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Transforming Mental Health Care in America

The Federal Action Agenda: First Steps

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Preface

Never in the history of America have we known so much about mental health and how to enable people with mental illnesses *to live, work, learn, and participate fully in the community.* Recovery from mental illness is now a realistic hope. Yet, much of what we know is not accessible to the people who need it most.

Today, we are on the threshold of achieving the promise of transforming mental health care in America. Government—Federal, State, and local—and thousands of organizations in the private sector are joining together to transform the mental health service delivery system across the Nation. While the States serve as the focus of many transformation activities, the Federal government has seized the opportunity to model collaborative activities and to support other critical participants in both the private and public sectors.

Transformation is a deep, profound, and continuous process along a continuum of innovation. It is a way of creating something possible from the perceived impossible. It implies profound change—not at the margins of a system, but at its very core. In transformation, new sources of power emerge and new competencies develop. Opportunities and challenges are looked at with a new perspective.

An unprecedented number of Federal Departments, agencies, and offices have taken the initiative to formally collaborate to transform the mental health system. The *Federal Mental Health Action Agenda* structures this continuing collaborative effort.

This *Federal Mental Health Action Agenda* is the collaborative product of U.S. Department of Health and Human Services (HHS) agencies and offices, along with five other Departments and the Social Security Administration as follows:

- Department of Education
- Department of Health and Human Services
  - Administration on Aging
  - Administration for Children and Families
  - Agency for Healthcare Research and Quality
  - Centers for Disease Control and Prevention
  - Centers for Medicare and Medicaid Services
  - Health Resources and Services Administration
  - Indian Health Service
  - National Institutes of Health
  - Office for Disability
  - Office for Civil Rights
  - Office of Public Health and Science
  - Substance Abuse and Mental Health Services Administration
- Department of Housing and Urban Development
- Department of Justice
- Department of Labor
- Department of Veterans Affairs
- Social Security Administration

In developing this document, each participating Federal Department and agency created an inventory of its current mental health activities. An additional list was created by each Federal partner outlining proposals for transforming programs and practices. From these inventories and lists of transforming activities, this first *Federal Mental Health Action Agenda* was developed.

Transformation requires vision, action, and accountability. The President has provided vision through his New Freedom Initiative. With this Action Agenda, the Federal agencies commit themselves to action and accountability in pursuit of this vision. Now, it is essential that others including consumers, family members, providers, payers, and policy makers continue to contribute in the extraordinary process of transforming mental health care throughout our Nation.

Executive Summary

The work of the New Freedom Commission on Mental Health is a key component of President George W. Bush's New Freedom Initiative. In its final report to the President, the Commission called for nothing short of *fundamental transformation* of the mental health care delivery system in the United States—from one dictated by outmoded bureaucratic and financial incentives to one driven by consumer and family needs that focuses on building resilience and facilitating recovery. The following *Federal Mental Health Action Agenda* articulates specific, actionable objectives for the initiation of a long-term strategy designed to move the Nation's public and private mental health service delivery systems toward the day when all adults with serious mental illnesses and all children with serious emotional disturbances will live, work, learn, and participate fully in their communities.

A keystone of the transformation process will be the protection and respect of the rights of adults with serious mental illnesses, children with serious emotional disturbances, and their parents. With respect to children and adolescents, the New Freedom Commission on Mental Health and this *Federal Mental Health Action Agenda* clearly recognize that parents are the decision-makers in the care for their children. Therefore, in this document, whenever the words *child or children* are used, it is understood that parents or guardians are the decision-makers in the process of making choices and decisions for minor children.

Background

New Freedom Commission on Mental Health

Launched by President Bush in February 2001, the New Freedom Initiative is designed to promote full access to community life for people with disabilities, including access to employment and educational opportunities and to assistive and universally designed technologies. The New Freedom Initiative builds on the 1990 Americans with Disabilities Act (ADA), the landmark legislation providing protections against discrimination, and on the U.S. Supreme Court's 1999 *Olmstead v. L.C.* decision, which affirmed the right of individuals to live in community settings.

In June 2001, President Bush issued Executive Order 13217 promoting community-based alternatives for all individuals with disabilities and directing key Federal agencies to work closely with States to ensure full compliance with the *Olmstead* decision and the ADA. Through comprehensive self-evaluations and extensive public input, a number of Federal agencies identified barriers to community integration in their policies, programs, regulations, and statutes, and developed priorities and action steps to address these barriers.[1]

In April 2002, the President signed Executive Order 13263 [see Appendix A] establishing the New Freedom Commission on Mental Health and charged the group with conducting a comprehensive study of the problems and gaps in the mental health service system and to make concrete recommendations for immediate improvements that the Federal government, State governments, local agencies, as well as public and private health care providers, can implement. The Commission members met for 1 year to study the research literature and to

1 Delivering on the Promise: Preliminary Report of Federal Agencies' Actions to Eliminate Barriers and Promote Community Integration. Presented to the President of the United States, December 21, 2001

receive comments from more than 2,300 mental health consumers, family members, providers, administrators, researchers, government officials, and other key stakeholders.

The Commission framed its work around the five principles set forth in the Executive Order that established its responsibilities. These principles seek to improve the outcomes of mental health care; promote collaborative, community-level models of care; maximize existing resources and reduce regulatory barriers; use mental health research findings to influence service delivery; and promote innovation, flexibility, and accountability at the Federal, State, and local levels. In particular, the President directed the Commission to:

- Focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
- Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
- Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.
- Consider how mental health research findings can be used most effectively to influence the delivery of services.
- Follow the principles of Federalism, and ensure that its recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.

The Vision of a Transformed Mental Health System

The Commission found that the mental health service delivery system is not oriented to the single most important goal of the people it serves—the goal of recovery. In contrast, the Commissioners envisioned a future "when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports." The Commission articulated a vision of a transformed system as one in which Americans understand that mental health is essential to overall health; mental health care is consumer and family driven; disparities in mental health services are eliminated; appropriate and early mental health screening, assessment, and referral to services occurs; excellent mental health care is delivered and research is accelerated; and technology is used to access mental health care and information.

Challenges to a Recovery-Oriented Mental Health System

Called *Achieving the Promise: Transforming Mental Health Care in America*, the final report of New Freedom Commission is ground-breaking in its emphasis on building a system that is evidence based, recovery focused, and consumer and family driven. The report helps Americans understand that mental illnesses and emotional disturbances are treatable and that recovery

should be the expectation. In a transformed mental health system, services and treatments must be geared to give consumers and families real and meaningful choices about treatment options and providers, and care must focus on increasing individuals' abilities to cope successfully with life's challenges, on building resilience, and on facilitating recovery.

To transform the mental health service delivery system, the Commission challenged the Federal government, State governments, local agencies, and public and private health care providers to:

- Close the 15- to 20-year gap it takes for new research findings to become part of day-to-day services for people with mental illnesses.
- Harness the power of health information technology to improve the quality of care for people with mental illnesses, to improve access to services, and to promote sound decision-making by consumers, families, providers, administrators, and policy makers.
- Identify better ways to work together at the Federal, State, and local levels to leverage human and economic resources and put them to their best use for children, adults, and older adults living with—or at risk for—mental disorders.
- Expand access to quality mental health care that serves the needs of racial and ethnic minorities and people in rural areas.
- Promote quality employment opportunities for people with mental illnesses.

Reform Is Not Enough

The word "transformation" was chosen carefully by the Commission to reflect its belief that mere reforms to the existing mental health system are insufficient. Transformation is a powerful word with implications for policy, funding, and practice, as well as for attitudes and beliefs. Indeed, transformation is not accomplished through change on the margin but, instead, through profound changes in kind and in degree. Applied to the task at hand, transformation represents a bold vision to change the very form and function of the mental health service delivery system to better meet the needs of the individuals and families it is designed to serve. As with any large-scale organizational change, transformation of the mental health system will be a complex process that proceeds in a non-linear fashion and that requires collaboration, innovation, sustained commitment, and a willingness to learn from mistakes.

A Broad-Based Commitment

To develop this *Federal Mental Health Action Agenda*, the Substance Abuse and Mental Health Services Administration (SAMHSA), in the U.S. Department of Health and Human Services (HHS), under the direction of SAMHSA Administrator Charles G. Curie, MA, ACSW, invited key Federal agencies to compile inventories of current programs and activities that address the Commission's vision, and to propose action steps to move the agenda forward. In addition to HHS, these agencies include the U.S. Departments of Education (ED), Housing and Urban Development (HUD), Justice (DOJ), Labor (DOL), and Veterans' Affairs (VA) and the Social Security Administration (SSA).

Goals of the Federal Collaboration

With this *Federal Mental Health Action Agenda,* HHS and its federal partners make an unprecedented commitment to collaborate on behalf of adults with serious mental illnesses and children with serious emotional disturbances to:

- Send the message that mental illnesses and emotional disturbances are treatable and that recovery is possible.
- Act immediately to reduce the number of suicides in the Nation through full implementation of the National Strategy for Suicide Prevention.
- Help States develop the infrastructure necessary to formulate and implement Comprehensive State Mental Health Plans that include the capacity to create individualized plans of care that promote resilience and recovery.
- Develop a plan to promote a mental health workforce better qualified to practice culturally competent mental health care based on evidence-based practices.
- Improve the interface of primary care and mental health services.
- Initiate a national effort focused on the mental health needs of children and promote early intervention for children identified to be at risk for mental disorders. Prevention and early intervention can help forestall or prevent disease and disability.
- Expand the "Science-to-Services" agenda and develop new evidence-based practices toolkits.
- Increase the employment of people with psychiatric disabilities.
- Design and initiate an electronic health record and information system that will help providers and consumers better manage mental health care and that will protect the privacy and confidentiality of consumers' health information.

Federal Leadership, Shared Responsibility

The Federal role in the *Federal Mental Health Action Agenda* is to act as a leader and a facilitator, promoting shared responsibility for change at the Federal, State, and local levels, as well as in the private sector. States, however, will be the very center of activity for system transformation. Many have already begun this critical work. Finally, an emphasis on individual recovery and resilience will transform not only service delivery systems but also hearts, minds, and lives for future generations.

The Federal Mental Health Action Agenda

Highlights of the Action Agenda follow, with an emphasis on those first steps that can yield immediate results. All action steps related to the principles of the Executive Order are delineated in the body of this report.

PRINCIPLE A **desired outcomes of mental health to attain each individual's maximum ment, self-care, interpersonal community participation.**

Initiate a National Public Education Campaign. SAMHSA will initiate a national public education campaign to improve the general understanding of mental illnesses and emotional disturbances across the age span. The public and private sectors will pool their resources and their expertise to plan, create, coordinate, and evaluate the campaign.

