumer involvement in providing crisis services; the Pennsylvania project is testing consumer involvement in a vocational rehabilitation program.

- Three research demonstration projects -- in Oregon, California and New York -- are testing approaches for using consumers as case managers, providers and researchers. The Oregon project involves using consumers in intensive case management working with individuals with severe mental illnesses, and the California project uses consumers to provide crisis response services as an alternative to involuntary treatment. The New York project also provides crisis response services as an alternative to involuntary treatment, but it is consumer-operated, including the research component.

- A new announcement will be issued in Spring 1994 to support demonstration projects to state mental health agencies to foster the development of consumer and family networks and enhance the involvement of consumers and family members in the policies, programs and quality assurance activities related to state mental health plans and the mental health components of health care reform.

- Grants will also be available to support research demonstration projects to test interventions that help people with severe mental illnesses secure and maintain employment in integrated settings.

Service System Improvement Grants

- Forty-four Service System Improvement grants to state mental health agencies are enhancing the involvement of family members and consumers in all aspects of mental health systems though family support and consumer self-help and involvement initiatives. Funds support staffing, travel, conferences, materials, training and advocacy efforts.

<u>ACCESS (Access to Community Care and Effective Services and Supports</u>

● The Center is funding nine states to test, improve and evaluate the availability, quality and comprehensiveness of services for homeless persons with mental illnesses. ACCESS is a five-year national demonstration program developed by HHS and HUD, working with the Departments of Labor, Veterans Affairs and Agriculture.

● The Connecticut project, for example, will utilize peer counselors. Two different approaches for providing outreach and case management services to African-American consumers in New Haven and to Latino consumers in Bridgeport will be tested.

● The Pennsylvania project will test two different approaches for providing outreach and case management services to consumers in West and Center City Philadelphia. The core service team in the West Philadelphia site is comprised entirely of consumers.

<u>Other Projects</u>

● CMHS is supporting a project, conducted by the Boston University Center for Psychiatric Rehabilitation, to develop and test an evaluation methodology for consumer-run drop-in centers. Preliminary findings indicate that most consumers use self-help as an adjunct to formal services, and find it useful in forming a community-based social support system.

<u>National Self-Help Technical Assistance Centers</u>

● CMHS supports national technical assistance self-help centers in Philadelphia, Pa., and Lawrence, Mass. The National Mental Health Consumers' Self-Help Clearinghouse in Philadelphia concentrates on technical assistance for initiating consumer-run programs and changing systems; the National Empowerment Center *in* Lawrence focuses on individual empowerment, client perspectives and recovery. Both centers maintain toll-free telephone numbers, provide information and consultation and develop resource materials.

Technical Assistance Resource Materials

● CMHS produces technical assistance materials on topics ranging from developing and operating consumer-run/peer support programs and preparing proposals to encouraging client "system" perspectives and developing strategies for system change.

<u>Conferences</u>

● The Center has supported nine annual national "Alternatives Conferences" convened by and for consumers of mental health services. The next conference is scheduled to be held in Los Angeles in August 1994.

<u>Other Family Support Activities</u>

● Several CMHS-funded projects have focused on outreach to minority families and training *sessions* for family leaders in every state.

● In an effort funded by CMHS and the U.S. Department of Education, Boston University and Thresholds Research Institute Rehabilitation Research and Training Centers are investigating family burdens and coping mechanisms.

● Through a model called the Planned Lifetime Assistance Network (PLAN), parents, siblings and others are helped in planning for the future care of their family members. The Center has supported the development of materials and will support training for family groups across the country.

● The Journey of Hope program funded by the Center offers "train the trainer" family education classes in 14 states and has established support groups in seven states. Family members are taught how to teach others the knowledge and skills to assist family members with severe mental illness. New programs involve African-American, Hispanic and Native American groups.

<u>CHILDREN</u>

<u>Child, Adolescent, and Family Branch Statewide Family Network Grants</u>

● Twenty-eight Service System Improvement grants to family-run organizations are helping to develop or expand statewide networks that provide support and information to families of children and adolescents with serious emotional disturbances. Examples of network activities include developing support groups; disseminating information and technical assistance through clearinghouses, maintaining toll-free telephone numbers, information and referral networks, and newsletters; sponsoring conferences and workshops; outreach activities; serving as liaison with various human services agencies; developing skills in organizational management and financial independence; and training and advocacy for children's services. Several of

these projects focus on the needs of ethnic minorities and rural families.

SPECIAL POPULATIONS

- The critical issues for improving the delivery of culturally competent treatment and assessing the state-of-the-art of service delivery for ethnic minority and rural populations have been identified. CMHS maintains a dialogue with representatives of consumer organizations serving African-American, Asian, Pacific Island, Hispanic and Native American populations. Asian, Pacific Island, Hispanic and Native American populations.

- Consumers are involved in program development activities to improve access to and quality of community-based treatment. For example, CMHS staff have met with the American Association of People *of* Color Mental Health Consumers for this purpose.

- In a special effort to improve the access and quality of care in the Pacific Islands, the Center supported a conference to link consumer and family members with Asian and Pacific Island mental health services providers.

Homeless Persons

- CMHS was the lead Federal agency on the Federal Task Force on Homelessness and Severe Mental Illness, and provides coordination and oversight for the implementation of 58 action steps to promote systems integration, outreach, access, housing options and alternative services. Consumers and family members were actively involved in guiding the deliberations of the task force.

- CMHS supports the National Resource Center on Homelessness and Mental Illness, a clearinghouse with information and technical assistance for consumers, families and providers.

- CMHS is supporting a conference in late March 1994 in Seattle, Washington; "Fitting the *Pieces* Together: Integrating Mental Health Treatment, Supports and Housing for Homeless Persons with Severe Mental Illnesses." Consumers and family members helped to plan the conference, and have been included as panelists and presenters in every concurrent session and in the majority of the plenary sessions.

POLICY MAKERS AND RESEARCHERS

Consumer/Survivor Research and Policy Workgroup

● Comprised of researchers and policy analysts who are former or current consumers/survivors of mental health services, this CMHS Workgroup seeks to foster significant roles for consumers/survivors in all phases of mental health research, data standards development, planning, policy and implementation of mental health services. The group has influenced state mental health data collection activities by ensuring that consumer-driven outcome measures and people-oriented data are included. The group has expanded its focus to the national mental health research agenda, emphasizing the kinds of research funded, and research design, focus and outcome measures used.

Consumer/Survivor focus Group On Mental Health Outcomes

● The Center supports the continuing development of consumer/survivor focus groups on mental health outcomes through several special meetings, including one on concept mapping* and one on outcomes, health care reform and the mental health "report card," which are organized by the Consumer/Survivor Mental Health Research and Policy Work Group.

*Concept mapping explores a range of conceptual and interpretational maps, which are useful tools in theory making and measurement by consumers/survivors. The use of these maps in outcome measurement and the implications for their integration into the mental health "report card" on health care reform are of particularinterest.

EVERYONE

● As a matter of policy, a consumer or family member is invited to participate on every community mental health center construction grant monitoring site visit. Indeed, consumers or family members participated in 80 percent of the 405 site visits completed between August 1, 1990 and January 31, 1994.

● The Center has held ~~five forums~~ in Los Angeles, Calif.; Lincoln, Neb.; Nashville, Tenn.; Portland, Ore.; and Albany, N.Y.; to get information from rural and urban consumers, families and providers for the Center's strategic planning process.

- The Emergency Services and Disaster Relief program is a cooperative effort of CMHS, the Federal Emergency Management Agency and the U.S. Public Health Service. CMHS staff coordinate support for direct counseling services to the victims of major disasters, such as the Northridge earthquake, the Midwest floods, Hurricane Andrew, Hurricane Hugo and the bombing of the World Trade Center.

Protection and Advocacy

- The Center funds the Protection and Advocacy Program in 50 states, the District of Columbia and five territories to protect the rights of consumers in or recently out of residential facilities and to investigate incidents of abuse and neglect.

Community Mental Health Services Block Grant

- Through the Community Mental Health Services Block Grant to states and territories, CMHS supports comprehensive, community-based services for adults with serious mental illnesses and children with serious emotional disturbances.

- Consumers and family members are legislatively mandated as part of the mental health block grant application process and review through participation in Mental Health Planning Councils in each state and territory.

- Five Mental Health Block Grant Regional Technical Assistance Meetings are planned for Fiscal Year 1994. Three of these meetings have already occurred; one in Silver Spring, Md.; one in Raleigh, N.C.; and one in Virginia Beach, Va. Consumers and family members are involved in planning, presenting and participating in these meetings.

- A technical assistance meeting for members of the State Mental Health Planning Councils, which will include participation by consumers and family members, will take place on March 15-16, 1994 in Baltimore, Md.

3/8/94

CMHS
Center for Mental Health Services

Office of the Director

THE PEOPLE WE SERVE

The Center for Mental Health Services has a FY 1994 budget of $417 million. CMHS awards grants to state, community and academic organizations to support and improve the provision of mental health services. The Center supports both formula and discretionary grants, including the Community Mental Health Services Block Grant, its largest program.

Formula (nondiscretionary) grants are available to states or state-designated agencies to support legislatively defined activities. Discretionary grants generally are open to a broader field of potential applicants, but in any year, a large share of the budget supports the continuation of existing projects.

FUNDING

Formula Grant Programs | **FY 1994 Budget**

Community Mental Health Services Block Grant	$278 million
Projects for Assistance in Transition from Homelessness	$ 29 million
Protection & Advocacy for Mentally Ill Individuals	$ 22 million

Discretionary Grant Programs

Comprehensive Community Mental Health Services for Children	$ 35 million
Community Support Programs/Child and Adolescent Service System Program Demonstrations	$ 24 million
McKinney Homeless Demonstrations (ACCESS)	$ 21 million
Clinical Training	$ 3 million
HIV/AIDS Professional Training	$ 3 million
HIV/AIDS Demonstration Program	$ 2 million

The FY 1994 budget includes a substantial increase for the Children's Mental Health Services initiative over the FY 1993 appropriation and a new line item for an HIV/AIDS Mental Health Services initiative.

STATUS

Several grant programs were announced competitively in FY 1993, including a new mental health services program for children with a serious emotional disturbance and a new demonstration program to promote ACCESS (Access to Community Care and Effective Services and Supports) to care for homeless people with co-occurring mental illnesses and substance use disorders. The Child and Adolescent Service System Program made new services demonstration awards, and the Community Support Program continued previous awards.

Requests for Applications (RFAs) and Program Announcements (PAs) explain eligibility requirements and include program requirements, the specific nature of the program and application procedures. In most cases, grant authorities limit awards to public and nonprofit private agencies. All CMHS RFAs and PAs are published in *the Federal Register.* In addition, the Center tries to make these available through the communication networks of state and local mental health agencies and other organizations.

For more information about the programs of the Center for Mental Health Services, contact the Office of Consumer, Family and Public Information.

PREVALENCE

- More than 48 million Americans have a mental disorder in a single year. (NIMH & CMHS, 1993)

- During the course of any given year, while more than 40 million adult Americans are affected by one or more mental disorders, 5.5 million Americans are disabled by severe mental illnesses. (NIMH, 1990)

- Estimates of the number of children who have mental disorders range from 7.7 million to 12.8 million. (CMHS, 1993)

- Less than 20 percent of the children under age 18 with a serious emotional disturbance receive mental health services. Often, the services are inappropriate. (Children's Defense Fund)

- An estimated 16.2 million Americans -- 8.8 percent of the population -- experience phobias. About 6.4 million -- 3.5 percent -- live with major depression. Some 2.9 million have obsessive compulsive disorder; 1.8 million have schizophrenia; 1.7 million have panic disorder; and 1.1 million experience manic depression. (NMHA, 1993)

- At least two-thirds of elderly nursing home residents have a diagnosis of a mental disorder such as major depression. (NIMH, 1990)

- Up to 25 percent of the populations with AIDS will develop AIDS-related cognitive dysfunction. Two-thirds of all people with AIDS will develop neuropsychiatric problems. (Mental Health Liaison Croup, 1993)

- A majority of the 29,000 Americans who commit suicide each year are believed to be mentally ill. Suicide is the eighth leading cause of death in the U.S. and the third leading cause of death among people aged 15 to 24. (NIMH)

- Nearly one-third of the nation's estimated 600,000 homeless individuals are believed to be severely mentally ill adults. (CMHS, 1992)

- More than 1 in 14 jail inmates has a mental illness. Twenty-nine percent of the nation's jails routinely hold people with mental illnesses without any criminal charges. (National Alliance for the Mentally Ill and Public Citizens Health Research Croup, 1992)

ECONOMIC COSTS

- Mental illnesses impose a multibillion dollar burden on the economy each year. Total economic costs amounted to $147.8 billion in 1990. More than 31 percent of those costs -- $46.6 billion -- are for anxiety disorders. (The Economic Burden of Affective Disorders, Dorothy P. Rice, Sc.D., and Leonard S. Miller, Ph.D., 1993)

- Direct costs - expenditures for professional health care for persons suffering from mental disorders, including care in mental specialty institutions, hospitals and nursing homes, physician and other professional services and prescription drugs -- accounted for $67 billion, or 11.4 percent of all personal health care expenditures in 1990. (Rice and Miller, 1993)

- Three independent studies between 1971 and 1985 found that mental health costs remained relatively constant during the past 20 years, ranging from 9 to 11 percent of direct treatment costs for health care. (Bazelon Center for Mental Health Law, 1993)

- Direct treatment and support costs comprise 45.3 percent of the total economic costs of mental disorders. The value of reduced or lost productivity comprise 42.7 percent of the total economic costs of mental disorders. Mortality costs comprise 8 percent and other related costs, including expenditures for criminal justice, the value of lost time due to incarceration and an imputed value for caregiver services, comprise 4 percent. (Rice and Miller, 1993)

- Morbidity costs - the value of goods and services not produced because of mental disorders - amounted to $63.1 billion for all mental disorders in 1990. Morbidity costs for anxiety disorders account for $34.2 billion; for schizophrenia, $10.7 billion. The morbidity costs for anxiety disorders reflect their prevalence in the population and the high rate of lost productivity. (Rice and Miller, 1993)

- Mortality costs -- the current value of lifetime earnings lost by all who died in 1990 because of mental disorders -- amounted to $11.8 billion in 1990. (Rice and Miller, 1993)

- Other related costs - the costs indirectly related to the treatment and lost productivity of people with mental disorders -- amounted to $6 billion in 1990. (Rice and Miller, 1993)

- The cost of mental health services is not a significant factor in rising costs of health care in the U.S. Mental health, combined with substance abuse treatment, ranks 25th in order of factors that influence the rise in health care costs in the U.S. (Modem Health Care's Compendium of Cost Factors)

FUNDING

- The mental health system relies on a high proportion of funds from public sources rather than private insurance and out-of-pocket payments. In 1990, 28 percent of funds for mental health care came from state and local governments. In general health care, the comparable figure was 14 percent. Medicare, Medicaid, VA and other Federal programs accounted for an additional 26 percent. (National Advisory Mental Health Council)

STAFF CONTACTS

CMHS
enter for Mental Health Services

OFFICE OF THE DIRECTOR

Director	Bernard S. Arons, M.D.	443-0001
Deputy Director	Vacant	
Associate Director for Medical Affairs	Melvyn R. Haas, M.D.	443-2120

CMHS HIV/AIDS Program

Program Management Officer	Elaine D. Corrigan, M. Sp.	443-7817

Office of Consumer, Family and Public Information

Director	Charlotte A. Mehuron	443-2792

Office of Extramural Policy and Review

Director (Acting)	Barbara J. Silver, Ph.D.	443-7883

Office of Policy and Planning

Director (Acting)	Jeffrey A. Buck, Ph.D.	443-2440

Office of Resource Management

Executive Officer	Edward B. Searle	443-0000
Budget Officer	Anita M. Sweetman	443-7983
Contracts Management Officer	Beatrice L. Woods	443-0043
Grants Management Officer	Carole Edison	443-4456

DIVISION OF DEMONSTRATION PROGRAMS

Director	Raymond F. Patterson., M.D.	443-3606

Child, Adolescent and Family Branch

Chief	Gary De Carolis, M.Ed.	443-1333

Community Support Programs Branch

Chief	Neal Brown, M.P.A.	443-3653

Homeless Programs Branch

Chief (Acting)	Walter A. Leginski, Ph.D.	443-3706

DIVISION OF PROGRAM DEVELOP- MENT, SPECIAL POPULA- TIONS AND PROJECTS	Director	James E. Pittman	443-2940
	CMHC Construction Monitoring Branch Chief	Lemuel B. Clark, M.D.	443-4113
	Emergency Services and Disaster Relief Branch Chief	Brian W. Flynn, Ed.D.	443-4735
	Prevention and Program Development Branch C h i e f	Maury Lieberman	443-7790
	Refugee Mental Health Branch Chief (Acting)	James E. Pittman	443-2940

DIVISION OF STATE AND COMMUNITY SYSTEMS DEVELOP- MENT	Director	Joyce T. Berry, Ph.D., J.D.	443-7710
	Human Resource Planning and Development Branch Chief (Acting)	Thomas F.A. Plaut, Ph.D.	443-5850
	State Planning and Systems Development Branch Chief	Carol T. Bush, Ph.D., R.N.	443-4257
	Protection and Advocacy Section Chief	Natalie Reatig	443-3667
	Survey and Analysis Branch Chief	Ronald W. Manderscheid, Ph.D.	443-3343

Mental Illness Awareness Week, 1993

By the President of the United States of America

A Proclamation

Almost 50 million Americans have serious emotional disorders or illnesses. The economic and human costs of these disorders are staggering. Treatment expenses and lost productivity cost the United States over one hundred billion dollars a year. The pain and suffering caused by mental illness are immeasurable for the individuals afflicted and their families.

The consequences of untreated mental illnesses and emotional disturbances are clear. Suicide is 39 times more common among people who are clinically depressed than among the general population. Persons with mental illness often live in poverty and are at risk for homelessness and disease. The mentally ill may find themselves in jail or prison, not for any criminal act, but rather because no other facilities are available to respond to psychiatric emergencies.

Research has led to major advances, not only in the development of treatments for mental illnesses, but also in the understanding of the needs of the individuals who live with mental illnesses. With appropriate care and support, many people who have these disorders can live productive and fulfilling lives. Unfortunately. less than one-third of all individuals in need of mental health services actually receive appropriate care. Children, probably the most vulnerable among the mentally ill population. are the least likely to receive care, with less than one-fifth of those in need of services receiving them. The barriers to effective treatment are numerous. Individuals may be unaware that treatment can help them or may be hesitant to seek help for fear of discrimination or ridicule. In many instances, individuals actually lack access to appropriate services. We must work to remove the stigma of mental illness and to educate the public about the availability and effectiveness of mental health treatment.

The Center for Mental Health Services (CMHS), a component of the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services. was created in 1992 to provide vigorous Federal leadership in the development and delivery of mental health services. CMHS plays a unique role in working with other Federal agencies and departments whose programs and policies affect the lives of the mentally ill, their families, and their communities. CMHS also works closely with State and local governments and the private sector to guarantee continuity, integration of services, and access to comprehensive systems of care. CMHS supports policy studies, evaluations, and assessments on service delivery issues that are critical for Federal, State, and local policymakers as they organize and finance systems of care.

In recognition of the importance of improving the delivery of mental health services and of educating the American public about the needs of individuals with mental illness, the Congress, by Senate Joint Resolution 61, has designated the week of October 3 through October 9, 1993, as Mental Illness Awareness Week.

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, do hereby proclaim the week beginning October 3, 1993, as Mental Illness Awareness Week. I call upon all citizens of the United States to observe this week with ceremonies and activities to increase the Nation's understanding and acceptance of people with mental illness and to encourage recognition of their need for a broad array of treatment services.

IN WITNESS WHEREOF, I have hereunto set my hand this fifth day of October, in the year of our Lord nineteen hundred and ninety-three. and of the Independence of the United States of America the two hundred and eighteenth.

William J Clinton

PUBLICATIONS

... national leadership for treatment and prevention of mental illnesses

To order single courtesy copies of CMHS: publications, please, complete and return the form on the last page.

CHILD, ADOLESCENT AND FAMILIES

CA 00-0202   The Epidemiology of Childhood Psychiatric Disorders: Prevalence Findings from Recent Studies. Brandenburg, N.A.; Friedman, R.M.; and Silver. S.E. *Journal of the American Academy of Child and Adolescent Psychiatry.* Volume 29, 1990, pages 76-83.

CA 00-0550   Children's Mental Health: Challenges for the Nineties. Duchnowski, A.J. and Friedman, R.M. *Journal of Mental Health Administration.* Volume 17, 1990. pages 3-12.

CA 00-0551   Examining the Research Base for Child Mental Health Services and Policy. Burns, B. and Friedman, R. *Journal of Mental Health Administration,* Volume 17, 1990, pages 87-98.

CA 004803   Family Functioning and Psychopathology Among Adolescents with Severe Emotional Disturbances. Prang. M.E.; Greenbaum P.E.; Silver, SE.; Friedman, R.M.; Kutash. K.; and Duchnowski. A.J. *Journal of Abnormal Child Psychology,* Volume 20, 1992, pages 83-102.

CA 00-0821   The Alternatives to Residential Treatment Study: Initial Findings. Duchnowski. A.J.; Johnson, M.K. ; Hall, K.S.; Kutash, K.; and Friedman, R.M. *Journal of Emotional and Behavioral Disorders,* Volume 1, 1993. pages 17-26.

CA 00-0826   Children in Residential Treatment - Policies for the '90s. Yelton, S. *Children and Youth Services Review,* Volume 15, 1993, pages 173-193.

CA 00-0900   Developing Comprehensive Systems for Troubled Youth: Issues in Mental Health. Duchnowski. A.J. and Kutash. K. Chapter in. *Shakedown Symposium II: Developing Comprehensive System for Troubled Youth,* 1993.

COMMUNITY SUPPORT

CS 00-0001   Exemplary **Practices** in Employment Services for People with Psychiatric Disabilities, 1994.

CS 00-0002   Training for the Future, 1993.

CS 00-0003   First National Conference: The Journey of Native American People with Serious Mental Illness. April 14-16. 1993, Executive Summary.

CS 00-0004   Proceedings of Roundtable Discussion on the Use of Involuntary Interventions: Multiple Perspectives. 1992.

CS 00-0005   Psychiatric Crisis Response Systems: A Descriptive Study, 1994.

CS 00-0006   Providing Community Support for People with Severe Mental Illness: A Demonstration of the Possibilities, 1993.

CS 00-0007   A Working Life: The Individual Placement and Support (IPS) Program, 1993.

CS 00-0008   Case Studies on Reasonable Accommodations for Workers with Psychiatric Disabilities, 1993.

CS 00-0009   Profiles of Psychiatric Crisis Response Systems, 1991.

CS 00-0010   Psychosocial Rehabilitation Journal - Special Issue: Serving Persons with Dual Disorders of Mental Illness and Substance Use, Volume 15, Number 2, October, 1991.

OM 00-4054   Community Support Systems: For Persons With Long-Term Mental Illness: Questions and Answers, 1988.

OM 00-4014   Crisis Residential Services in a Community Support System, August 1987.

CONSUMER/SURVIVOR

DSCSD 15   A Critique by a Fall-1993 Subcommittee of the Consumer/Survivor Mental Health Research and Policy Work Group of Mental Health Statistics Improvement Program - Current Status and Future Directions, May 1992.