Launch the National Action Alliance for Suicide Prevention. HHS will launch the National Action Alliance for Suicide Prevention, a public-private partnership that will oversee full implementation of the National Strategy for Suicide Prevention. Coordinated national efforts to prevent suicide will be supported by a broad base of stakeholders in both the public and private sectors.

Educate the Public about Men and Depression. The National Institute of Mental Health (NIMH) will continue its "Men and Depression" Campaign, a major HHS public information effort to encourage men and their families to recognize depression—the disease that causes the most disability in America—and to seek treatment.

Develop Prototype Individualized Plans of Care that Promote Resilience and Recovery. SAMHSA will convene a consensus development meeting to discuss the meaning and process of recovery for children and their parents, adults, and older adults with mental disorders, review current best practices, and provide technical assistance to States and providers on the design and development of prototype individualized plans of care for children, adults, and older adults.

Promote Quality Services in the Workforce Development System for People with Psychiatric Disabilities. DOL will work with its federal partners to promote the use of customized employment strategies, to promote the transition of youth with serious emotional disturbances from school to post-secondary opportunities and/or employment, to develop an employer initiative to increase recruitment, employment, advancement, and retention of people with mental illnesses.

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to conduct a pilot demonstration of early intervention employment strategies; to disseminate information on mental health issues through DOL grant initiatives and programs such as Work Incentive Grants, Customized Employment Grants, Chronically Homeless Grants, Incarcerated Veterans' Transition Program, Homeless Veterans' Reintegration Program, Veterans' Workforce Investment Program, Youth Offender Demonstration Program, Serious and Violent Re-entry Initiative, High School/High Tech Grants, Youth Demonstration Grants, and Ready4Work Grants; to assist youth with serious emotional disturbances involved with the juvenile justice system to transition into employment; to promote employment of people with mental illnesses who are chronically homeless; to strengthen linkages between DOL's and SSA's joint Disability Program Navigator Initiative, SAMHSA's related State and local mental health systems; and to establish a DOL Work Group to promote quality employment of adults with serious mental illnesses and youth with serious emotional disturbances.

Initiate a National Effort Focused on Meeting the Mental Health Needs of Children as Part of Overall Health Care. A Task Force of the Federal Executive Steering Committee on Mental Health (described below under Principle B) will develop a national public education initiative for parents, providers, and policy makers about the importance of the first years of life in developing a healthy foundation for social, emotional, and cognitive development. The Task Force also will propose a comprehensive approach at the Federal and State levels to appropriately assess, with parental consent, children identified to be at risk for mental disorders in early childhood settings, educate and train professionals and families in effective treatment approaches and supports, and eliminate barriers to serving this population.

Launch a User-Friendly, Consumer-Oriented Web Site. SAMHSA's Center for Mental Health Services (CMHS) will explore investing in the development of a user-friendly, consumer-oriented web site in 25 geographically diverse locations around the country. The web site will provide information on mental illnesses and community resources and give individuals and family members the ability to create personal health records on a secure server, the privacy of such records is protected according to Health Insurance Portability and Accountability Act (HIPAA) regulations. The Federal funding will serve as seed money to the local jurisdictions.

Protect and Enhance the Rights of People With Mental Illnesses. The Office for Civil Rights (OCR) will carry out the specific recommendation of the *New Freedom Commission on Mental Health* to continue *Olmstead* voluntary compliance initiatives, including providing technical assistance to States in conjunction with other HHS components, disseminating information about Olmstead compliance, and promoting ADA compliance and community care.

PRINCIPLE B ...community-level models of care that ... multiple health and ... public and private ... treatment and

Launch the Federal Executive Steering Committee on Mental Health. HHS will lead an intra- and inter-agency Federal Executive Steering Committee to guide the collaborative work of mental health systems transformation. Members will be high-level representatives from agencies within HHS and from other Federal departments that serve children, adults, and older adults who have mental disorders. The group will provide ongoing stewardship for the work that has resulted from the New Freedom Initiative and the President's New Freedom Commission on Mental Health.

Include Eliminating Disparities in Mental Health Services as Part of the HHS "Close the Gap Initiative." A Task Force of the Federal Executive Steering Committee on Mental Health will work closely with the Secretary's Health Disparities Council to ensure that eliminating disparities in mental health services is integral to the Department's overall "Close the Gap Initiative."

Create a National Strategic Workforce Development Plan to Reduce Mental Health Disparities. A Task Force of the Federal Executive Steering Committee on Mental Health will convene selected behavioral health care leaders from both the public and private sectors to create and manage a national strategic planning process. The national strategic plan will be designed to develop a mental health workforce better able to deliver culturally competent, evidence-based 21st century health care.

Initiate a Project to Examine Cultural Competence in Behavioral Health Care Education and Training Programs. SAMHSA will initiate a project to examine all current behavioral health care education and training programs that receive Federal funds to help determine the extent to which they recruit and retain racial and ethnic minority and bilingual trainees, emphasize the development of cultural and linguistic competence in clinical practice, develop appropriate curricula, engage minority consumers and families in workforce development and training, and educate trainees about evidence-based mental health interventions.

Develop a National Rural Mental Health Plan. A Task Force of the Federal Executive Steering Committee on Mental Health will work with the HHS Secretary's Rural Task Force to identify and convene key leaders in both the public and private behavioral health care sectors and will provide leadership and logistical support toward the development of a national rural mental

health plan. The plan will address the integration of mental health and physical health care, financing incentives, alternative insurance mechanisms, workforce enhancement programs, and the effectiveness of telehealth technologies.

Promote Strategies to Appropriately Serve Children With Mental Health Problems in Relevant Service Systems. Serious emotional disturbance (SED) in childhood can be an important precursor to the development of serious mental illnesses as an adult. Supporting the mental health of children and adolescents with SED and their families is a strategic investment that will create long-term benefits for individuals, systems, and society. HHS agencies—together with ED and DOJ, mental health consumers, parents, and youth—will gather and review current screening instruments to determine which are developmentally, culturally, and environmentally appropriate for children. This Federal review group will assess the feasibility of implementing one or a combination of these instruments across service systems in which children identified to be at risk for mental disorders present for care and where providers can work with parents to link children to appropriate services and interventions, as needed.

Include Mental Health in Community Health Center Consumer Assessment Tools. Mental disorders may go undiagnosed, untreated, or under-treated in primary care. SAMHSA, the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA) will collaborate to facilitate serving adults and older adults identified to be at risk for depression and, with prior parental consent, children and adolescents identified to be at risk for mental, emotional, and behavioral problems in federally funded Community Health Centers and to coordinate followup treatment with community mental health agencies or other appropriate providers.

PRINCIPLE C: Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.

Initiate Medicaid Demonstration Projects. The Centers for Medicare and Medicaid Services (CMS) will support demonstrations (as authorized and funded by Congress, where required) of supported employment, respite care services for caregivers of adults or children with disabilities, alternatives to psychiatric residential treatment for children with serious emotional disturbances, efforts that promote self-determination and consumer direction in mental health service systems, and systems of flexible financing for long-term care that allow money to follow the individual.

Help Parents Avoid Relinquishing Custody and Obtain Mental Health Services for Their Children. The Commission decried the fact that some parents have been forced to relinquish

custody to obtain needed mental health services for their children. The HHS will lead an effort among Federal agencies to implement a multifaceted approach across systems with the goal of ending this tragic practice and increasing families' access to home- and community-based services and systems of care for their children with serious emotional disturbances.

Support the Ticket to Work Program. The Ticket to Work and Work Incentives Improvement Act of 1999 addresses many of the work disincentives faced by people receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), such as loss of cash benefits and medical coverage. As part of its overall support for the Ticket to Work Act, CMS will release a solicitation to provide health care and other support services to individuals, including those with serious mental illnesses, who may be at risk of losing employment and independence. This solicitation will be for the Demonstration to Maintain Independence and Employment. Additionally, CMS will provide assistance to States through a Medicaid Infrastructure Grant Program. The Medicaid Infrastructure Grant Program for 2004 includes a provision that will allow States to propose the use of funding to lessen or remove the primary barriers to employment for adults with disabilities through a comprehensive, coordinated approach between Medicaid and non-Medicaid programs.

Educate Employers and Benefits Managers on the Practicability of Paying for Mental Health Services. A multidisciplinary group of mental health consumers, corporate benefit managers, health care consultants, pharmacy benefit managers, and Employee Assistance professionals will be invited to form an Employer Toolkit Workgroup to review the work of the New Freedom Commission on Mental Health and to suggest a comprehensive approach for employers in selecting and purchasing mental health services.

Develop a Strategy to Implement Innovative Technology in the Mental Health Field. SAMHSA will convene a consensus development workgroup to review the current status of telemedicine, information technology, Internet technology, and electronic decision support tools in health care; examine the current status of implementation of these tools in mental health; and prepare key recommendations for immediate next steps in technology support for mental health services.

Explore Creation of a Capital Investment Fund for Technology. SAMHSA will explore the creation of a Capital Investment Fund for Technology to work with States to design and implement an electronic health record and information system that incorporates an individualized plan of care and is consistent with the proposed Comprehensive State Mental Health Plan. The electronic health record will provide decision support to consumers and service providers and will offer an unprecedented, real-time disease management system.

PRINCIPLE D: ...research findings can influence the delivery

Accelerate Research to Reduce the Burden of Mental Illnesses. Building on the discoveries emerging rapidly from the decoding of the human genome and from new, more powerful imaging techniques, NIMH will reorganize and streamline research to produce new interventions. The ultimate goal will be to prevent or cure mental illnesses.

Expand the National Registry of Evidence-Based Programs and Practices to Include Mental Health. SAMHSA will expand its National Registry of Evidence-based Programs and Practices (NREPP) to include the best evidence-based mental illness prevention and treatment interventions. The Agency will develop a procedure to identify, review, and summarize evidence-based practices; survey the implementation of evidence-based practices in parallel fields, such as primary care; and recommend a procedure through which consensus might be developed across key mental health groups, consumers, and family members regarding implementation of evidence-based practices.

Develop New Toolkits on Specific Evidence-Based Mental Health Practices. To disseminate more broadly known, evidence-based practices to the field, SAMHSA will expand its National Evidence-Based Practices Project with the addition of toolkits in areas that may include children's services, supportive housing, older adults, trauma and violence, collaborative models in primary care, consumer-operated service approaches, and supported education.

Expand the "Science-to-Services" Agenda. SAMHSA and the National Institutes of Health (NIH) have begun a formal "Science-to-Services" agenda to further develop and expand evidence-based practices in the field. CMHS and NIMH are spearheading this effort for the area of mental health. To enhance this effort, a Task Force of the Federal Executive Steering Committee on Mental Health will work with HHS agencies to identify those evidence-based and promising practices that warrant further research, those that are ready for field implementation, and those that can and should be funded at the State and local levels.