DSCSD 16   A Report for the State Mental Health Agency Profiling System: Mapping Mental Health Outcomes from the Perspective of Consumers/Survivors, Technical Report Series. NASMHPD Research Institute, Inc., 1993.

DSCSD 17   Humanizing Decision Support Systems, Consumer/Survivor Mental Health Research and Policy Work Group, October, 1993.

DSCSD 18   Mental Health Consumer/Survivor Outcome Research Proposal. Consumer/Survivor Outcomes Task Force, Consumer/Survivor Mental Health Research and Policy Work Group, 1992.

DSCSD 19   NIMH Community Support Program Consumer-Operated Services Demonstration Project Summaries.

DSCSD 20   Ethical Dilemmas of the Consumer/Professional.

DSCSD 21   Outcome Assessment in Psychiatric Rehabilitation Services for Persons with Severe and Persistent Mental Illness, 1992.

DSCSD 22   Toward a Working Model of Outcome Measures For the Public Welfare Domain, NIMH Workshop, 1992.

DSCSD 23   A Review of Measures in the Clinical Domain for Research on Persons with Severe and Persistent Mental Disorders, The Rand Corporation, 1992.

DSCSD 24   Measures of Humanistic Outcomes (Quality of Life) Among Persons with Severe and Persistent Mental Disorders, University of Maryland, 1992.

CONSUMERISM ARTICLES

DSCSD 31   Consumerism is Not a Fad. Bevilaqua, J.J. **Resources: Workforce Issues in Mental Health Services,** Volume 5, Spring, 1993, pages 1-2.

DSCSD 32   Human Resource Association & National Association of Consumer/Survivor Mental Health Administrators: Preliminary Thoughts On Best Practices for Establishing State Offices of Consumer/Ex-Patient Affairs. National Association of Consumer/Survivor Mental Health Administrators, 1993.

DSCSD 33   Reports #l, #2. Consumer/Survivor Mental Health Research and Policy Work Group, 1992

DSCSD 34   From Lab Rat to Researcher: The History, Model and Policy Implications of Consumer/ Survivor Involvement in Research. Fourth Annual National Conference on State Mental Health Agency Services Research and Program Evaluation Proceedings, October, 1993.

DSCSD 35   How to Assure Quality of Services. The Ninth Annual Rosalynn Carter Symposium on Mental Health Policy, November, 1993.

DSCSD 36   The National Empowerment Center Newsletter, Spring, 1994.

DSCSD 37   The Audio Tape Catalogue of the National Empowerment Center, Spring, 1994.

EMERGENCY AND DISASTER ASSISTANCE

ADM 87-1422   Disaster Work and Mental Health: Prevention and Control of Stress Among Workers, 1987.
ADM 87-0537   Field Manual for Human Service Workers in Major Disasters, 1987.
ADM 90-1505   Human Problems in Major Disasters: A Training Curriculum for Emergency Medical Personnel, 1990.
ADM 90-1390   Innovations in Mental Health Services to Disaster Victims, 1990.
ADM 86-1070   Manual for Child Health Workers in Major Disasters, 1986.
ADM 90-1496   Prevention and Control of Stress Among Emergency Workers: A Pamphlet for Team Managers, 1990.
ADM 90-1497   Prevention and Control of Stress Among Emergency Workers: A Pamphlet for Workers, 1990.
ADM 90-0538   Training Manual for Human Service Workers in Major Disasters, 1990.

HEALTH CARE REFORM RECOMMENDATIONS BY CONSUMER WORKGROUPS

DSCSD 25   Looking with New Eyes: Towards a New Methodological Rigor, Research Designs in Housing and Support Services. The Ninth National CSP Learning Community Conference. The Well-Being Programs, Inc.

DSCSD 26   Recommendations for National Mental Health Care, Support Coalition International.

DSCSD 27   Health Care Reform Ought To and Can Enhance Consumer Choice, Power and Knowledge, Consumer/Survivor Mental Health Research and Policy Work Group, 1993.

DSCSD 28   The Altered State, Newsletter of Altered States of the Arts, Volume I: Issue II, February, 1992.

DSCSD 29   Commissioners Guidance Questionnaire Survey Results. Virginia Mental Health Consumers
            Association. 1992.

DSCSD 30   Mental Health Care System Reform - A Consumer Empowerment Perspective of Health Care
            Reform, 1993.

HOMELESSNESS AND MENTAL ILLNESS

HM 00-0001   Creating Community: Integrating Elderly and Severely Mentally Ill Persons in Public Housing,
               1993.

HM 00-0002   Blueprint for a Cooperative Agreement Between Public Housing Agencies and Local Mental
               Health Authorities, 1994.

HM 00-0003   Integrating Mental Health and Substance Abuse Services for Homeless People with
               Co-occurring Mental and Substance Use Disorders, 1993, Ridgely, S. and Dixon, L.

HM 00-0004   Working for Change: Employment of Consumers/Survivors in the Design and Provision of
               Services for Persons Who Are Homeless and Mentally Disabled, 1993, Tosh, L.V.; Finkle,
               M.; Hartman, B.; Lewis, C.; Plumlee, L.A.; and Susko, M.A.

HM 00-0005   Outcasts on Mainstreet: Implementation Report, 1992, Milstrey, S.E.; Lezak, A.D; and
               Dennis, D.L.

HM 00-0006   Making a Difference -- Interim Status Report of the McKinney Research Demonstration
               Program for Homeless Mentally Ill Adults, 1994.

HUMAN RESOURCE DEVELOPMENT

SMA 93-2003   Child Mental Health in the 1990s: Curricula for Graduate and Undergraduate Professional
               Education, 1993.
OM 00-0503   Workforce Training and Development for Mental Health Systems, 1993.
OM 00-0504   Report to Congress on Mental Health Clinical Training Program Payback Requirement, 1993.
OM 00-0506   Strategies for Public Mental Health Workforce Development, 1993.

MENTAL HEALTH ADMINISTRATION, EVALUATION, POLICY AND SERVICES

ADM 87-1300   An Introduction to Automated Mental Health Information Systems and Their Acquisition,
               1987.
ADM 82-1134   Consultation Liaison Psychiatry: Evaluating Its Effectiveness, 1982.
ADM 92-0214   A Consumer's Guide to Services, 1992 (A joint publication with the National Institute of
               Mental Health)
ADM 90-1707   Mental Health Directory, 1990.
OM 00-4063   Information Packet on Use of Mental Health Services by Children and Adolescents, Updated
               1993.
OM 00-0500   Mental Health Statistics Improvement Program (MHSIP) Updates, Spring, 1994.
SMA 92-1942   Mental Health, United States, 1992.

MENTAL HEALTH DATA AND STATISTICAL INFORMATION

Series AN

No. 1   The Assessment of Psychopathology and Behavioral Problems in Children: A Review of Scales Suitable for Epidemiological and Clinical Research (1967-1979). ADM 83-1037.

Series BN   <u>Needs Assessment and Evaluation</u>

No. 8   Needs Assessment: Its Future. ADM 88-1550.

Series CN   <u>Mental Health National Statistics</u>

No. 12   Specialty Mental Health Organizations, United States, 1986. ADM 90-1700.
No. 13   State and County Mental Hospitals, United States and Each State, 1986. ADM 90-1706.
No. 14   Specialty Mental Health Organizations, United States, 1988. ADM 91-1820.

Series DN   <u>Health/Mental Health Research</u>

No. 3   Coordinated Mental Health Care in Neighborhood Health Centers, 1983. ADM 83-0996.
No. 7   Overview of Mental Health Practices in Primary Care Settings, With Recommendations for Further Research. 1986. ADM 86-1467.

Series FN   <u>Information Systems</u>

No. 1   Automated Management Information Systems for Mental Health Agencies: A Planning and Acquisition Guide, 1980. ADM 80-0797.
No. 2   Guidelines for a Minimum Statistical and Accounting System for Community Mental Health Centers, 1980. ADM 80-0014.
No. 3   A Cost-Effectiveness Methodology for Community Mental Health Centers, 1981. ADM 81-0767.
No. 4   A Client-Oriented System of Mental Health Service Delivery and Program Management: A Workbook and Guide, 1980. ADM 80-0307.
No. 6   Accounting and Budgeting Systems for Mental Health Organizations, 1983. ADM 83-1046.
No. 8   The Design and Content of a National Mental Health Statistics System, 1983. ADM 83-1095.
No. 10   Data Standards for Mental Health Decision Support Systems, 1989. ADM 89-1589.

Series HN   <u>Occasional</u>

No. 3   A History of the United States National Reporting Program for Mental Health Statistics, 1840-1983. ADM 86-1296.

Series MR   <u>Miscellaneous Reports</u>

No. 12   Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States 1990. MR-00-0012.
No. 14   Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States 1991. MR-00-0014.
No. 15   Additions and Resident Patients at End of Year, State and County Mental Hospitals, by Age and Diagnosis, by State, United States 1992. MR-00-0015.

MENTAL HEALTH STATISTICAL NOTES

REFUGEE MENTAL HEALTH

VIDEOS

OM 00-4064   Hospital Without Walls (1993)

An in-depth introduction to the Programs for Assertive Community Treatment, which is a community-based service approach that helps people with severe mental illnesses remain in their own homes, control symptoms and become contributing members of their community.

OM 00-4065   Making The Numbers' Work For You

This videotape is about 25 minutes long and chronicles the development of a system for gathering statistical information on services for persons with mental illness. It provides the viewer with a better understanding of how and why the Federal Government, in collaboration with the states, goes about collecting this much-needed information.

OM 00-4066   Faces In The Fire: One Year Later

This 34 minute videotape includes interviews with survivors of a major fire at various intervals following the disaster. Survivors describe, in their own words, the emotional impact and their recovery from trauma.

OM 00-4067   Hurricane Blues

This 13 minute videotape drama demonstrates the impact of a disaster on a family. A brief instructive segment follows as an example of how any local crisis counseling could add a "trailer" to highlight their specific program on disaster.

OM 00-4069   Children and Trauma (The School's Response)

A 30 minute training videotape developed by a California crisis counseling project for use with school and mental health workers. The tape outlines key concepts of disaster mental health services for elementary school children.

OM 00-4070   Voices of Wisdom (Seniors Cone with Disaster)

Developed by the County of San Bernardino, California
Counseling Ordinary People in Emergencies, The Earthquake Recovery Project (COPE)
Spanish speaking version also available.

CENTER FOR MENTAL HEALTH SERVICES
CHECKLIST

ADM	SERIES	STATISTICAL NOTES	OM
__ 90-0537	__ AN-1 83-1037	__ SN-189	__ 00-4014
__ 90-0538		__ SN-190	__ 00-4054
__ 86-1070	__ BN-8 88-1550	__ SN-191	__ 00-4063
__ 82-1134		__ SN-192	
__ 87-1300	__ CN-12 90-1700	__ SN-193	__ 00-0500
__ 90-1390	__ CN-13 90-1706	__ SN-194	__ 00-0503
__ 87-1422	__ CN-14 91-1820	__ SN-195	__ 00-0504
__ 90-1496		__ SN-196	__ 00-0506
__ 90-1497	__ DN-3 83-0996	__ SN-197	
__ 90-1505	__ DN-7 86-1467	__ SN-198	CA
__ 91-1824		__ SN-199	
__ 92-0214	__ FN-1 80-0797	__ SN-200	__ 00-0202
__ 90-1707	__ FN-2 80-0014	__ SN-201	__ 00-0550
	__ FN-3 81-0767	__ SN-202	__ 00-0551
DSCSD	__ FN-4 80-0307	__ SN-203	__ 00-0803
	__ FN-6 83-1046	__ SN-204	__ 00-0821
__ 15	__ FN-8 83-1095	__ SN-205	__ 00-0826
__ 16	__ FN-10 89-1589	__ SN-206	__ 00-0900
__ 17		__ SN-207	
__ 18	__ HN-3 86-1296	__ SN-208	HM
__ 19		__ SN-209	
__ 20	CS	__ SN-210	__ 00-0001
__ 21		__ SN-211	__ 00-0002
__ 22	__ 00-0001	__ SN-212	__ 00-0003
__ 23	__ 00-0002	__ SN-213	__ 00-0004
__ 24	__ 00-0003		__ 00-0005
__ 25	__ 00-0004	SMA	__ 00-0006
__ 26	__ 00-0005		
__ 27	__ 00-0006	__ 92-1942	VIDEOS
__ 28	__ 00-0007	__ 93-2003	
__ 29	__ 00-0008		__ 00-4064
__ 30	__ 00-0009	MR	__ 00-4065
__ 31	__ 00-0010		__ 00-4066
__ 32		__ 00-0012	__ 00-4067
__ 33		__ 00-0014	__ 00-4069
__ 34		__ 00-0015	__ 00-4070
__ 35			
__ 36			
__ 37			

RETURN TO:
Center for Mental Health Services
Office of Consumer, Family and Public Information
5600 Fishers Lane, Room 13-103
Rockville, Maryland 20857

NAME:_____

ORGANIZATION:_____

ADDRESS:_____

CITY: _____ STATE:_____ ZIP CODE: _____

TELEPHONE: _____ FAX: _____

CMHS
Center for Mental Health Services

CLEARINGHOUSES

. . . national leadership for treatment and prevention of mental illnesses

Office of Consumer, Family and Public Information, Center for Mental Health Services, 5600 Fishers Lane, Room 13-103, Rockville, Maryland 20857 ■ (301) 443-2792
U.S. Department of Health and Human Services ■ Public Health Service ■ Substance Abuse and Mental Health Services Administration

The following Clearinghouses are supported by the Center for Mental Health Services. Services may include technical assistance, information and referral, on-site consultation, training, library services, publications, annotated bibliographies, etc. Many services are available free of charge, but in some cases, charges are applicable.

1. Children and Adolescent Service System Program (CASSP) Technical Assistance Center
    Georgetown University Child Development Center
    3307 M Street, NW
    Washington, DC 20007-3935
    Phone: (202) 687-5000
    FAX: **(202) 687-5034**

    o   Information packets, issue briefs and monographs on children and adolescents with serious emotional disturbances
    o   Conferences and training institutes on planning, delivery and financing of services
    o   Consultation on systems change and services development and delivery
    o   Agency and organization collaboration

2. National Mental Health Consumer's Self-Help Clearinghouse
    311 South Juniper Street, Suite 1000
    Philadelphia, Pennsylvania 19107
    Phone: (800) 553-4539
    FAX: (215) 735-0275

    o   Information and referral
    o   On-site consultation
    o   Training events - project development including teleconferences and national conferences
    o   Consumer library

3. National Empowerment Center
    20 Ballard Road
    Lawrence, Massachusetts 01843
    Phone: (800) 769-3728
    FAX: (508) 681-6426

    o   National directory of mutual support groups, drop-in centers and state-wide organizations
    o   Networking and coalition building
    o   Workshops, public speaking and training to providers

4   National Resource Center on Homelessness and Mental Illness
262 Delaware Avenue
Delmar, New York 10254
Phone: (800) 444-7415
FAX: (518) 439-7612

    o   Information packet on financing services for homeless persons with mental illnesses
    o   Annotated bibliographies - standard and specialized database searches
    o   Organizational referral list - includes listing of 80 Federal agencies and national organizations

5.   Rehabilitation and Research Training Center
Boston University Psychiatric Rehabilitation Center
730 Commonwealth Avenue
Boston, Massachusetts 02215
Phone: (617) 353-3550
FAX: (617) 353-7700

       Research and training for psychiatric rehabilitation
       Short-term consultation
       Information and referral services through an electronic bulletin board

6.   Research and Training Center for Children's Mental Health
Florida Mental Health Institute
University of South Florida
13301 Bruce B. Downs Boulevard
Tampa, Florida 33612-3899
Phone: (8 13) 974-4657
FAX: (813) 974-4436

       Epidemiological and service system research
       Annual research conference

7.   Research and Training Center on Family Support and Children's Mental Health
Regional Research Institute of Portland State University
P.O. Box 751
Portland, Oregon 97207-0751
Phone: (503) 725-4040
FAX: (503) 725-4180

       Research and training focused on family support issues, family-professional collaboration and diverse
         cultural groups
       Training of professionals to provide community-based services

Mrs. Gore Visits Drug Treatment Program

Earlier this summer Tipper Gore-wife of the Vice President-visited a SAMHSA-funded alcohol and drug addiction treatment program in Lemon Grove, CA, and asked participants to tell her "what works. and what we need to do more of in this country." Mrs. Gore has been the leading Clinton Administration advocate for persons with mental and addictive disorders.

At the San Diego County "Options for Recovery" residential treatment program for pregnant and parenting women. she heard participants describe their attempts to stop using drugs and what had helped them succeed.

The 40-bed program. funded in part through SAMHSA's Substance Abuse Prevention and Treatment Block Grant. is a therapeutic community which provides an alternative to inpatient hospitalization and allows children to remain with their mothers. Twelve beds are reserved for the "Project Hope" program which specifically serves African-American women and their children.

The program's services include alcohol

Tipper Gore meets participunts at the San Diego County "Options for Recovery" program in California.

and other drug education. individual and group counseling. relapse prevention. nutrition education, prenatal education. and parenting classes. Other services include prenatal care and onsite child development activities.

In their discussion with Mrs. Gore. the women emphasized the importance of having a safe living situation, away from readily available street drugs and potentially abusive relationships.   The women also expressed their wish to keep their children with them. both during and after treatment.

According to San Diego County Alcohol and Drug Program Administrator Joan Friedenberg. the county's Perinatal

Services division achieved a 91 percent drug-free birth rate in a total of 345 births in 1993-1994.

Mrs. Gore, who had gone to San Diego to address the annual meeting of the National Association of State Alcohol and Drug Abuse Directors, told delegates, "Financial evidence continues to mount proving what we have all known for a long time-alcohol and other drug abuse treatment is cost effective and affordable."

She added that treatment saves money. "For every dollar invested in treatment, we save about $7.00 in police. prisons, welfare, and extra health care costs. These figures can not be ignored," she said.

-Deborah Goodman ∎

Dr. Nelba Chavez Confirmed as SAMHSA Administrator

Nelba R. Chavez, Ph.D., was confirmed as the new Administrator of the Substance Abuse and Mental Health Services Administration by unanimous consent of the United States Senate on July 14.

Dr. Chavez had been director of Juvenile Probation Services for the City and County of San Francisco since January 1991.

Prior to that she served a 14-year tenure as clinical director, then executive director and chief operating officer of La Frontera Center, Tucson, AZ, a comprehensive community mental health center providing mental health, drug abuse and alcoholism services.

From 1989 to 1991 she headed Chavez and Associates, a firm providing training in behavioral health and substance abuse prevention for community organizations and in developing mental health programs for Hispanics.

She has served on the U.S. Senate Hispanic Advisory Committee. the President's National Council on the Handicapped the Task Force on Community Support Systems of the President's Commission on Mental Health, the Board of Directors of the National Coalition of Hispanic Mental Health and Human Service Organizations. and the Tucson Mayor's Task Force on Children, among many other advisory and policy groups.

Dr. Chavez earned the Ph.D. degree in Social Work in 1975 from the University of Denver. She also holds an M.S.W. from the University of California at Los Angeles. and a Bachelor's degree from the University of Arizona in sociology/psychology.

SAMHSA News will have an interview with Dr. Chavez in the next issue. ∎

David Mactas Named CSAT Director

Department of Health and Human Services Secretary Donna E. Shalala has announced that David J. Mactas, M.A., president of one of the oldest and largest drug and alcohol treatment agencies in New England, will be the new Director of the Center for Substance Abuse Treatment.

Mr. Mactas has been president of Marathon. Inc. of Providence, RI, since 1976. From 1973-1976, he served as assistant commissioner of the New York City Addiction Services Agency, an agency responsible for funding and coordinating drug prevention and treatment efforts in the city.

"During David Mactas' tenure, Marathon became an innovator and leader in the drug and alcohol treatment field," said Secretary Shalala. "I am confident he will bring similar leadership and innovation to CSAT and to the continued improvement of alcohol and other-drug abuse treatment services and their availability throughout the Nation."

Marathon House, where Mr. Mactas has served as president for 18 years, provides residential and outpatient treatment. medical detoxification, substance abuse crisis intervention. emergency shelter and residential treatment programs for adolescents, and substance abuse education and prevention programs for prison inmates and parolees through its criminal justice programs.

Mr. Mactas received his bachelor's degree in psychology from City College of New York in 1966 and his master's degree in psychology from the New School for Social Research, New York, in 1971.

He served as president of the Therapeutic Communities of America from 1984 to 1988. ●

Statistics Paint The Picture of Mental Health

When health care reform became a national priority in 1993, the Nation began a spirited debate about the pros and cons of President Clinton's proposed plan and what it would mean for all Americans.

While Congress has been sorting through a daunting array of alternatives and options, one of the most controversial issues continues to be the extent and cost of coverage for mental health treatment.

For many mental health policy analysts seeking to document the impact of the array of plans, the data and statistical analyses provided by staff within SAMHSA's Center for Mental Health Services (CMHS) have become the "mother lode."

The Survey and Analysis Branch within the CMHS Division of State and Community Systems Development has been collaborating with staff from the National Institute of Mental Health to help the President's Task Force on Health Care Reform provide answers to questions at the heart of mental health care:

- What are the implications of the various health care reform proposals for mental illness prevention and care?
- How much will it cost to cover mental health treatment for all Americans?
- How would people with severe mental illness who are homeless fare under the President's proposed plan? Would those people, who are often unable to deal adequately with many activities of daily living, be able to take advantage of universal mental health coverage?

Task Force members realized that they could use already existing statistical data to make informed projections.

But where do these data come from? In 1840, the U.S. Census Bureau conducted the first survey of persons with mental illness and mental retardation and continued to conduct surveys until 1946, when responsibility shifted to the U.S. Public Health Service. In fact. no Federal activi-
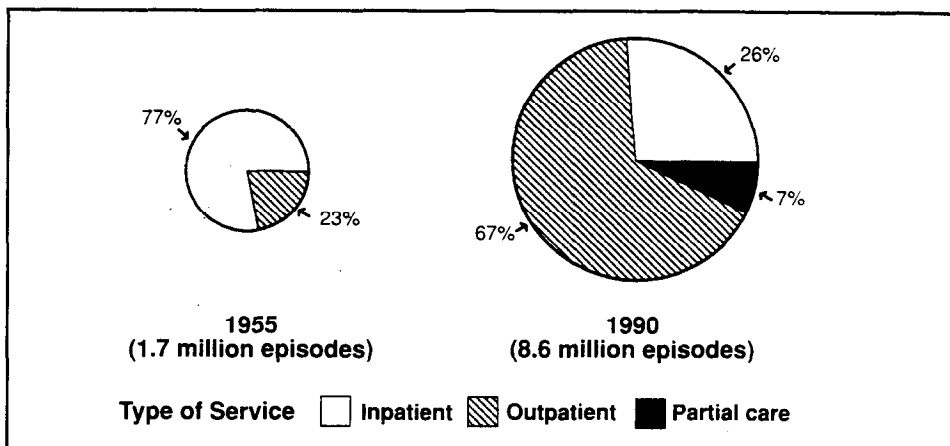

Figure 1. Patient care episodes in mental health organizations in 1955 and 1990

ty charged with gathering health statistics can trace as long a lineage. (See article, "History of Mental Health Data Collection," p. 4.)