Conduct Research to Reduce Mental Health Disparities. NIMH is expanding its support for programs that conduct research to reduce health disparities by issuing a new program announcement (2004) for the development of Advanced Centers for Mental Health Disparities Research. The Institute also will continue its support for the Disparities in Mental Health Services Research Program, the Socio-Cultural Research Program, the Office of Special Populations, and the Office of Rural Mental Health.

PRINCIPLE E: Follow the principles of Federalism, and ensure that the Commission's recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.

Award State Mental Health Transformation Grants. SAMHSA's Center for Mental Health Services (CMHS) will continue to support 3-year State Mental Health Transformation Grants. These grants are designed to assist States in their efforts to develop a Comprehensive Mental Health Plan, build mental health services infrastructure, and to promote implementation of science-based mental health interventions.

Award Child and Adolescent State Infrastructure Grants. SAMHSA will continue to support Child and Adolescent State Infrastructure Grants to States. These grants help States increase their system infrastructures to support mental health and/or substance abuse services and programs for children and adolescents with mental, substance use, and/or co-occurring disorders. These 5-year grants will complement the State Mental Health Transformation Grants.

Establish a Foundation for the Samaritan Initiative. Based on experience with the $35 million Collaborative Initiative to Help End Chronic Homelessness, the President proposed the Samaritan Initiative at $200 million in his Fiscal Year 2005 budget. This initiative would provide funding for permanent supportive housing for people who experience chronic homelessness.

Initiative for Ex-Prisoners With Psychiatric Disabilities. HUD's 2006 budget request includes $25 million as a part of a prevention initiative for prisoners returning to the community, many of whom are struggling with serious mental illnesses. HUD will collaborate with DOL and DOJ in this effort.

Award Seclusion and Restraint State Incentive Grants. SAMHSA will continue to support grants designed to enhance State capacity to provide staff training to implement alternatives to seclusion and restraint in mental health care settings. These grants will support programs in eight States as well as a Resource Center, which will act as a central repository on effective practices to reduce and eliminate seclusion and restraint and provide technical assistance to the grantees.

Moving Forward

Transformation is a long-term process, but this Action Agenda can and will be initiated in the first year of a multi-year effort to transform the form and function of the mental health service delivery system in America. Each step requires the full commitment of the agencies and individuals involved, and all steps speak to the need for the public/private partnerships that will make the Commission's vision a reality. Ultimately, the Action Agenda is a living document that will move the Nation closer to the day when adults with serious mental illnesses and children with serious emotional disturbances will live, work, learn, and participate fully in their communities.

Introduction

We envision a future when everyone with a mental illness can recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports—essentials for living, working, learning, and participating fully in the community.[2]

In April 2002, President George W. Bush issued Executive Order 13263 [see Appendix A] establishing the New Freedom Commission on Mental Health. He charged the Commission with conducting a comprehensive study of the public- and private-sector mental health service delivery systems and recommending improvements to enable adults with serious mental illnesses and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. In response, the Commission called for nothing short of *fundamental transformation* of the mental health care delivery system in the United States, from one dictated by outmoded bureaucratic and financial incentives to one driven by consumer and family needs that focuses on building resilience and facilitating recovery. This *Federal Mental Health Action Agenda* follows the principles of the Executive Order to highlight specifics for the first year of a long-term strategy designed to move the Nation's public and private mental health service delivery systems toward this visionary goal.

Background on the New Freedom Initiative

New Freedom Commission on Mental Health

The work of the New Freedom Commission on Mental Health is a key component of President George W. Bush's New Freedom Initiative. Launched in February 2001, the New Freedom Initiative is designed to promote full access to community life for people with disabilities, including access to employment and educational opportunities and to assistive and universally designed technologies. The New Freedom Initiative builds on the 1990 Americans with Disabilities Act (ADA), the landmark legislation providing protections against discrimination, and on the U.S. Supreme Court's 1999 *Olmstead v. L.C.* decision, which affirmed the right of individuals to live in community settings.

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When the President appointed the New Freedom Commission on Mental Health in April 2002, he asked the group to study the problems and gaps in the mental health system and to make concrete recommendations for immediate improvements that the Federal government, State

2 New Freedom Commission on Mental Health (2003) *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub No. SMA-03-3832. Rockville, MD: Department of Health and Human Services.

1 Delivering on the Promise: Preliminary Report of Federal Agencies' Actions to Eliminate Barriers and Promote Community Integration. Presented to the President of the United States, December 21, 2001.

governments, local agencies, as well as public and private health care providers, can implement. The Commission met for 1 year to study the research literature and to receive comments from more than 2,300 mental health consumers, family members, providers, administrators, researchers, government officials, and other key stakeholders.

The Commission framed its work around the five principles set forth in Executive Order 13263, which seek to improve the outcomes of mental health care; promote collaborative, community-level models of care; maximize existing resources and reduce regulatory barriers; use mental health research findings to influence service delivery; and promote innovation, flexibility, and accountability at the Federal, State, and local levels. In particular, the President's Executive Order directed the Commission to:

- Focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
- Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
- Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.
- Consider how mental health research findings can be used most effectively to influence the delivery of services.
- Follow the principles of Federalism, and ensure that its recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.

A keystone of the transformation process will be the protection and respect of the rights of adults with serious mental illnesses, children with serious emotional disturbances, and their parents. With respect to children and adolescents, the New Freedom Commission on Mental Health and this *Federal Mental Health Action Agenda* clearly recognize that parents are the decision-makers in the care for their children and if any services, including screening, appear to be an appropriate action, parental consent must be obtained before it occurs. Therefore, in this document, whenever *child or children* is used, it is understood that parents or guardians are the decision-makers in the process of making choices and decisions for minor children. This same support and guidance can also include family members for individuals older than 18 years of age.

Achieving the Promise: Transforming Mental Health Care in America

The Commission delivered its final report, *Achieving the Promise: Transforming Mental Health Care in America*, to the President in July 2003. Immediately following receipt of the report by the President, the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Administrator, Charles G. Curie, MA, ACSW, was charged with the goal of implementing appropriate action steps to strengthen the Nation's mental health system. Signaling Congressional

interest in mental health system transformation, in November 2003, Mr. Curie—along with representatives of the public and private sectors and a consumer family member—were called to testify about the *Final Report* before the Senate Subcommittee on Substance Abuse and Mental Health Services.

A Broad-Based Commitment

The New Freedom Commission on Mental Health called for immediate and profound changes, and the Federal government—in partnership with States, communities, consumers, families, and the private sector—is responding. The *Federal Mental Health Action Agenda* is a specific and affirmative plan for the initial Federal response to the charge for wholesale transformation.

Because children, adults, and older adults with mental disorders are seen in multiple systems and sectors, the *Federal Mental Health Action Agenda* represents a broad-based commitment for collaboration on the part of all Federal agencies whose programs can and do serve these individuals. In addition to the U.S. Department of Health and Human Services (HHS), these agencies include the U.S. Departments of Education (ED), Housing and Urban Development (HUD), Justice (DOJ), Labor (DOL), and Veterans' Affairs, and the Social Security Administration (SSA). Together, these agencies recognize that the action steps presented herein are ambitious and have substantial implications for coordination and sequencing of effort; they are prepared to meet the challenges that lie ahead.

Indeed, HHS is gratified by the caliber and degree of contribution to date from its Federal partners and expects more agencies and offices to join this landmark effort. Each agency brings value added to mental health system transformation, and the whole becomes greater than the sum of its parts. Together, the Federal partners are committed to working side-by-side, not to perpetuate the status quo, but to fundamentally alter for generations to come the way the Nation's mental health care system works. The synergy produced by this dynamic Federal partnership will be a guiding force for the work of mental health system transformation at the State and local levels.

Federal Leadership, Shared Responsibility

The Commission pointed out that no agency, individual, or organization can single-handedly transform the mental health service delivery system in this country. The Federal role is to act as a leader and a facilitator, promoting shared responsibility for change at the Federal, State, and local levels, and in the private sector, in such areas as education, research, service system capacity, and technology development. States, however, will be the very center of gravity for system transformation; many already have begun this critical work. Their leadership in planning, financing, service delivery, and evaluating consumer- and family-driven services will significantly advance the transformation agenda. Finally, an emphasis on individual recovery and resilience will transform not only service delivery systems but also hearts, minds, and lives for future generations.

The Need for a Transformed Mental Health System

In its October 29, 2002, *Interim Report to the President*, the Commission declared that the mental health service delivery system must be robust and responsive to consumers' needs because its failings may lead to "unnecessary and costly disability, homelessness, school failure, and incarceration." The *Interim Report* concluded that the system is not oriented to the single most important goal of the people it serves—the hope of recovery. State-of-the-art treatments, based on decades of research, are not being transferred to community settings. In many communities, access to quality care is poor, resulting in wasted resources and lost opportunities for recovery. This is particularly true in rural areas and among racial and ethnic minorities. More individuals would recover from even the most serious mental illnesses and emotional disturbances if they had earlier access in their communities to treatment and supports that are evidence-based and tailored to their needs.

Reform Is Not Enough

The Commission's findings make clear that simple reforms no longer are adequate to respond to the needs of children and their parents, adults, and older adults with mental disorders. Wholesale and fundamental transformation of the mental health service delivery system is required. The Commission articulated a vision of a transformed system as one in which Americans understand that mental health is essential to overall health; mental health care is consumer and family driven; disparities in mental health services are eliminated; in high-risk settings such as juvenile justice and child welfare, appropriate and early mental health screening, assessment, and referral to services occurs; excellent mental health care is delivered and research is accelerated; and technology is used to access mental health care and information.

This is a bold vision that points the Nation forward, to a future in which everyone, from public policy makers to consumers and family members, understands that mental health is a vital and integral part of overall health; a future in which every man, woman, and child in need—regardless of age, gender, race, ethnicity, or geography—receives the best research-based care available; a future that harnesses the tremendous power of technology to inform consumers, aid health care practitioners, and speed high-quality health care to underserved areas. This transformation will necessitate a shift in the beliefs of most Americans and will require the Nation to expand its paradigm of public and personal health care. It is nothing short of revolutionary.

Promoting Recovery

The *Final Report* points out that mental illnesses and emotional disturbances are treatable, and that recovery should be the expectation. Successfully transforming the mental health service delivery system to promote recovery rests on two key principles:

- First, services and treatments must be consumer- and family-driven—geared to give consumers real and meaningful choices about treatment options and providers—and not oriented to the requirements of bureaucracies.
- Second, care must focus on increasing individuals' ability to cope successfully with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.