Today, the CMHS Survey and Analysis Branch is principally responsible for the Federal effort in painting the picture of the mental health services infrastructure and the clients it serves.

Ronald W. Manderscheid Ph.D.. Chief of the CMHS Survey and Analysis 'Branch, said the data both reflect past trends in treatment of mental disorders and help forecast the future state of treatment as it evolves under the process of health care reform.

In fact, mental health statistics may not only reflect trends but may also contribute to the development of health care policy in treatment of mental disorders over time.

Statistics and Trends

The experience of the Survey and Analysis Branch confirms the value of consistent long-term surveys. In the comprehensive report. *Mental Health. United States,* 1992, the Branch documented the great shifts in mental health care trends between 1955 and 1990.

Trend: Inpatient to Outpatient Care

In the 1950s mental health care began to change from predominately inpatient

care to outpatient care. The same period saw a sharp increase in Federal expertise and interest in statistical descriptions of persons with severe mental illness who were then largely residents of State mental hospitals. When the statistics became widely accessible in the mid- 1950s, public discussions about the treatment of persons with serious mental illness began to be influenced by hard data.

It is impossible to trace all the influences on the decisions to cut back on inpatient treatment for persons with mental illness-what came to be called "deinstitutionalization." However. along with the emergence of effective medications for mental disorders, and media coverage of the poor treatment of mentally ill patients in hospitals, the availability of accurate public data may very well have been a contributing factor.

A comparison of statistics collected in 1955 with those of 1990 reveals the shift from inpatient to ambulatory care (Figure 1). In 1955, of a total 1.7 million episodes' in the U.S., 77 percent were

---

[1] *The episode count included every new admission plus the number of patients at the start of the year. This meant that a single patient could have been represented as more than one episode and in more than one institution.*

inpatient episodes and 23 percent outpatient.

By 1990, the number of patient care episodes in organized settings had quintupled to 8.6 million episodes, but only 26 percent were inpatient while outpatient episodes jumped to 67 percent-almost ,a reversal of the data gathered 35 years earlier. A new category, partial care, accounted for 7 percent of the 1990 total.

Change in Organizations Providing Care

Data from these same years also show a change in the type of organizations providing care (Figure 2).

In 1955, 63 percent of the inpatient episodes occurred in State and county mental hospitals; but by 1990, the proportion had plummeted to only 16 percent.

By contrast, psychiatric inpatient services in general hospitals and private psychiatric hospitals, which accounted for only 21 and 9 percent respectively, of the inpatient episodes in 1955, rose to 44 and 22 percent by 1990.

These data, along with data from related social and economic trends, raise many policy questions:

- Should State mental hospitals be closed, maintained, or even expanded?
- Is there a proper balance between community-based and State mental hospital services. and if so. who should decide?
- What should be the roles of inpatient and ambulatory services in treatment?
- Should inpatient services be contracted out?

The Current Program

Almost all the work of the CMHS Survey and Analysis Branch is carried out in two programs: the National Reporting Program for Mental Health Statistics (NRP), and the Mental Health Statistics improvement Program (MHSIP).

History of U.S. Mental Health Data Collection

The history of mental health data collection began more than 150 years ago with a single question on the U.S. Census of 1840. That one question, regarding what were then called "the insane and idiotic," marked the first attempt to measure the extent of mental illness and mental retardation in the United States.

From 1850 until 1910 the Bureau of the Census counted the number of persons with mental illness during each decennial census. The count resumed in 1923 and continued annually from 1925 to 1946. During the latter period, efforts to standardize classification of mental illness made possible the inclusion of "diagnosis" as a category for describing patients.

In 1946, Congress created the National Institute of Mental Health (NIMH), which assumed responsibility for conducting annual censuses of patients in public and private mental hospitals and in psychiatric wards in 1947.

In 1951, NIMH developed a Model Reporting Area (MRA) for Mental Hospital Statistics, whose role was to help establish statistical uniformity across the States. By 1954, NIMH had added a nationwide reporting program for outpatient psychiatric clin-

its, with data collection focusing on the staffing, patients, services, and geographical distribution of the clinics.

In 1969, NIMH replaced the annual census with simpler and shorter sample surveys to collect data on overall admissions and discharges, as well as more specific information broken down by type of patient care and type of facility.

Because the MRA succeeded in coordinating data gathering among 11 State mental health agencies, expanded to 34 States over two decades, NIMH created the more comprehensive and ambitious Mental Health Statistics Improvement Program (MHSIP) in 1976. NIMH stipulated that State participation would be entirely voluntary.

MHSIP, which became a lattice of advisory groups, regional user groups, and State-Federal working groups, was designed to expand and enhance the capabilities of State mental health data systems and to provide uniform definitions and content for statistical data.

In 1992, when the Center for Mental Health Services (CMHS) was created within the newly formed Substance Abuse and Mental Health Services Administration, CMHS became responsible for collecting and evaluating mental health data as part

of its broader mandate to improve mental health services. Now a part of CMHS, the Survey and Analysis Branch, within the Division of State and Community Systems Development, continues to be responsible for the National Reporting Program and MHSIP, and has produced data and analyses without interruption.

Other Public Health Service agencies, especially the National Center for Health Statistics (NCHS), contribute important data that help delineate the national picture.

As Marilyn J. Henderson, M.P.A., Assistant Chief of the Survey and Analysis Branch, noted, "In 1989, NCHS included a special mental health supplement in their epidemiological National Health Interview Survey. We have been working with them since to include mental health items in their core questionnaire."

Ms. Henderson is optimistic that the prior and ongoing discussions will result in NCHS's inclusion of mental health questions, possibly in Fiscal Year 1996. She added, "Data that are collected over time in the same form can be invaluable for trend analyses."

The National Reporting Program

NRP, the data collection arm of the Branch, is responsible for collecting and analyzing national data on mental health organizations (e.g., hospitals, clinics, multiple service centers) and their clients—the patients who use them. The biennial report *Mental Health, United States,* the premier publication of the NRP, is the result of a collaboration of a number of U.S. Government agencies, State mental health agencies, and professional associations. These groups contribute data from their own surveys and other data-collection instruments. The next issue of *Mental Health, United States* is due out later in 1994.

NRP also coordinates a biennial national survey, the "Inventory of Mental Health Organizations and General Hospital Mental Health Services." This data file is based on a comprehensive survey of mental health care-providing organizations and their characteristics, services they provide, staffing, revenues, and expenditures.

In recent years, the NRP has begun to plan the inclusion of data describing the mental health of prisoners, parolees, and residents of juvenile detention facilities. Emphasis on criminal justice survey questions is likely to continue and perhaps grow in the next decade.

Michael J. Witkin, M.A., C.P.A., who is responsible for producing the Inventory of Mental Health Services, points out that the information is used in a large number of ways: to respond to Congressional requests, to cite in Supreme Court briefs, to use in research, to justify State budgets, and to build the current Administration's proposed health care reform plan.

Analysts of the health care proposals under discussion have found this tool particularly useful. Richard Frank, Ph.D., a health economist and professor at The Johns Hopkins School of Public Health, put it this way: "We have estimated how mental health budgets and care would be affected by various health reform propos-
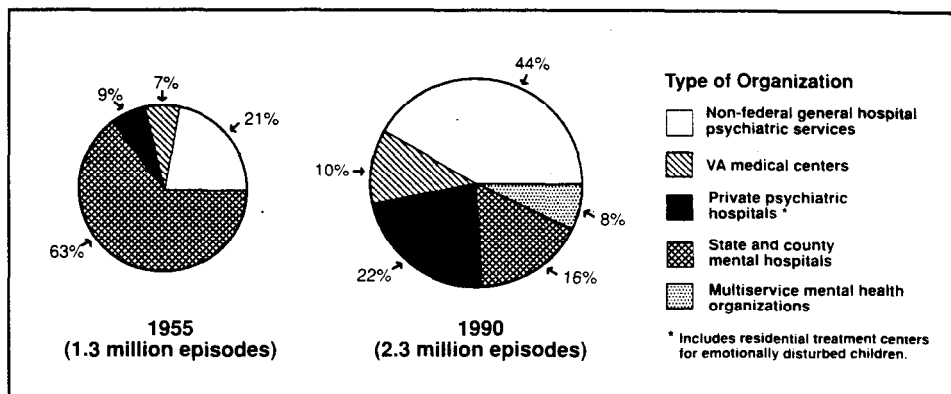

Figure 2. Inpatient and residential treatment care episodes in mental health organizations in 1955 and 1990

als. We relied heavily on the CMHS Inventory of Mental Health Organizations to help track down where we spend our mental health dollars."

NRP also organizes and runs the annual National Conference on Mental Health Statistics, which is attended primarily by State and Federal analysts of mental health data and by mental health policy researchers. The latest conference took place in Washington, DC, in June. The agenda this year focused on measuring the outcomes and economic consequences of health care reform, and on the latest information technology applicable to collecting and analyzing mental health data. (See article, "The 43rd National Conference on Mental Health Statistics," p. 14.)

The Mental Health Statistics Improvement Program (MHSIP)

MHSIP (pronounced 'missip'), the second major component of the Survey and Analysis Branch activities, has been primarily a capacity-building program for the States.

"MHSIP is not a single organizational entity, but rather a community of individuals, organizations, and associations who are actively working towards improving information management capacity to support decision-making in meeting the needs of persons diagnosed with mental disorders," according to the MHSIP

report, *Current Status and Directions for the Future, 1994.*

In a loose sense, within CMHS, MHSIP is the research and development arm of the Survey and Analysis Branch.

State mental health authorities, which are integral elements of MHSIP, support the activities of MHSIP in standardizing the definitions and descriptions of core data to be collected across the Nation.

According to Dr. Manderscheid, "The CMHS philosophy of improving the ability of the States to construct and maintain useful data bases starts with the premise that it is better to know things than not to know them. It is better to be able to compare our knowledge reliably with others than to be unaware of related activities. It is better to do this consensually than by mandate. And it is better to collaborate broadly—with the States, the private sector including academia, and other Federal agencies—than to work in splendid isolation."

MHSIP's comprehensive book of data standards, known as "FN10" in the field, states that MHSIP is expected to "...permit the linkage of data on patients, treatments, human resources, and finances as a standard for mental health service providers."

The FN10 undergoes periodic revision, and new recommendations are being circulated this year. Harlan K. Zinn, M.S.,

1993 Household Survey: "Good and Bad News"

This summer SAMHSA released the results of the 1993 National Household Survey on Drug Abuse which showed:

- No-reportable change in the number of Americans using illicit drugs between 1992 and 1993, when the number of drug abusers stood at 11.7 million.
- The number of persons using cocaine weekly persisted at around a half-million in 1993, showing no sign of abating since 1985.
- Illicit drug use, heavy drinking, and smoking go hand in hand among millions of Americans. Of 11 million heavy drinkers in 1993, 26 percent were also "current" illicit drug users (used within last 30 days). Among 50 million "current" smokers, 12 percent were illicit drug users.

"The news from this survey is both good and bad," according to Health and Human Services Secretary Donna E. Shalala. "It is good because we have sustained the progress made in stemming Americans' use of marijuana. cocaine. and other illicit drugs," she said.

"But the survey also sounds a warning: since 1979, we've seen the number of current users drop, consistently, year after year. Between 1992 and 1993, we saw no such decrease."

Secretary Shalala said the new survey points to the need to focus treatment efforts on longer-term, "hard core" drug abusers. "We must enhance and expand treatment options for so-called chronic hard-core drug abusers if we are ever going to solve America's drug problem."

The survey is carried out annually by SAMHSA's Office of Applied Studies to estimate the prevalence of legal and illegal drug use in the U.S., and to monitor the trends in use over time. It is based on a representative sample of the general U.S. population aged 12 and older.