Roadmap for Transformation

To transform the mental health service delivery system, the Commission challenged the Federal government, State governments, local agencies, and public and private health care providers to:

- **Close the 15- to 20-year gap it takes for new research findings to become part of day-to-day services for people with mental illnesses.** Waiting for the research to make its journey down an already clogged pipeline equates to generations lost in the process. Too many Americans already are underserved, and many more are done a disservice when they receive outmoded or unproven therapies that fail to improve their quality of life while they wait for the latest research to make its way into their communities.
- **Harness the power of health information technology to improve the quality of care for people with mental illnesses,** to improve access to services, and to promote sound decision-making by consumers, families, providers, administrators, and policy makers. The application of information technology to health care may well be the most important medical advance of the 21st century, and practitioners, consumers, and family members must have access to its unparalleled benefits and protection from its potential abuses.
- **Identify better ways to work together at the Federal, State, and local levels to leverage human and economic resources to their best use for children, adults, and older adults living with—or identified at risk for—mental disorders.** The time has come for agencies and individuals to step out of a silo mentality and learn to work across traditional administrative, philosophical, and funding boundaries.
- **Expand access to quality mental health care that serves the needs of racial and ethnic minorities and people in rural areas.** Disparities in access to and quality of mental health services must be eliminated.
- **Promote quality employment opportunities for people with mental illnesses.** People with mental illnesses want and need to work and employment can be both a goal of and a tool for recovery.

In response to the President's charge, the New Freedom Commission developed far more than a set of "might do" and "could try" activities. The group's recommendations are a roadmap for full-scale transformation of the mental health care delivery system in America. As such, the message of full community participation for children and their parents, adults, and older adults with mental disorders must be part of every strategy session, budget decision, and public debate concerning mental health service delivery and health care reforms.

The Focus on Recovery

Individual recovery is at the heart of the New Freedom Commission's vision to transform the mental health service delivery system in America. The good news at the heart of the Commission's *Final Report* is that adults with serious mental illnesses and children with serious emotional disturbances can and do recover. The Commission makes clear that success means a system grounded in recovery—one that reflects a belief in recovery, one that demonstrates a commitment to providing recovery-based services, and one that, through its actions, inspires in consumers and their families the hopefulness of recovery.

Recovery, as defined by the Commission, is the process by which people are able to live, work, learn, and participate fully in their communities. For some individuals, the Commission noted, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or remission of symptoms. For many people, recovery is a transformative process, one that is less about returning to a former self and more about discovering who one can become.[4] Science has shown that having hope plays an integral role in an individual's recovery.

Though the term is most frequently applied to adults with serious mental illnesses, recovery is for everyone—children and adolescents, adults, and older adults. No one is too young or too old to recover a valued social role[5] in his or her family and community. Recovery touches the adult or child who receives mental health services and the family members, friends, and supporters who play a vital role in the person's life. Building resilience (i.e., strengthening those factors that allow an individual to overcome adversity) to facilitate recovery is the goal of every individual and organization that is part of the mental health service delivery system in this country.

The Process of Transformation

The word "transformation" was chosen carefully by the Commission to reflect its belief that mere reforms to the existing mental health system are insufficient. Transformation is a powerful word with implications for policy, funding, and practice, as well as for attitudes and beliefs.[6] Indeed, transformation is not accomplished through changes at the margin but, instead, through profound changes in kind and in degree. These changes result in new behaviors and new competencies. Transformation is a continuous process, meant to create or anticipate the future. Once begun, the process of transformation leads to an organization that is profoundly different in structure, culture, policy, and programs.

Applied to the task at hand, transformation represents a bold vision to change the very form and function of the mental health service delivery system to better meet the needs of the individuals and families it is designed to serve. As with any large-scale organizational change, transformation of the mental health system will be a complex process that proceeds in a non-linear fashion and that requires collaboration, innovation, sustained commitment, and a willingness to learn from mistakes. In particular, transformation requires that:

4 Mary Ellen Copeland in National Technical Assistance Center for State Mental Health Planning, Embracing recovery. A simple yet powerful vision. Networks, winter 1999, p. 1.

5 The term "valued social role" as it applies to recovery is often credited to Daniel B. Fisher, M.D., Ph.D. See, for example, Fitzgerald, C. A new world of serious mental illness. Recovery. Behavioral Healthcare Tomorrow, 11(4), August 2002.

6 The material in this paragraph is based on the work of Retired Vice Admiral Arthur Cebrowski, Special Assistant for Transformation for the U.S. Department of Defense.

- Consumers and family members are active partners in the transformation agenda. Their participation in transforming the system to meet their needs is not just a critical piece of the puzzle—it is the reason for doing the difficult, but necessary, work the Commission envisions.
- Federal agencies examine all funding, policies, and administrative vehicles (e.g., grants, contracts, technical assistance centers, etc.) and align them with the Commission's vision.
- The public and private sectors come together in partnerships designed to ensure that consumers are able to access the care they need through any door in any system.

The Action Agenda: Transforming the Mental Health System

To develop this *Federal Mental Health Action Agenda*, SAMHSA invited key Federal agencies to compile inventories of current programs and activities that address the Commission's vision and to propose action steps to move the agenda forward. The pages that follow present the Federal response to the principles of the Executive Order and the Commission's work, with an emphasis on those first steps that will yield immediate results. The Introduction features highlights of the Action Agenda—the "big picture" items on which future action steps will build. Highlighted action steps are described in more detail in the body of the report, called the *Federal Mental Health Action Agenda*.

Preview of the Federal Mental Health Action Agenda

The elements of the *Federal Mental Health Action Agenda* include:

- The five principles in the Executive Order around which the New Freedom Commission on Mental Health framed its vision of a transformed mental health service system.
- The "State of Success" for each principle, which reflects the elements of a transformed mental health system over the long term.
- Action steps for each principle that will move the mental health service system toward transformation.
- A look at representative current activities that reflect each principle. These lists are illustrative but not exhaustive. An inventory of current, relevant Federal activities that respond to the Commission's vision has been completed by SAMHSA.

Moving Forward

Transformation is a long-term process. This *Federal Mental Health Action Agenda* outlines the initial steps in a multi-year effort to transform the form and function of the mental health service delivery system in America. Each step requires the full commitment of the agencies and individuals involved; all steps speak to the need for the public/private partnerships that will make the Commission's vision a reality. Ultimately, the *Federal Mental Health Action Agenda* is

a living document that will move the Nation closer to the day when adults with serious mental illnesses and children with serious emotional disturbances will live, work, learn, and participate fully in their communities.

Highlights of the Action Agenda: The Federal Response

Highlights of the Federal Action Agenda follow. These represent signature items that respond to the Commission's vision for mental health system transformation, organized under the five principles of the Executive Order. These items will be addressed in the first of a multi-year effort to alter the form and function of mental health service delivery for children, adults, and older adults.

PRINCIPLE A: Focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.

Every man, woman, and child with or at risk for mental disorders deserves a life in the community, with meaningful employment, interpersonal relationships, and community participation. They also need the tools of self-care that will make their recovery possible. In fact, a wide array of effective mental health services and treatments is available to allow children, adults, and older adults to be vital contributors to their communities. Yet, many people remain unserved, in part because of the stigma of seeking help. Racial and ethnic minorities and people living in rural areas are particularly ill served. This situation cannot be allowed to remain unchanged, especially when there is so much hope for recovery. Agencies, programs, and individuals must forge the interpersonal relationships that form the foundation for recovery from mental illnesses and emotional disturbances, and connect people with mental disorders to employment that provides both income and a measure of self worth. Highlights of the Federal response to this principle follow.

Initiate a National Public Education Campaign

SAMHSA will initiate a national public education campaign to improve the general understanding of mental illnesses and emotional disturbances, and to encourage help-seeking behaviors across the age span for people in need. It is expected that the public and private sectors will pool their resources and their expertise to plan, create, coordinate, and evaluate the campaign. Campaign materials will be customized to address gender-specific mental health issues for children and adolescents, adults, and older adults, and will be appropriate for racial and ethnic minorities and for urban and rural residents. The campaign also will address both private and public sector employers with a business case for hiring people with mental illnesses. Information and technical assistance will be readily available to support the campaign.

Launch the National Action Alliance for Suicide Prevention

In the United States, suicide claims approximately 30,000 lives each year. The vast majority of all people who die by suicide have mental disorders—often undiagnosed or untreated. HHS will launch the National Action Alliance for Suicide Prevention, a public-private partnership to oversee full implementation of the National Strategy for Suicide Prevention. A broad base of stakeholders in both the public and private sectors will support coordinated national efforts to prevent suicide, including ongoing support for the Suicide Prevention Resource Center and further nationwide development of suicide/crisis hotlines. The National Institutes of Health (NIH) in the HHS, through its National Institute of Mental Health (NIMH), will manage an aggressive suicide prevention research portfolio.

Educate the Public About Men and Depression

NIMH will continue its "Men and Depression" Campaign, a major HHS public information effort to encourage men and their families to recognize depression—the disease condition that causes the most disability in America—and seek treatment.

Develop Prototype Individualized Plans of Care That Promote Resilience and Recovery

The Commission recommended development of an individualized plan of care for every adult with a serious mental illness and every child with a serious emotional disturbance. These customized plans, developed in full partnership with consumers, parents of children and adolescents, and other family members as appropriate, must include evidence-based and promising practices in prevention and treatment, and must promote resilience and recovery. To this end, SAMHSA will convene a consensus development meeting to discuss the meaning and process of recovery for children, adults, and older adults. The agency will build on this meeting by reviewing current best practices and providing technical assistance to States and providers on the design and development of prototype individualized plans of care for children, adults, and older adults. These plans will describe the services and supports that must be coordinated from among multiple systems for an individual to achieve recovery and will be designed to be flexible so they can be adapted to meet an individual's changing needs and preferences. When developed, these prototype plans will be shared with States, communities, providers, consumers, and family members to promote the use of customized plans of care in transformed mental health systems.

Promote Quality Services in the Workforce Development System for People With Mental Illnesses

DOL will work with its Federal partners to initiate the following strategies designed to increase employment opportunities for adults and youth with mental disorders.

- Develop an employer initiative to increase recruitment, employment, advancement, and retention of people with mental illnesses.
- Promote the use of customized employment strategies, including self-employment, micro-enterprise development, and small business options for people with mental illnesses.
- Help mental health support systems become Employment Networks under the Ticket to Work and Work Incentives Improvement Act.
- Disseminate information on mental health issues through DOL grant initiatives and programs such as: Work Incentive Grants, Customized Employment Grants, Homeless Veterans' Reintegration Program, Incarcerated Veterans' Reintegration Program, Veterans' Workforce Investment Program, Transition Program, Youth Offender Demonstration Program, Serious and Violent Re-entry Initiative, Ready4Work Grants, High School/High Tech Grants, and Chronically Homeless Grants.
- Assist youth with serious emotional disturbances involved with the juvenile justice system to transition into employment.
- Promote the employment of people with mental illnesses who are chronically homeless.
- Facilitate linkages between DOL/SSA's joint Disability Program Navigator Initiative, SAMHSA, and related State and local mental health service systems.
- Establish a DOL Work Group to promote quality employment of adults with serious mental illnesses and children with serious emotional disturbances.

Much concern was expressed by the Commission for youth with serious emotional disturbances dropping out of school with little prospects for meaningful employment. ED's Office of Special Education and Rehabilitation Services will work with DOL, SAMHSA, and SSA to assist older youth to transition from school to a post-secondary education program or employment.

As the largest provider of comprehensive health services in America, the Veterans Health Administration has created an action agenda to implement all relevant recommendations in the *Final Report of the President's New Freedom Commission on Mental Health*. An internal Steering Committee, along with participants from various Federal partners, already has embarked upon this challenging undertaking. The action agenda will drive a sustained effort over time to orient the Veterans Health Administration toward the expectation of recovery and veteran-centered care with a commitment to the provision of evidence-based services.

Initiate a National Effort Focused on Meeting the Mental Health Needs of Children as Part of Overall Health Care

The Commission highlighted the need for a national focus on the mental health needs of children and their parents/guardians that includes screening, assessment, early intervention, treatment, training, and financing services for children identified to be at risk for developing mental disorders. A Task Force of the Federal Executive Steering Committee (described below under Principle B) will develop a national public education initiative for parents, providers, and policy makers about the importance of the first years of life in developing a healthy foundation for social, emotional, and cognitive development. In addition, the Task Force will propose a comprehensive approach at the Federal and State levels for children identified to be at risk for mental disorders, assessment, and intervention in early childhood settings; educating and training professionals and families in effective treatment approaches and supports for young children identified to be at risk and their parents; and eliminating disincentives and barriers, particularly in financing systems, to serving this population.

Expand Consumer-Oriented Web Site

Personal health information systems can help consumers manage their own care while gaining computer literacy skills. To this end, SAMHSA's Center for Mental Health Services (CMHS) will explore investing in the development of a user-friendly, consumer-oriented web site—such as the San Diego Network of Care for Mental Health—in 25 geographically diverse locations around the country. The San Diego web site was featured as a model program in the *Final Report* of the President's New Freedom Commission. It provides information on mental illnesses and community resources and gives individuals and family members the ability to create personal health records on a secure server. Consumers can control personal health records, and the privacy of such records is protected according to regulations under the Health Insurance Portability and Accountability Act (HIPAA). The Federal funding will serve as seed money to the local jurisdictions, which will fund ongoing development and support of this vital resource that will put mental health information and services as close as the nearest Internet connection. Information technology accessibility for all individuals with disabilities is mandated by Section 508 of the Rehabilitation Act and is a cornerstone of the President's New Freedom Initiative.

Continue ADA, *Olmstead* Compliance Efforts

The Office of Civil Rights (OCR) in the HHS Office of the Secretary, together with the SAMHSA/CMHS New Freedom Initiative technical assistance center, will continue *Olmstead* voluntary compliance initiatives, including providing technical assistance to States, disseminating information about *Olmstead* compliance, and promoting ADA compliance and community care. In keeping with its compliance responsibilities, OCR also will continue to investigate complaints and conduct compliance reviews to protect and enhance the rights of people with mental

illnesses under Section 504 of the Rehabilitation Act and the ADA, with particular emphasis on Title II ADA most integrated setting complaints (i.e., *Olmstead* complaints) and will protect the rights of people with mental illnesses under the HIPAA Privacy Rule to prevent inappropriate disclosures of mental health information.

PRINCIPLE B **Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.**

Consumers and families told the Commission that feeling hopeful and having the opportunity to regain control of their lives was vital to their recovery and to their children's recovery. However, understandably, consumers and family members feel overwhelmed and bewildered when they must access and integrate mental health care, support services, and disability benefits across multiple, disconnected programs that span Federal, State, and local agencies, as well as the private sector. This situation must be reversed so consumers of mental health services and family members stand at the center of the system of care. In particular relevant Federal programs must be aligned to improve access and accountability for mental health services at the Federal level and to serve as an example of such coordination at the State and local level. The Commissioners also urged that disparities in access to and quality of mental health services be eliminated. Highlights of the Federal response to this principle follow.

Launch the Federal Executive Steering Committee on Mental Health

The Federal government must take a leadership role to promote and model the type of collaborative efforts required for system transformation at the State and local levels. To this end, HHS will lead an intra- and inter-agency Federal Executive Steering Committee to guide the work of mental health system transformation. The Department will appoint as members high-level representatives from agencies within the HHS and from other Federal departments that serve children, adults, and older adults who have mental disorders. The Department will charge this group with providing ongoing stewardship for the work that resulted from the New Freedom Initiative and the President's New Freedom Commission on Mental Health to promote access and effective services for adults with mental illnesses and children with emotional disturbances in all spheres of community life.

The Department will require the entire Executive Steering Committee and selected Task Forces it appoints to meet regularly. These Task Forces will oversee vital elements of the transformation agenda and will include groups on workforce development, rural issues, children, eliminating disparities, and evidence-based practices, among others. In carrying out its specific charge, each Task Force will consider all elements key to community integration for children, adults, and older adults with mental disorders, including housing, employment, transportation, education, and

assistive technology. Finally, the Department will require the Steering Committee to submit a progress report every 2 years, including a report on measurable benchmarks for success.

Include Eliminating Disparities in Mental Health Services as Part of the HHS "Close the Gap Initiative"

A Task Force of the Federal Executive Steering Committee on Mental Health will work closely with the Secretary's Health Disparities Council to ensure that eliminating disparities in mental health services is integral to the Department's overall "Close the Gap Initiative."

Create a National Strategic Workforce Development Plan to Reduce Mental Health Disparities

The mental health service delivery system can be only as good as the practitioners who staff it. Therefore, the Commission recommended making strong efforts to train, educate, recruit, retain, and enhance an ethnically, culturally, and linguistically competent mental health workforce throughout the country. In response, a Task Force of the Federal Executive Steering Committee will oversee creation of a national strategic plan to develop a mental health workforce better able to deliver culturally competent, evidence-based, 21st century health care. The strategic plan should address a wide range of providers, including psychiatrists, psychologists, nurses, social workers, consumers, and family members.

The Task Force will convene selected behavioral health care leaders from both the public and private sectors to create and manage a national strategic planning process. The goal of this effort will be to expand and improve the capacity of the mental health workforce to meet the needs of racial and ethnic minority consumers, children, and families; to address the concerns of rural mental health consumers and family members; to make consistent and appropriate use of evidence-based mental health prevention and treatment interventions; and to work at the interface of primary care and behavioral health care settings.

Initiate a Project to Examine Status of Competencies in Relevant Health Care Education and Training Programs

The Commission recommended that all federally funded health and mental health training programs explicitly include cultural competence in their curricula and training experiences.

To this end, SAMHSA will initiate a project to examine all current behavioral health care education and training programs that receive federal funds to help determine the extent to which they recruit and retain racial and ethnic minority and bilingual trainees, emphasize the development of cultural and linguistic competence in clinical practice; develop and include curricula that address the impact of culture, race, ethnicity, and geography on mental health and mental illnesses, on help-seeking behaviors, and on service use; engage minority consumers and families in workforce development and training; and educate trainees about evidence-based mental health interventions, among other areas.

Develop a National Rural Mental Health Plan

Despite the fact that rural America is home to approximately 25 percent of the U.S. population, rural issues are often misunderstood, minimized, and not considered in forming national mental health policy. A Task Force of the Federal Executive Steering Committee will work with the HHS Secretary's Rural Task Force to identify and convene key leaders in both the public and private behavioral health care sectors and will provide leadership and logistical support toward the development of a national rural mental health plan. At a minimum, this plan will address the integration of mental health and physical health care, financing incentives, alternative insurance mechanisms, workforce enhancement programs, and the effectiveness of mental health services delivered by distant providers using telehealth technologies.

Include Mental Health in Community Health Center Consumer Assessment Tools

Despite the fact that people with mental disorders are seen routinely in primary care settings, their mental health disorders may go undiagnosed, untreated, or undertreated in primary care. Based on findings of the U.S. Preventive Services Task Force and the Institute of Medicine report, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (2000), SAMHSA, the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA) will collaborate to facilitate serving adults and older adults identified to be at risk for depression, and, with prior parental consent, children and adolescents identified to be at risk for mental, emotional, and behavioral problems in federally funded Community Health Centers, and to coordinate followup treatment with community mental health agencies or other appropriate providers.

Promote Strategies to Appropriately Serve Children With Mental Health Problems in Relevant Service Systems

Serious emotional disturbance (SED) in childhood can be an important precursor to the development of serious mental illnesses as an adult. Supporting the mental health of children and adolescents with SED and their families is a strategic investment that will create long-term benefits for individuals, systems, and society. Children at risk for development of mental disorders and serious emotional disturbances are seen in numerous service systems, including schools, primary health care clinics, child care programs, the child welfare system, and the juvenile justice system. Neither *Achieving the Promise* nor this *Action Agenda* recommends mandatory and/or universal screening of children. The Commission recognized that parents are the decision-makers in the care for their children and if screening appears to be an appropriate action, parental consent must be obtained before it occurs. For these children, early detection through screening may help parents identify emotional or behavioral problems and assist them in getting appropriate services and supports before problems worsen and have longer-term consequences. Therefore, HHS agencies—including SAMHSA, Administration for Children and Families (ACF) and its Administration on Developmental Disabilities, the Agency for Healthcare Research and

Quality (AHRQ), the Office on Disability, and HRSA—together with ED and DOJ, will gather and review current screening instruments to determine which are the most developmentally, culturally, and environmentally appropriate for children. Mental health consumers, parents/guardians, and youth will participate in this review.

This Federal review group will make a commitment to assess the feasibility of implementing one or a combination of these instruments in specific service systems where children identified to be at risk for mental disorders present for care and where providers can work with parents to link children to appropriate services and interventions, as needed. The goal is to recognize emotional and behavioral problems at an early stage so preventive interventions can help forestall future disease and disability and reduce the need for extensive treatment.

PRINCIPLE C **Focus financing policies that maximize the ... resources by increasing ... and reducing unnecessary ... burdens or ... regulatory barriers.**

Fragmented services often result from regulatory barriers that require a program or agency to use its funds to serve particular individuals with specific problems, even though people with mental illnesses have multiple and complex needs and require a broad array of services to address these needs. This narrow approach leads to increased costs, duplication of services, lack of services, and confusion for individuals and family members. Financial and regulatory barriers must be addressed to allow adults with serious mental illnesses and children with serious emotional disturbances to gain access to the type and level of care they need and to permit the most effective use of existing resources. Highlights of the Federal response to this principle follow.