Shift in Drug Use to Older Age Groups

Although there was no significant change between 1992 and 1993 in rates of illicit drug use for any age group, the rates of "current" drug use have dropped dramatically since 1979 for all groups (12-17, 18-25, and 26-34) except those 35 and older. In 1993, 28 percent of illicit drug users were in the 35 and over group, compared to only 10 percent in 1979. This shift appears to be linked to the aging of the drug using cohorts of the 1970's.

Other 1993 Findings

Marijuana

Marijuana was the most commonly used illicit drug among the survey population. Sixty percent of all current illicit drug users used only marijuana, and an additional 16 percent used marijuana plus one or more other illicit drugs. About 5.1 million persons used marijuana weekly, unchanged since 1991 but down from 8.9 million in 1985.

Cocaine

"Current" cocaine users numbered 1.3 million, the same as in 1992, down from a peak of 5.3 million in 1985. "Occasional" users (less often than monthly) numbered 3 million in 1993. down from 8.1 million in 1985.

Crack

The estimated number of "current" crack users was less than one-half million, with no indication of increases or decreases since 1991.

Other Illicit Drugs

There were no major changes in 1993 in "current" use of inhalants. hallucinogens. or heroin. Estimates of heroin use from the survey are considered very conservative. due to the probable undercoverage of the population of heroin users.
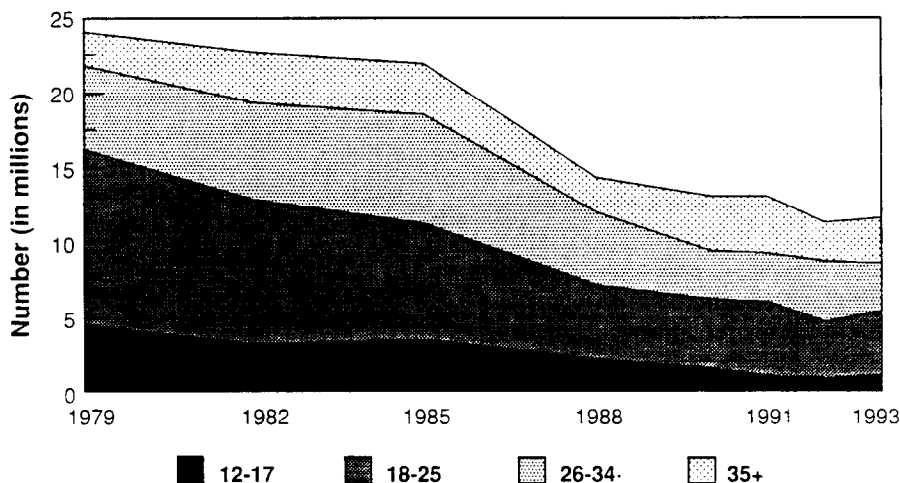
Cigarettes

Current cigarette smokers declined from 26 to 24 percent of the survey population from 1992 to 1993. Decreases were apparent in every age group but 12-17 year olds, which remained at around 10 percent.

Alcohol

In 1993, approximately 103 million persons were "current" drinkers, and 11 million were heavy drinkers (5 or more drinks on 5 or more days in the past 30 days). Neither category had changed significantly from 1992. Of the 11 million heavy drinkers, 26 percent also were current illicit drug users.

Gender, Race

Men continued to have a higher rate (7.4 percent) of illicit drug use than women (4.1 percent). The rate was 6.8 percent for blacks, 6.2 percent for Hispanics, and 5.5 percent for whites. Seventy-four percent of all current illicit

Number of Current Illicit Drug Users, by Age

Community Partnership Brings Prevention to Gloucester

When 13-year-old Lisa Bryant and three of her classmates wanted to pass a city-wide law prohibiting cigarette vending machines in all public places accessible to underage youth. they knew where to turn for help.

In the small fishing community of Gloucester. MA, the Gloucester Prevention Network (GPN). a grantee of SAMHSA's Center for Substance Abuse Prevention (CSAP), helped the girls try to turn their idea into a reality. GPN supplied the girls with information and guidance and helped them write the speech they gave to the city council.

"We had learned a lot about substance abuse from GPN and we wanted to do something for the health of people in our town." Lisa said. "We knew the Gloucester Prevention Network would help us."

In its fourth year now. GPN, sponsored by CSAP's Community Partnership Demonstration Program. has succeeded in getting many Gloucester residents to think about substance abuse. It has done so by encouraging already existing community groups-both formal and informal-to work together to promote substance abuse prevention.

Community Partnership Program

The Community Partnership Demonstration Grant Program supports communities across the Nation in their development of comprehensive programs for substance abuse prevention. The Program began in Fiscal Year 1990 and was developed based on evidence that prevention activities are more likely to be effective, efficient, and long-lasting when associated with community-wide approaches.

CSAP Director Elaine M. Johnson, Ph.D.. said the conceptual framework underlying the community partnership approach is based on three themes:

- Inclusion of all community groups in all prevention efforts;

- Cultural competency-valuing and celebrating the ethnic and cultural diversity of the community; and
- Community empowerment-shifting responsibility for planning and decision making from agencies and professionals to the community.

"At CSAP, this aspect of community empowerment-collaboration and coalition building-underlies everything we stand for." said Dr. Johnson.

"We've been especially pleased with Gloucester's success," said Ruth Sanchez-Way, Ph.D.. Director of CSAPS Division of Community Prevention and Training.

In July 1993, GPN was one of only 11 projects throughout the Nation selected for an exemplary alcohol and other drug prevention program award by CSAP in collaboration with the National Association of State Alcohol and Drug Abuse Directors and the National Prevention Network.

Gloucester

Gloucester is a working class fishing

community of 28.000. located in the northeastern part of Massachusetts. Its population is mixed white-ethnic. with 23 percent of the population of Sicilian background and 12 percent ethnic Portuguese.

Gloucester's heroin use and alcohol consumption are significantly higher than national drug use, according to Carol R. Coles. GPN's Assistant Director.

"Gloucester. as a maritime community. has a history of alcohol and other drug
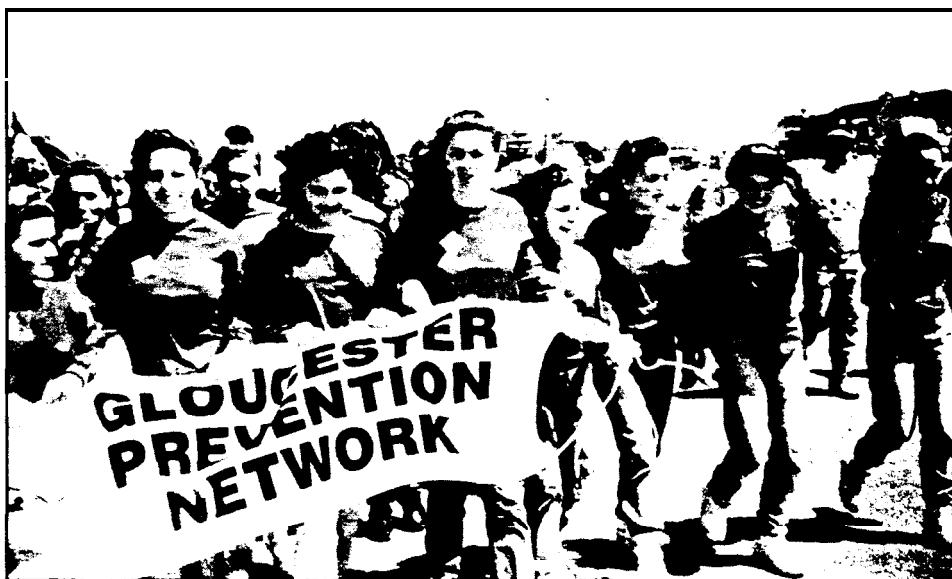
Teenage girls in the Young Women's Coalition participate in the annual "Gloucester Pride Stride." The pledge walk enables the girls to raise friends for community service projects. The Young Women's Coalition is composed of 80 girls ages 12-15 and 20 adult women.

abuse." she said. "The downtown waterfront area has a disproportionate number of bars and fraternal clubs where fishermen and others have customarily gathered to socialize and conduct business transactions."

Also, conservation measures have limited when. where, and what kind of fish may be caught. These limitations have increased the rate of unemployment. she said.

Both factors have contributed to a higher than normal rate of alcohol, tobacco. and other drug USC. Ms. Coles said.

The GPN Approach

According to GPN Director Philip L. Salzman, GPN's ultimate goal is to reduce the use of alcohol. tobacco. and other drugs and the harm that such use causes. GPN seeks to do this by encouraging healthy community "norms," or attitudes about these substances among Gloucester residents. He emphasized that GPN does not preach morals to the community or make community decisions.

"It's been the norm here for kids to drink a lot," said Matt Buchanan, a junior at Gloucester High School. "No one ever taught my age group about alcohol and drugs like GPN is doing with the younger kids now."

GPN's overall approach is to infuse alcohol, tobacco, and other drug prevention values into people's lives by forming linkages between already existing community systems, such as Gloucester's school system, the religious community, and sports organizations. Informal groups, such as neighborhoods. ethnic communities. and extended families, also serve as good linkage points.

"On an average day. kids in this community are encountering prevention practices through many functions of their daily lives, not just from one." said Mr. Salzman. "They're receiving overlapping prevention messages from school. work. the pulpit. the playground the neighborhood and the family. They're starting to receive the message that promoting wellness is what this community wants."

Coalitions formed since the project's inception include: the Aging Network. the Coalition for Young Women. the Young Mothers' Group. the Parent Coalition. the Religious Coalition. the Sports and Recreation Coalition, the Stop Using Nicotine (S.U.N.) Coalition, the

Over 600 youths participate annually in the New Directions Youth Basketball League which provides basic skills, fair play rules, and fun for girls and boys in grade 3-8 (above). One hundredparent-coaches volunteered a total of 3,000 hours to work in five schools with the youth. The Gloucester Prevention Network logo is clearly visible in the upper right hand corner of the tee shirts worn by each boy. At right, high school football players provide pre-season training for young boys in neighborhood teams. In addition to teaching football skills the high school students promote "wellness maintenance" through training about diet and health and instruction in drug use prevention. Their high school coaches provide similar training to the neighborhood sports organizations' volunteer coaches.

Workplace Coalition, Water Safety, and the Young Men's Coalition.

Coalition members and volunteers plan prevention activities, education, and training. They also seek to infuse prevention practices into their ongoing community and social functions.

With over a quarter of Gloucester residents participating in GPN programs or "coalitions," it is the community which keeps the network running. GPN's staff strongly believe GPN would fail if prevention weren't viewed as a group effort.

With its office located on downtown Gloucester's Main Street, and its storefront windows decorated with prevention posters and community notices, GPN is very visible and accessible to people. Residents feel comfortable just walking in any time. When this year's registration for team sports was held at the GPN office, hundreds of residents came by everyday to sign up their children.

GPN has also become a part of the community fabric through publicity in the local media. Articles about GPN-sponsored activities have appeared regularly in the *Gloucester Daily Times.* In a monthly newspaper column entitled 'An Ounce of Prevention," which also runs in the *Times,* Mr. Salzman (assisted by other professionals) answers questions from the community about public health issues and subjects related to the use of alcohol, tobacco, and other drugs. In addition, 15 public service announcements featuring GPN efforts in youth sports activities, boating safety, and other areas and have appeared on local television.

GPN sponsors numerous activities for community youth.

"It seems like there's more stuff for kids *to* do now than before," Matt Buchanan said "and GPN is often the group behind those extra activities, like dances for the younger kids, or concerts for my age group. You know how kids always say they're bored and there's nothing to do where they live? I don't think a lot of kids in Gloucester say that anymore."

PREVENTION NETWORK

Volunteers visit Gloucester schools annually to talk to students about the hazards of drinking, smoking, and doing drugs.