Initiate Medicaid Demonstration Projects

Medicaid is the largest single funder of public mental health services in this Country, and Medicare is a significant payer, as well. As such, the Centers for Medicare and Medicaid Services (CMS) in the HHS is a critical player in the Federal response to mental health system transformation. Current Medicaid policies may act as disincentives to the development of community-based services for children, adults, and older adults with mental disorders. In response, CMS is committed to convening key stakeholders to discuss these barriers and to supporting demonstration projects to test the feasibility of alternative approaches, if authorized and funded by Congress. These may include demonstrations of:

- Supported employment, a mental health evidence-based practice;
- Respite care services for caregivers of adults or children with disabilities, including mental illnesses;
- Alternatives to psychiatric residential treatment for children with serious emotional disturbances;
- Efforts that promote self-determination and consumer direction in mental health systems, such as person-centered planning, vouchers, and consumer-operated services; and
- Systems of flexible financing for long-term care that allow money to follow the individual.

In each case, these projects will demonstrate funding strategies that promote and support community-based treatment for children, adults, and older adults with mental disorders. CMS makes funding available through Systems Change Grants for feasibility studies for several of the demonstrations mentioned above. Additionally, CMS provides technical assistance for States pursuing these projects.

Help Parents Avoid Relinquishing Custody and Obtain Mental Health Services for Their Children

The Commission decried the fact that some parents have been forced to relinquish custody to obtain needed mental health services for their children. HHS will lead an effort among Federal agencies to initiate a multifaceted approach across systems with the goal of ending this tragic practice and increasing families' access to home- and community-based services and systems of care for their children with serious emotional disturbances. At a minimum, this effort will include the provision of technical assistance and dissemination of information to families and States on the State Children's Health Insurance Program (SCHIP) and on Medicaid options, such as the provision of home- and community-based services for children with mental or physical disabilities as authorized by the Tax Equity and Fiscal Responsibility Act (TEFRA); the Home- and Community-Based Services Waiver; the Rehabilitation Option; and proposed Medicaid demonstration projects, including respite services for caregivers and alternatives to psychiatric residential treatment for children with serious emotional disturbances. In addition, HHS and its Administration for Children and Families (ACF) will clarify Federal law, Title IV-E, and develop model legislation clarifying the responsibility of State Child Welfare Agencies and prohibiting custody relinquishment to access mental health services.

Support the Ticket to Work Program

As part of its overall support for the Ticket to Work and Work Incentives Improvement Act of 1999, CMS will release a solicitation to provide health care and other support services to individuals, including those with serious mental illnesses, who may be at risk of losing employment and independence. This solicitation will be for the Demonstration to Maintain Independence and Employment.

Additionally, under the Ticket to Work and Work Incentives Improvement Act, CMS will provide assistance to States through a Medicaid Infrastructure Grant Program. The Ticket to Work Act addresses many of the work disincentives faced by people receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), such as loss of cash benefits and medical coverage. The Medicaid Infrastructure Grant program for 2004 includes a provision that will allow States to propose the use of funding to lessen or remove the primary barriers to employment for adults with disabilities through a comprehensive, coordinated approach between Medicaid and non-Medicaid programs.

The major objectives of this program, called Comprehensive Employment Opportunities Infrastructure Development, are (1) protection of health care coverage, (2) availability of key supportive services, and (3) increased coordination of programs and policies. While the proposals

submitted by States will vary, CMS expects that States participating in this program will use the funds to remove barriers to work for people with disabilities, including people with mental disorders, by creating health systems change through the Medicaid program or by bridging Medicaid and other programs to further remove barriers.

Educate Employers and Benefits Managers on the Practicability of Paying for Mental Health Services

A multidisciplinary group of mental health consumers, corporate benefit managers, health care consultants, pharmacy benefit managers, and Employee Assistance professionals will be invited to form an Employer Toolkit Workgroup to review the recommendations of the New Freedom Commission on Mental Health and to suggest a comprehensive approach for employers in selecting and purchasing mental health services. A toolkit for employers to use will contain several items, including a Solution Brief outlining the issues, guidelines for selecting a mental health vendor, recommendations for evaluating performance of mental health vendors, disability programs, and pharmacy vendors. The toolkit will provide guidance for the structure and operations of these various programs, including sample policies and procedures.

Develop a Strategy to Implement Innovative Technologies in the Mental Health Field

SAMHSA will convene a consensus development workgroup, including HHS Office of the National Coordinator for Health Information Technology (ONCHIT), HRSA's Office for the Advancement of Telehealth, public mental health and private-sector experts, consumers, and family members, to:

- Review the current status of telemedicine, information technology, Internet technology, and electronic decision support tools in health care;
- Examine the current status of implementation of these tools in mental health; and
- Prepare key recommendations for immediate next steps in technology support for mental health services.

Explore Creation of a Capital Investment Fund for Technology

Studies show that technology can be used to improve the quality, accountability, and cost-effectiveness of health care services. To help harness the tremendous power of technology for mental health care, SAMHSA will explore the creation of a Capital Investment Fund for Technology. The Capital Investment Fund will be used to work with States to design and initiate an electronic health record and information system that is consistent with the Institute of Medicine Report, *Patient Safety: Achieving a New Standard of Care (2004)*. The electronic health record and information system will incorporate an individualized plan of care and will be consistent with the proposed Comprehensive State Mental Health Plan. It will provide decision support to service providers as they order tests, diagnose illness, and devise treatment plans. The system also will provide the capacity for an unprecedented, real-time disease surveillance and management system.

PRINCIPLE D: [illegible] research findings can influence the delivery

Effective, state-of-the-art treatments vital for quality care and recovery are now available for most serious mental illnesses and serious emotional disturbances. Yet these new, effective practices often are not being used to benefit countless people with mental disorders. There is a significant lag time between discovering effective forms of treatment and incorporating them into routine patient care. Further, even when new discoveries become available routinely at the community level, clinical practice may be inconsistent with the original treatment model, especially when staff are not adequately trained to provide evidence-based care. The lag time between research and practice must be shortened, and evidence-based practices must become a part of routine mental health care for all children, adults, and older adults with mental disorders. In addition, more research is needed in the critical areas of mental health disparities, the long-term effects of medications, trauma, and acute care.

Accelerate Research to Reduce the Burden of Mental Illnesses

Building on the discoveries rapidly emerging from the decoding of the human genome and from new, more powerful imaging techniques, NIMH will reorganize and streamline research to produce new interventions. The ultimate goal will be to prevent or cure mental illnesses.

Expand the National Registry of Evidence-Based Programs and Practices to Include Mental Health

The Nation must have a more effective system to identify, disseminate, and apply proven treatments and evidence-based practices to mental health care, the Commission noted. In response, SAMHSA will expand its National Registry of Evidence-based Programs and Practices (NREPP) to include the best evidence-based mental health promotion and treatment interventions for mental disorders. The Agency will:

- Identify a procedure through which the status of evidence-based practices can be reviewed and summarized for the public and private mental health service delivery fields;
- Summarize action steps currently being taken in parallel fields, such as primary care, to implement evidence-based practices;
- Review the activities of the Practice Guideline Coalition and NREPP, and make recommendations for how they might be integrated and implemented in the mental health services; and
- Recommend a procedure through which consensus can be developed across key mental health groups, consumers, and family members regarding implementation of evidence-based practices.

Develop New Toolkits on Specific Evidence-Based Mental Health Practices

To disseminate more broadly known evidence-based practices to the field, SAMHSA will expand its National Evidence-Based Practices Project with the addition of toolkits in areas that may include children's services, supportive housing, older adults, trauma and violence, collaborative models in primary care, consumer-operated service approaches, and supported education. The toolkits, developed in collaboration with private partners, will include materials for administrators, clinicians, consumers, and family members on the implementation of evidence-based practices and will be tested in pilot States.

Expand the "Science-to-Services" Agenda

The 15- to 20-year gap it takes for new research findings in mental health prevention and treatment to become part of everyday services for children, adults, and older adults is simply unacceptable. SAMHSA and NIH have begun a formal "Science-to-Services" agenda to further develop and expand evidence-based practices in the field. This is an ongoing, reciprocal relationship in which science informs services, and the experiences of service providers identify priority areas for further research. SAMHSA's CMHS and NIMH are spearheading this effort for the area of mental health. To expand these efforts, a Task Force of the Federal Executive Steering Committee will work with SAMHSA, NIH, AHRQ, and CMS to identify those evidence-based and promising practices that warrant further research, those that are ready for field implementation, and those that can and should be funded at the State and local level. The Task Force will consider all three legs of the research-to-practice stool—science, services, and funding—and will establish guidance to the field about the practical application of research findings.

Conduct Research to Reduce Mental Health Disparities

NIMH is expanding its support for programs that conduct research to reduce health disparities by issuing a new program announcement (2004) for the development of Advanced Centers for Mental Health Disparities Research. The purpose of this initiative is to promote the enhancement of established research core infrastructures and investigator-initiated research aimed at understanding and ameliorating mental health disparities. Research projects may include, but are not limited to, studies of mental health disparities among American Indians, Alaska Natives, Asian Americans, African Americans, Hispanics, and Native Hawaiians and Pacific Islanders. Studies of ethnic subpopulations within these broad categories are also encouraged. The Institute will also continue its support for the Disparities in Mental Health Services Research Program, the Socio-Cultural Research Program, the Office of Special Populations, and the Office of Rural Mental Health (NIH).

PRINCIPLE E **Follow the principles of Federalism, and ensure that [the Commission's] recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.**

The Commission made clear that much of the work of system transformation will take place at the State and local levels, as well as in the private sector. The Federal government, in turn, can facilitate innovation and flexibility by promoting the development of transformed systems of care for adults with serious mental illnesses and children with serious emotional disturbances. State Incentive Grants and similar vehicles encourage innovation and require accountability; however, funding for such grants is necessary but not sufficient. Federal agencies and programs have a key role to play in providing the types and range of technical assistance and training that will move the field forward, from one in which individual agencies treat specific clients to one in which a comprehensive system of care is accessible to adults and children with mental disorders and their family members. Highlights of the Federal response to this principle follow.

Award State Mental Health Transformation Grants

The Commission vested States with one of the most critical elements of system transformation: creation of Comprehensive State Mental Health Plans. Development of the State plans requires that all key stakeholders be at the table, including consumers and family members, and those who work in systems that serve children, adults, and older adults with mental disorders, such as criminal and juvenile justice, child welfare, health housing, homelessness, employment, education, and transportation.

President Bush's Fiscal Year 2005 proposed budget contained $44 million and Congress appropriated $20 million to help States develop comprehensive plans. CMHS will design, implement, and evaluate a 3-year State Mental Health Transformation Grant program to support State efforts to develop a Comprehensive Mental Health Plan. These grants are expected to support State mental health services infrastructures and to promote implementation of science-based mental health interventions. SAMHSA will help grantees identify prototype State plans and provide technical assistance to customize these plans for specific State needs.

Award Child and Adolescent State Infrastructure Grants

SAMHSA will continue to support the Child and Adolescent State Infrastructure Grant program. These grants help States increase their system infrastructures to support mental health and/or substance abuse services and programs for children and adolescents with mental, substance use, and/or co-occurring disorders. These 5-year grants will focus on strengthening State capacity to transform the service delivery system to meet the needs of this population of youth and their parents/guardians, including cross-system coordination and collaboration, financing, increased access to services, workforce development, data management and accountability, implementation

of evidence-based interventions, individualized care planning, service integration, family and youth involvement, and sustainability of system reforms. These grants will complement and help prepare States for SAMHSA's State Mental Health Transformation Grants and the development of their Comprehensive State Mental Health Plans, which include cross-system planning for children who have serious emotional disturbances.

Develop Statewide Systems of Care for Children With Mental Disorders

HRSA's State Maternal and Child Health Early Childhood Comprehensive Systems Grants will bring in other Federal partners to plan for and develop statewide systems of care to support the healthy social and emotional development of children. These grants enable States to plan, develop, and implement comprehensive, collaborative systems to improve childhood outcomes. In particular, grants support the development of a State plan that addresses access to health insurance and regular primary care services, mental health and social-emotional development interventions, early child care and educational supports, and parent education and family support. These are 2-year planning grants followed by multi-year implementation grants.

Establish a Foundation for the Samaritan Initiative

Based on experience with the $35 million Collaborative Initiative to Help End Chronic Homelessness, the President proposed the Samaritan Initiative at $200 million in his Fiscal Year 2005 budget. This initiative would provide funding for permanent supportive housing for people who experience chronic homelessness.

Establish the Reentry Initiative for Ex-Prisoners With Psychiatric Disabilities

HUD's 2006 budget request includes $25 million as a part of a prevention initiative for prisoners returning to the community, many of whom are struggling with serious mental illnesses. HUD will collaborate with DOL and DOJ in this effort.

In addition, DOL will compile data on people served and types of services provided to people with psychiatric disabilities who are incarcerated. Information will be solicited from SAMHSA and DOJ's Bureau of Prisons, National Bureau of Corrections, and relevant foundations and associations. DOL's Employment and Training Administration, VETS, and the Faith-Based Office will support One-Stop Centers to identify resources and effective practices. Policy recommendations will be developed to address service gaps systematically and strategically.

Award Seclusion and Restraint State Incentive Grants

SAMHSA will continue to support grants designed to enhance State capacity to provide staff training to implement alternatives to seclusion and restraint in mental health care settings. This program also supports a Resource Center, which is a central repository on effective practices to reduce and eliminate seclusion and restraint and provides technical assistance to the grantees.

Highlights of the Federal Action Agenda

Highlighted Action Steps to Transform the Mental Health System		
Principle A	**Focus on the Outcomes of Mental Health Care, Including Employment, Self-Care, Interpersonal Relationships, and Community Participation.**	
	Action Steps	• Initiate a National Public Education Campaign. • Launch the National Action Alliance for Suicide Prevention. • Educate the Public about Men and Depression. • Respond to refugees' mental health needs. • Develop prototype individualized plans of care that promote resilience and recovery. • Provide technical assistance on resilience and recovery. • Promote the use of customized employment strategies. • Promote the transition of youth with serious emotional disturbances from school to post-secondary opportunities and/or employment. • Develop an employer initiative to increase the recruitment, employment, advancement, and retention of people with psychiatric disabilities. • Assist youth with serious emotional disturbances involved with the juvenile justice system to transition into employment. • Promote the employment of people with mental illnesses who are chronically homeless. • Establish a DOL Work Group to promote quality employment of adults with serious mental illnesses and youth with serious emotional disturbances. • Provide treatment and vocational rehabilitation that supports employment for people with mental disorders. • Conduct outreach to homeless individuals with mental disorders. • Initiate a national effort focused on meeting the mental health needs of young children as part of overall health care. • Create a comprehensive action agenda for implementing throughout the Veterans Health Administration all relevant recommendations of the President's New Freedom Commission on Mental Health. • Launch a user-friendly, consumer-oriented web site. • Promote ADA compliance, support and work to eliminate unnecessary institutionalization, and help eliminate discrimination.
Principle B	**Focus on Community-Level Models of Care That Coordinate Multiple Mental Health and Human Service Providers and Private and Public Payers.**	
	Action Steps	• Include issues critical to mental health in health care reform. • Launch the Federal Executive Steering Committee on Mental Health. • Build on and expand criminal and juvenile justice and mental health collaborations. • Support the Interagency Autism Coordinating Committee. • Review standards and set guidelines for culturally competent care. • Create a National Strategic Workforce Development Plan to reduce mental health disparities. • Initiate a project to examine cultural competence in behavioral health care education and training programs. • Advance efforts to integrate mental health and primary care services for racial and ethnic minorities. • Participate in HHS "Close the Gap Initiative." • Develop a National Rural Mental Health Plan. • Promote strategies to appropriately serve children at risk for mental health problems in high risk service systems. • Develop a demonstration project for children in foster care. • Foster joint responsibility and implementation strategies for children, youth, adults, and older adults with co-occurring disorders. • Focus on children in the juvenile justice and child welfare settings. • Include mental health in Community Health Center consumer assessment tools.

Highlighted Action Steps to Transform the Mental Health System (continued)		
Principle C	**Maximize Existing Resources by Increasing Cost Effectiveness and Reducing Unnecessary and Burdensome Regulatory Barriers.**	
	Action Steps	• Educate employers and benefits managers on the practicability of paying for mental health care. • Evaluate and report the impact of mental health parity. • Initiate Medicaid Demonstration Projects. • Convene Directors of State Mental Health, State Medicaid, and Regional Medicare Programs. • Help parents avoid relinquishing custody and obtain mental health services for their children • Support the Ticket to Work Program. • Address reimbursement in primary care. • Develop a strategy to implement innovative technology in the mental health field. • Explore creation of a Capital Investment Fund for Technology
Principle D	**Use Mental Health Research Findings to Influence the Delivery of Services.**	
	Action Steps	• Accelerate research to reduce the burden of mental illnesses • Foster a research partnership • Expand the "Science-to-Services" agenda. • Conduct research to understand co-occurring disorders. • Harness research to improve care. • Support research to develop new medications • Expand the National Registry of Evidence-based Programs and Practices to include mental health. • Develop new toolkits on specific evidence-based mental health practices • Develop the knowledge base in understudied areas • Conduct research to reduce mental health disparities • Review the literature and develop new studies on mental illness/general health • Conduct mental health services research in diverse populations and settings • Test new treatments for co-occurring disorders in community settings • Disseminate findings of the Juvenile Justice and Mental Health Project
Principle E	**Ensure Innovation, Flexibility, and Accountability at All Levels of Government and Respect the Constitutional Role of the States and Indian Tribes**	
	Action Steps	• Award State Mental Health Transformation Grants • Provide technical assistance to help develop comprehensive State Mental Health Plans • Award Child and Adolescent State Infrastructure Grants • Track State mental health system transformation activities • Establish a foundation for the Samaritan Initiative • Establish the Re-Entry Initiative for ex-prisoners with psychiatric disabilities • Award Seclusion and Restraint State Incentive Grants • Develop statewide systems of care for children with mental disorders • Provide technical assistance to States on systems of care for children with serious emotional disturbances and their parents and other family members • Convene State leadership to develop Statewide plans to serve children with serious emotional disturbances • Expand the Partnerships for Youth Transition Grant Program • Provide technical assistance on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) • Facilitate linkages between DOL/SSA's joint Disability Program Navigator Initiative, SAMHSA, and related State and local mental health systems • Disseminate information on mental health issues through DOL grant and program initiatives

The Federal Mental Health Action Agenda

Fundamentally Altering the Mental Health System

The *Federal Mental Health Action Agenda* offers an unprecedented opportunity to fundamentally alter the form and function of the mental health service delivery system in this country to one that puts individuals—adults with mental illnesses, children with emotional disturbances, and family members—at its very core. Gone will be a system in which outmoded and contradictory regulations dictate the services an individual receives and the funding that is available. In its place will be a seamless system of care designed to help children, adults, and older adults achieve their maximum potential in all spheres of life and at all points in their development.

Transformation of the mental health system will not be easy, nor will it happen overnight. Such wholesale change requires an unparalleled commitment on the part of the Federal government, State governments, communities, public- and private-sector providers, insurers, researchers, consumers, and family members to work together toward a single vision: the day when all adults with serious mental illnesses and all children with serious emotional disturbances live, work, learn, and participate fully in their communities. This *Federal Mental Health Action Agenda* represents the response of those Federal agencies that have a vital role to play as a catalyst for change at the State and local level.

The President's Executive Order 13263 [Appendix A] articulated five principles around which the New Freedom Commission on Mental Health framed its work. These principles embody the vision of transformation that will guide the challenging but necessary work that lies ahead. Each principle is listed below followed by a description of what a transformed mental health system will look like when this principle is applied—the "state of success" over the long term. Specific action steps for each principle represent those immediate activities that Federal agencies will initiate, not to improve on the status quo, but to begin the process of wholesale transformation of the mental health service system called for by the Commission and embraced by the President. Representative current Federal activities that reflect each of the principles are highlighted.

This is not the end of the work that lies ahead; it is, instead, a very exciting and productive beginning of a long-term process that will alter the face of mental health care in this country for generations to come.

PRINCIPLE **Focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.**

The State of Success

In a transformed mental health system:

- Americans seek mental health care when they need it, with the same confidence that they seek treatment for other health problems.
- The stigma that surrounds both mental illnesses and seeking care for mental illnesses is reduced or eliminated.
- The rate of suicide in the United States is reduced significantly.
- Recovery experiences are identified, valued, and promoted as evidence-based practices.
- Mental health services are readily available in the most integrated, community-based setting possible. Parents no longer have to relinquish custody of their children to secure needed mental health services.
- A telecommunication-based personal health information system enables every American, particularly those in rural areas for whom access to care is problematic, to obtain, maintain, and share reliable information that is crucial to his or her recovery.

Initial Action Steps

Action *Initiate a National Public Education Campaign*

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services (HHS) will convene an interagency, public-private sector workgroup to plan, create, and begin coordinating and evaluating a targeted public education campaign designed to:

- Improve the general understanding of mental illnesses and emotional disturbances;
- Make clear that recovery is possible; and
- Encourage help-seeking behaviors across the age span.