"Everyone listens when they come in. and no one fools around," Lisa Bryant said. "We get the message. I think we started learning prevention early enough for it to have an effect on us."

Sports and Recreation Coalition

One of the most visible and successful Gloucester community initiatives is the Sports and Recreation Coalition. This group has reached many residents because sports in Gloucester is a "life system" enjoyed by all ages.

Over 4.000 Gloucester elementary. middle, and high school boys and girls play on community sports teams. Adults are heavily involved in sports as coaches. volunteers. and parents.

Because community sports involve so many Gloucester residents. the Sports and Recreation Coalition ties much of the community together. Mr. Salzman said. It brings together teams from the Gloucester school system. the local YMCA. eight neighborhood sports groups, Little League, Fisherman Youth Soccer. and the City's Beach & Recreation Department.

On the playing fields, youth from all these teams wear the GPN logo or "patch" on their uniforms. It serves as a reminder to each player, coach. and parent that sports activities are designed to promote

Gloucester's Young Men's Coalition sponsors monthly activities for elementary school-age boys, mostly from single, female-headed households. The annual highlight is a camp-out on an island to which the boys travel by dory—a type of row boat traditionally used by Gloucester fishermen in the past.

the wellness of all participants, and that wellness means not using alcohol, tobacco, and other drugs.

Signs hanging by the sides of the soccer fields and on baseball field backstops display the logo as well.

"I see that GPN logo over and over again." said Matt Buchanan, who plays soccer year-round for Gloucester High School and Fisherman Youth Soccer. "With GPN being such a part of the community, you start to feel like GPN really cares, and that the Prevention Network is a good thing."

The Coalition has established several training and other programs since 1992.

In 1993. the Sports and Recreation Coalition had a significant impact on the Massachusetts Interscholastic Amateur Athletic (M.I.A.A.) substance abuse training, an annual substance abuse prevention program required by the State for all high school athletes. The Coalition restructured the State program to encourage parents, coaches. and teachers, as well as students. to attend.

The Coalition also included overall health and wellness education in addition to substance abuse training. At the last M.I.A.A. training in the fall of 1993, over 400 students participated with their parents and coaches in four workshops with topics of nutrition, injury prevention. coaching, and weight training.

"The workshops showed us the direct relationship between good health and athletic playing ability, which made a big impression on kids," said Matt Buchanan. Particular focus was placed on self-esteem and self-respect, he added.

The Coalition eliminated the serving of alcoholic beverages at youth sports banquets and prohibited adults from smoking during games and practices. GPN impressed upon coaches and parents the importance of good role-modeling.

Agreements between the Coalition and local schools have also made it possible for community teams to practice in school gyms at no cost. The school gyms have thus become community resources, creat-ing a social bond for youth between their outside activities and their schools.

Sports and Recreation coalition members and volunteers also organize health fairs for the community, sports and medicine clinics, and training for adults to integrate coaching activities with substance abuse prevention programs.,

PreventionWORKS!

CSAP Public Health Advisor Dennis A. Wynne, who serves as Project Officer for GPN said "Kids in Gloucester are learning about prevention because they're living it and seeing it."

According to Mr. Wynne, CSAP has made youth empowerment an integral part of the Community Partnership Program. Grantees are encouraged to include young people on their boards and councils, and in other decision-making roles.

For example, GPN formed a Youth Services Commission which was put into place with the help of Gloucester's Superintendent of Schools Howard Goodrow, D.Ed., and former Mayor William Rafter. The Commission advocates solely for the needs of Gloucester's young people and is composed of seven members. two of whom must be high school age youths. The Commission was established under the city's government and is part of the city charter.

Visible Results

GPN developed and administered to high school and middle school students a Youth Survey examining their attitudes and behaviors with regard to tobacco, alcohol, and illegal drug use. The survey has been administered three times between 1990 and 1993, with 844 high school students and 618 middle school students responding to the latest survey.

Recent survey data showed that:

- The percentage of students using three or more substances dropped for all high school grades, particularly grades 11 and 12.

- Use of marijuana continues to decline at every high school grade level. with the exception of 10th grade.
- Students reported that it would be harder for them to obtain illicit drugs than it was in 1992, marking the second year 'in a row that Gloucester students reported a decline in access to drugs.

- Gloucester youth continued a 3-year increase in the number of students who perceive the use of alcohol and tobacco as a health risk.
- Compared to the national average. Gloucester youth's disapproval rating of the use of alcohol, tobacco. LSD and crack/cocaine exceeds that of students from across the country.

Overall. the 1993 GPN Youth Survey and its 3-year comparison reveal a trend of good news: Youth view alcohol, tobacco. and other drugs as more harmful now than in 1990 and are using them less.

Parents were sent a summary of the survey results.

"I think it taught a lot of them what's really going on." Matt Buchanan said. "It taught me, too, about stuff I didn't know was going on."

Apart from statistics, the community prevention approach has demonstrated to residents that they can make a difference in their own communities. On October 8, 1993. in response to efforts by Lisa Bryant and her friends, Gloucester's city council passed a law banning cigarette machines from all public places except bars.

"Gloucester is a very positive place now." said Lisa, speaking of her sense of accomplishment at turning an idea into a city law. "Kids here get the message that it's important to stay healthy and be involved."

-Rosalee Sanchez and Deborah Goodman ∎

Theater Helps Asian Americans in Recovery

Confronting feelings and personal problems is something that does not come easily to many Asian Americans. Later this year. however, four residents of a substance abuse prevention and treatment program will take to the stage and depict thoughts about families and the peer pressure that led to their drug dependency.

What makes this theatrical performance all the more poignant is that the script is drawn from the group's own life experiences.

"The *'I Can Do That Theater'* is our way to use the creative arts to teach our patients how to express themselves," explained Alan Wong, Director of Treatment Services of the San Francisco-based Asian American Recovery Services (AARS), a grantee of SAMHSA's Center for Substance Abuse Treatment (CSAT). "The development of this theater, which is quite extraordinary and touching, makes people sensitive to the issues."

The unorthodox theatrical performances won AARS first place in substance abuse education at the American Film and Video Festival in 1989.

Appearing on stage is therapeutic for both actor and audience, and helps families come to terms with the consequences of substance abuse, according to Mr. Wong. The aim is to address underlying issues that serve as a basis of substance abuse and unhealthy lifestyles in the Asian American community. This includes the absence of physical demonstrations of affection, conflicting expectations of what abusers' duties are to themselves and their families, and the disgrace of not measuring up to rigid standards.

"Ordinarily, outreach is very difficult because of the cultural dynamics within the community," said Mr. Wong. "Theater is a way of making the community more receptive to admitting that a problem exists and saying there is an alternative."

According to Mr. Wong, the shame and stigma associated with drug abuse within the Asian community "have swept the problem under the rug" and made it hard to measure its precise scope.

County-funded drug and alcohol treatment programs documented more than 750 admissions of Asian patient episodes

in the San Francisco metropolitan area from 1991-1992. but Mr. Wong says these numbers belie the epidemic abuse of cocaine. alcohol. and other untracked drugs.

CSAT Project Officer Nancy Ramos-Sayre, who oversees AARS and other treatment programs for racial/ethnic minorities, explained: "When you talk about shame. stigma. and loss of face. it's not just the patient but families who are affected. By the time the individual goes into treatment, the family members know there is nothing more they can to do. They are disgraced. That means the addict loses his standing before the people to whom he is closest."

Residential Treatment

AARS is one of only two therapeutic community programs of its kind in the Nation serving Asians and Pacific Islanders.

A therapeutic community is a residential substance abuse treatment program located in a non-hospital setting. People in the therapeutic community are regarded as members of a family rather than as patients in an institution.

The approach emphasizes group interaction. self-revelation, peer support, personal growth, personal responsibility, and integration within the therapeutic community as precursors to readiness for reintegration within the larger society.

Most referrals to the AARS program come from the criminal justice system. Self-referrals, families, and community-based organizations are less common avenues for patient intakes, but this is changing. Mr. Wong credited the increase in self-referrals to AARS' specialized community outreach service, a newly-funded CSAT project. Its outreach workers seek out abusers in the streets, neighborhoods, and jails.

Theatrical tour de force is just one of many programmatic features that makes AARS distinct.

Patients in the Asian American Recovery Services program, a culturally sensitive substance abuse treatmentprogram, learn tai chi.

The AARS long-term 26 bed residential drug treatment program was established in 1985 primarily to serve Asian American adults over the age of 18. Many of the residents are polydrug abusers whose primary drugs of choice are crack, cocaine,. and alcohol. Mr. Wong said there has been a resurgence in heroin usage and a decline in barbiturates.

The program consists of individual, group. and family counseling, educational seminars, recreational activities, art and drama therapy. and vocational/educational development. It also provides a unique culturally sensitive focus.

"The family and community approach helps patients begin to move back into their own community. which is important as the majority of our patients have been community connected" Mr. Wong said.

The CSAT grant has enabled the residential program to enhance existing services. These include linkages with more than 35 public and private agencies, hospitals, and clinics that provide information and access to primary health care; substance abuse and mental health counseling; assistance in such areas as HIV and tobacco education, assessments and treatment; dental work; and acupuncture.

Counselors are responsible for individual. group, and family counseling. as well as appointment scheduling and other activities. These include devising resources for recreation, educational and vocational activities, and continuing care.

Originally, the CSAT grant provided for a recreational counselor. a resource coordinator, a health coordinator, and a continuing care counselor. However, AARS recently downsized and consolidated various functions because of a desire to operate more efficiently in limited space. It also relies on an auxiliary team of consultants who work on an on-call basis.

A psychiatrist under contract assesses newly admitted residents and participates in case conferences. A consulting nutritionist instructs residents in menu planning, meal preparation. and components of a sensible diet. A recreational therapy

Preparatory to the theater presentation for family and friends, patients in the AARS program attend expressive arts sessions in which their self-understanding deepens through the development of dramatic scenes which depict events from their lives.

segment exposes residents to camping, horseback riding. rafting and ropes courses, fishing. and nature activities.

AARS offers in-house schooling with GED preparation, vocational assessment. computer training, and a family component with bicultural and bilingual capabilities. A consultant conducts parenting skills training classes for patients and provides consultations for staff.

AARS stays in touch with its graduates. Many volunteer their time to participate in camping trips or ethnic festivals. Some work for pay as electricians or plumbers, take current patients out on passes, and provide counseling on an informal basis through their alumni network.

"Before the program expanded we relied on graduates contacting the program at their convenience." said Mr. Wong. "Now, we maintain regular contact and invite them to various activities and

events with current residents."

Evaluation is a critical tool for keeping AARS attuned to its patients and the community. The program compiles data as a basis to refine and improve existing services. A case in point: retention rates for continuing services dropped off after the first year of the CSAT grant.

"We went from a record-breaking retention rate to average. By the third year, our retention track-record was the lowest ever." Mr. Wong said.

AARS subsequently did some major programmatic restructuring that called for downsizing and a different orientation. Treatment retention has been enhanced by culturally oriented care, culturally sensitive psychological assessments, and staff training. Services are now geared to a more economically disadvantaged, less well-educated population with a history of physical and sexual abuse and fewer family and community supports. Within the

last 18 months, the AARS retention track-record doubled and stabilized.

Day Treatment Program

AARS' Asian Drug and Alcohol Prevention and Treatment Project (ADAPT) was established with a CSAT grant in 1993. This intensive day treatment program is designed to serve immigrant Chinese, Filipino, and Vietnamese substance abusers between the ages of 18-64 whose drugs of choice are alcohol and cocaine.

The term "day treatment" is somewhat of a misnomer. Daytime services include vocational development, and counseling services are available at night to accommodate various work schedules. ADAPT has the bilingual and bicultural staff to offer vocational training, substance abuse counseling, health education, and continuing care for patients who speak primarily Mandarin, Cantonese, Tagalog, or Vietnamese.

Through contracts with other service providers, ADAPT is able to provide primary health care, detoxification services, child care, family services, legal assistance, and vocational training.

The vocational training modules consist of English as a second language, hospitality industry service training, computer training with an emphasis on workplace requirements, customer service, job orientation, and basic clerical/computer skills.

"Immigrants come to the United States with the hope of gaining economic opportunities, but, because their language and skills are minimal, they have a hard time obtaining work," said Mr. Wong. "These modules are an avenue to learn job-specific terminology, which is a stepping-stone to the job market."

Mr. Wong is optimistic that AARS will continue to make strides in the treatment arena. Staging theatrical productions and adapting its program to the changing needs of its patients are two of AARS' ongoing outreach efforts designed to set the stage for achieving major breakthroughs in this community.

CSAT also funds four other projects providing treatment to Asians and Pacific Islanders: the Union of Pan Asian Communities, an outpatient demonstration project based in San Diego: the Drug and Alcohol Treatment Association of Rhode Island located in Providence; the Hawaiian Addiction Center In Wai'anae. Oahu, a day treatment program; and the Asian American Drug Abuse Program in Los Angeles.

For additional information about Asian American Residential Recovery Services and other demonstration programs supported by the Center for Substance Abuse Treatment. contact Nancy Ramos-Sayre, (301) 443-6533. ■

CSAP Grantee Wins Silver Apple Award

A grantee of SAMHSA's Center for Substance Abuse Prevention (CSAP) has received the Silver Apple Award from the National Educational and Video Film Festival.

The CSAP grantee, Novela Health Education, has been developing "novelas" (mini-dramas) for health education since 1987. In conjunction with the University of Washington in Seattle, WA, Novela recently created an innovative set of novelas on alcohol abuse and prevention.

La Esperanza del Valle (The Hope of the Valley) tells the story of the Ortegas, a farming community family living in Washington state. They are a hard-working family struggling with alcohol-related problems. Family members include 17-year-old Fernando, his brother Hector.

their mother Celia. and Hector's wife. Sandra. Each 22-minute episode covers many aspects of family life dealing with situations brought about by alcohol and drug consumption.

The novelas, in both English and Spanish, are available in several formats:

- The "telenovela." which uses soap opera serial format and is available as videocassettes for use in schools, churches, and community-based organizations. and on public television;
- The "radionovela," which uses a radio-drama style and is available as audio-cassettes; and
- The "fotonovela,' which uses photos and text in a tabloid comic-book style.

To obtain a copy of the novelas, phone *1-800-677-4799*. ■

The 43rd National Conference on Mental Health Statistics

From May 31st to June 3rd approximately 400 analysts, state mental health administrators, data collectors, and academics met in Washington, DC, to discuss a broad range of issues that seemed to extend beyond the conference title, "mental health statistics." As the names of the sessions and the subjects of the talks implied, the agenda included far more than simply statistics. Indeed, health care reform from the viewpoint of mental health was the leitmotif of the conference.

The audience heard the current status of President Clinton's proposed health care reform plan from Susanne Stoiber, Director of the Office of Health Care Reform in the U.S. Department of Health and Human Services. Ms. Stoiber asserted that, despite the current limitation on mental health benefits in the plan, the Administration will continue to press for mental health coverage that will eventually match that of other illnesses.

In support of "full" coverage of mental health benefits, CMHS Director Bernard S. Arons, M.D., challenged the common assumption that mental health treatments are more costly than those for physical illness-a belief that is one cornerstone of the insurance industry's opposition to reimbursement of mental health costs at a rate identical to that of other illnesses.

In his talk, "The Challenges of Health Care Reform and Future Directions for the Center for Mental Health Services," Dr. Arons also discussed the future of data collection and analysis in the Center. He described the changes that health care reform will bring and how they will create demands for better data on who is being served, where the services are being provided, what is their nature, and how they are being paid for. CMHS will have to answer questions on access and quality, and will need data from Medicaid, Medicare, private health plans and mental health managed care programs.

Dr. Arons reminded participants that these changes must be made during a period when no new dollars are available for data activities and staff are decreasing. Difficult decisions will need to be made that reflect choices based on limited resources.

Nevertheless, CMHS plans to forge a new national data effort ultimately reflecting consumer needs and benefits, with assistance from all sectors of the mental health community.

"Person-Centered care" was discussed often by many speakers, but perhaps Ann Loder, past chair of the Consumer/Survivor Mental Health Research and Policy Work Group, and "a survivor of mental health services" in her own words, best summed up its meaning. To her, person-centered care means responding humanely to people who are diagnosed and labeled as having mental disorders. She observed that all people, including those who encounter the mental health system, want to be treated humanely. According to Ms. Loder, for some people in mental institutions, even sensitive, caring human contact cannot undo the deep dullness caused by years of neglect.

Much of the rest of the conference dealt with questions that relate more directly to data collection and statistics. Several speakers discussed measures of project and program evaluation especially outcome measures.

who facilitates the program, said the book is viewed as the "foundation of MHSIP."

Since the late 1980s. MHSIP has helped build greater data collection, analysis, and design capacity within all the States. States are continuing to upgrade their data-collection capacity according to their own needs with the help of 54 ongoing grants from CMHS.

The grant program has two goals: First, to organize the statistical data so that State mental health agencies can respond more quickly and confidently to data requests from the mental health policy and decision makers. Second. to develop better measures for each State to determine how well they are meeting the needs of persons with mental illness. Awards for the latest grants will be made in September.

Joyce T. Berry. Ph.D., Director of the CMHS Division of State and Community Systems Development. emphasized the significance of the MHSIP program as a model in the health care statistics field. Its influence continues to expand she said as evidenced by its incorporation in statistical components of State alcohol and drug abuse programs, in mental health programs of the Indian Health Service. and within countries under the auspices of the World Health Organization.

Looking Ahead

Most recently. the powerful tide of the consumer movement in the mental health arena has spawned new demands for patients' rights, more humane treatment, and fewer autocratic decisions by hospital administrators. Members of this movement seek to address concerns about inci-

dences of coerced unwarranted, long-term hospitalization of individuals with mental illness.

The central goal of this "person-centered" movement is to humanize the lives of mental health system clients. This goal is reflected in recommendations for a new orientation in mental health information systems.

As Dr. Manderscheid noted, "Person-centered data collection means looking at people...irrespective of the facilities in which they get care. It means responding to the perspective of individuals and to what care means to them."

To ensure that the perspective of people who had been clients of mental health services would be heard MHSIP established a Consumer/Survivor Mental Health Research and Policy Work Group. This emphasis on the consumer of mental health services is new, but the MHSIP document, **Current Status and Directions** *for* **the Future.** has already declared that "this [person-centered] orientation provides the guidance required for planning

the development of MHSIP into the 21st century."

The Survey and Analysis Branch is likely to increase its accent on person-centered care by creating new data collection and analysis activities.

CMHS will continue to update the national data collections to keep pace with changes in the field including information on the types of disabilities encountered by people with mental illnesses, their patterns of use of health and social services, and costs of care. both direct and indirect.

Information technology seems to be on the verge of new techniques and innovations (e.g., the information superhighway, artificial intelligence. and virtual reality), and CMHS will need to be ready to take advantage of these rapid changes.

Good data will continue to stimulate policy discussions. and as the data collection improves. new questions and answers will emerge from the analyses.

-Sam A. Rosenfeld and
Zoe Rosenfeld ∎

drug users were white. 13 percent black, and 10 percent Hispanic.

Education

Illicit drug use rates remain highly correlated with educational status. Among 18-34 year olds in 1993. those who had not completed high school had the highest rate of use, 15.4 percent. while college graduates had the lowest rate. 6.0 percent.

Employment

Current employment status was also highly correlated with rates of illicit drug use, with 11.6 percent of unemployed adults (18 and older) being current drug users in 1993. compared with 6.2 percent of employed adults. However. 71 percent of all current illicit drug users aged 18 and older were employed in 1993.

Perception of Risk, Availability

The Household Survey also collects information on the respondents' perceptions of the risk of harm from using various drugs. and on the availability of drugs. In 1993. only half of youths 12-17 felt there is great risk in using marijuana occasionally, or in trying cocaine. PCP, or heroin. This is little changed since 1990. Seventy-seven percent of the overall population associated great risk with regular marijuana use. and the majority perceived great risk in even trying cocaine (6.7 percent). PCP (7 I percent), or heroin (75 percent) once or twice.

Fifty-eight percent of the population in 1993 reported that they thought marijuana would be easy for them to get, and 39 percent said the same of cocaine. The percentages saying they believed heroin, LSD. and PCP would be easy to get were 26, 27, 24, respectively.

Nine percent of the population reported having been approached in the past month by someone selling drugs, and 11 percent said they had seen people selling drugs in their neighborhood occasionally or more often. Seven percent of whites, 37 percent of blacks and 21 percent of Hispanics reported observing such drug sales. ∎

PHOTO BY CATHERINE BROWN

Center for Mental Health Services Survey and Analysis Branch Chief Ronald L. Manderscheid, Ph.D. (left). and Division of State and Community Systems Development Director Joyce T. Berry, Ph.D.

Superintendent of Documents Subscription Order Form

Charge your order.
It's Easy! MasterCard VISA

To fax your orders (202) 512-2233

☐ **YES,** enter _____ subscriptions to **SAMHSA NEWS,** Substance Abuse and Mental Health Services Administration (ADAN) at $11 ($13.75 foreign) per year.

The total cost of my order is $ _____. Price includes regular domestic postage and handling and is subject to change.

_____
(Company or Personal Name)   (Please type or print)

_____
(Additional address/attention line)

_____
(Street address)

_____
(City, State, ZIP Code)

_____
(Daytime phone including area code)

_____
(Purchase Order No.)

For privacy protection, check the box below:
☐ Do not make my name available to other mailers

Please choose method of payment:
☐ Check Payable to the Superintendent of Documents
☐ GPO Deposit Account ☐☐☐☐☐☐☐–☐
☐ VISA or MasterCard Account

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

☐☐☐☐ (Credit card expiration date)   ***Thank you for your order!***

_____
(Authorizing Signature)   4/93

Mail To: Superintendent of Documents
          P.O. Box 371954, Pittsburgh, PA 15250-7954

Moving? New address?
Please snip off the lower portion of this page, *with your mailing label,* and write your new address next to it.
Mail in envelope to: SAMHSA News, Room 13C-05, 5600 Fishers Lane, Rockville, MD 20857

DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Public Health Service
Substance Abuse and Mental Health
Services Administration
Rockville, MD 20857

Official Business
Penalty for Private Use $300

CREATING JAIL MENTAL HEALTH SERVICES
FOR TOMORROW'S HEALTH CARE SYSTEMS

Center for Mental Health Services

National Institute of Corrections

Public Forum
Evaluation Form

Please take a few minutes to provide feedback on the National Public Forum.

1. Please check the field you represent

_____ Local Jail

_____ Probation/Parole

_____ Mental Health Provider

_____ Family/Consumer Advocate

_____ Legal

_____ Other

2. Please rate the following presentations using the following scale:

1. Poor   **2.** Fair   **3.** Good   4. Excellent

_____ Creating a Healthier Jail Environment
Through Training and Programs

_____ San Francisco's New Generation Program

_____ San Francisco's Garden Project

_____ Special Issues for Women in Jail

_____ Jail Workgroups

_____ Report Outs

_____ Open Mike Session

3. What do you feel were the strengths of the program on the first day:

_____

_____

_____

_____

_____

4. The first day could be improved by:

_____

_____

_____

_____

5. What were the overall strengths of the workgroups?

_____

_____

_____

6. The workgroups can be improved by:

_____

_____

_____

7. Overall impression of the Forum?

_____

_____

_____

8. How will the material learned at the Forum be useful to you?

_____

_____

_____

_____