In addition, suicide prevention messages will be part of the awareness campaigns in many States and communities (see action step below). The workgroup will include mental health consumers and family members, and representatives of private- and public-sector groups with experience in developing effective public health education campaigns. Participants will be requested to pool resources to fund a mutually acceptable, comprehensive campaign over 3 years.

The public-private workgroup will develop a plan that will:

- Target educational efforts to specific sectors of America's population, e.g., racial and ethnic minorities, rural communities, education, labor, housing, primary care providers, etc. The group may convene roundtables representative of each sector to solicit recommended approaches to stigma reduction.
- Identify and promulgate research-based public health messages and activities.
- Support local efforts to reduce stigma by using SAMHSA's National Mental Health Information Center as a primary point of contact for information, publications, and service program referrals.
- Develop and initiate a marketing campaign, targeted at public and private employers, that makes a business case for hiring people with psychiatric disabilities.

Action — *Launch the National Action Alliance for Suicide Prevention*

HHS will launch the National Action Alliance for Suicide Prevention, a public-private partnership that will oversee full implementation of the National Strategy for Suicide Prevention. The Federal agencies that helped develop the National Strategy for Suicide Prevention will contribute expertise and financial resources to support the work of both the public and public-private collaborative efforts. In particular:

- Federal agencies will continue their support for the Suicide Prevention Resource Center (SPRC). The SPRC will provide assistance in planning and program implementation, identification of evidence-based practices, and program evaluation.
- Through the Hotline Evaluation and Linkage Program (HELP) managed by SAMHSA, Federal agencies will:
  - Create a mechanism to certify or accredit 200 suicide/crisis hotlines nationwide; linking the hotlines through a centralized, toll-free number; and provide a local mental health resources database for their use.
  - Gather evidence to support or refute (1) within-call effectiveness of crisis hotline interventions; (2) use and acceptance of a linked, locally based, toll-free crisis hotline; (3) reduction of self-harming behaviors; and (4) effectiveness of crisis hotline interventions to promote the use of community mental health resources for post-crisis care.
- The National Action Alliance for Suicide Prevention will garner broad stakeholder support, leverage both public and private resources, and coordinate national efforts to prevent suicide.
- SAMHSA will complete the Indicators of Success initiative, through which baseline data will be gathered for each of the National Strategy for Suicide Prevention's 11 goals and 68 objectives.
- The National Institute of Mental Health's (NIMH) Suicide Research Consortium will continue to identify new centers of excellence and manage an aggressive suicide prevention research portfolio.

- The Centers for Disease Control and Prevention (CDC) will initiate and expand several activities to improve the ability to measure and monitor fatal and nonfatal suicidal behavior, among them:
  - The National Violent Death Reporting System, which provides objective, high-quality data useful for monitoring the magnitude and characteristics of violent deaths, and for developing and evaluating prevention programs and policies.
  - The National Electronic Injury Surveillance System, which will be expanded through a collaboration between CDC and the Consumer Product Safety Commission to collect surveillance data on all types of unintentional and violent injury in a national sample of cases treated at hospital emergency departments.
  - A scientific process, overseen by a panel of experts, to develop uniform definitions for self-directed violence.

Action *Educate the public about Men and Depression*

NIMH will continue its "Men and Depression" Campaign, a major HHS public information effort to encourage men and their families to recognize depression—the illness that causes the most disability in America—and seek treatment.

Action *Respond to refugees' mental health needs*

The Administration on Children and Families' (ACF) Office of Refugee Resettlement (ORR) and the Center for Mental Health Services (CMHS) will continue to develop their intra-agency agreement through which CMHS staff will provide the following services to ORR:

- Technical assistance and consultation on mental health and social adjustment issues to resettlement agencies and community-based organizations.
- Expert consultation on new program initiatives in refugee mental health.
- Education and consultation to public and private mental health clinics and programs about the mental health and social adjustment needs of refugees.
- Regional workgroup meetings, conferences, and symposia on refugee mental health needs and emerging issues that affect refugee groups.
- Response to refugee emergencies or special initiatives.

Action *Develop prototype individualized plans of care that promote resilience and recovery*

Individualized plans of care must be developed in full partnership with consumers and family members, must include evidence-based and promising practices in prevention and treatment, and must promote resilience and recovery, including integrated employment that pays above

minimum wage, includes benefits, and provides for career advancement. To this end, CMHS will design and initiate a project to:

- Convene a consensus development meeting to discuss the meaning and process of mental health recovery for children, adults, and older adults. Consumers and families will be actively involved in developing knowledge about recovery and in contributing to measurement development activities currently underway.
- Review current best practices in the field for individualized recovery plans that can be customized for children, adults, and older adults. Consensus panels will be used to assess evidence and recommend model plans.
- Design a prototype individualized recovery plan that includes evidence-based and promising practices, and that is flexible enough to change over time.
- Disseminate this prototype model through appropriate technical assistance.

Action — *Provide technical assistance on resilience and recovery*

CMHS will continue to fund Consumer and Consumer Supporter Technical Assistance Centers. The Centers help improve State and local mental health service systems by providing consumers and their supporters, service providers, and the general public with skills to foster self-help approaches. In addition, CMHS will continue to fund family technical assistance and resource centers to help State and local mental health service systems work collaboratively with families and youth to promote delivery of child- and parent/family-driven care.

Action — *Promote the use of customized employment strategies*

The Department of Labor (DOL) will work with the Small Business Administration, the Rehabilitation Services Administration, HHS, and the Social Security Administration (SSA) to generalize to the mental health community the customized employment model established by the DOL Office of Disability Employment Policy. This not only includes self-employment, micro-enterprise, and small business development, but also the use of Individual Training Accounts and Individual Development Accounts to focus on training, support, and accommodations for people with psychiatric disabilities. The goals of this effort are to help underemployed and unemployed individuals achieve competitive employment based on individual choice; increase earnings, benefits, and career development opportunities; and use technology to promote employment.

Action — *Promote the transition of youth with serious emotional [illegible] from school to post-secondary opportunities and/or emp[illegible]*

The Department of Education's (ED's) Office of Special Education and Rehabilitation Services will work with DOL, SAMHSA, and SSA on this issue. Activities will include researching, demonstrating, and disseminating successful strategies to transition youth and young adults

with mental disorders into employment and developing policy, regulatory, and systemic change to ensure that strategies are implemented. These activities will be coordinated with SAMHSA's Partnerships for Youth Transition Grants Program (see Principle E).

Action *Develop an employer initiative to increase the recruitment, employment, advancement, and retention of people with psychiatric disabilities*

DOL will increase the participation of people with psychiatric disabilities in high-growth industries and expanding sectors of the economy by marketing to employers the business case for hiring these individuals. Employer focus groups will be used to identify barriers to hiring people with psychiatric disabilities. The initiative will involve local business leadership networks, Chambers of Commerce, and various trade associations. This initiative also will include working with the Federal government to increase the hiring of people with psychiatric disabilities.

Action *Assist youth with serious emotional disturbances who are involved with the juvenile justice system to transition into employment*

DOL will work with the Department of Justice (DOJ) and SAMHSA to identify youth with serious emotional disturbances who are involved with the juvenile justice system. Once these potential workforce development customers are identified, DOL, through its One-Stop Centers, will support their efforts to find employment in the community.

Action *Promote employment of people with psychiatric disabilities who are chronically homeless*

DOL and the Department of Housing and Urban Development (HUD) will jointly fund five chronically homeless employment 5-year demonstration grants. These grants are system-change grants. DOL will fund a Technical Assistance Initiative to support these projects, along with identifying and disseminating information on effective practices. SAMHSA's PATH program and its other homeless initiatives will be linked with these grants and the workforce development system.

Action *Establish a DOL Work Group to promote quality employment of adults with serious mental illnesses and youth with serious emotional disturbances*

Under the auspices of its Office of Disability Policy, DOL will convene an intra-Department workgroup to develop a multi-pronged strategy, including policy research and demonstration grants, to promote quality employment outcomes for adults with serious mental illnesses and youth with serious emotional disturbances. A uniform data collection system will be developed to provide a clear picture of the impact of DOL's programs, including discretionary grants, Workforce Investment Act-mandated programs, and other programs not mandated by the Workforce Investment Act. Based upon this information, a research agenda will be developed.

Action *Provide treatment and vocational rehabilitation that support employment for people with mental disorders*

The SSA's Mental Health Treatment Study will determine the effect of treatment funding on the health, health care, and job-seeking behaviors of disability beneficiaries for whom a mental disorder is the primary diagnosis. The study will pay for outpatient mental health treatments (pharmaceutical and psychotherapeutic) and/or vocational rehabilitation services that are not covered by other insurance.

Action *Conduct outreach to homeless individuals with mental disorders*

Congress appropriated $8 million for SSA to conduct outreach to homeless individuals, including those with serious mental illnesses, and other underserved populations. SSA awarded cooperative agreements with medical and social service providers currently doing outreach to homeless people to help connect these individuals to benefits for which they are eligible.

Action *Initiate a national effort focused on meeting the mental health needs of young children as part of overall health care*

A Task Force of the Federal Executive Steering Com. tee (described below under Principle B) will focus on the mental health needs of young children. The Task Force will do the following:

- Develop a national public education plan for parents, providers, and policy makers about the importance of the first years of life in developing a healthy foundation for social, emotional, and cognitive development.
- Propose a comprehensive approach at the Federal and State levels for the appropriate intervention for children identified to be at risk for mental disorders in early childhood settings; educating and training professionals and families in effective treatment approaches and supports for young children identified to be at risk and their parents; and eliminating disincentives and barriers, particularly in financing systems, to serving this population.

The national effort will build on and coordinate Federal and State programs that are intended to address the needs of at risk young children and their parents, such as:

- Head Start,
- Parts B and C of the Individuals with Disabilities Education Act (IDEA),
- ACF's Child Care Development Fund,
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT),
- The Health Resources and Services Administration's (HRSA's) State Maternal and Child Health Early Childhood Comprehensive Systems Grants and federally funded health centers, and
- DOJ's Safe Start program.

For this and all other proposed actions related to children and adolescents, the *Federal Mental Health Action Agenda* clearly recognize that parents are the decision-makers in the care for their children and if any services, including screening, appear to be an appropriate action, parental consent must be obtained before it occurs. Parents or guardians should always be included in the process of making choices and decisions for minor children. This same support and guidance can also include family members for individuals older than 18 years of age.

Action

Create a comprehensive action agenda to implement the Veterans Health Administration all relevant recommendations of the President's New Freedom Commission on Mental Health

As the largest provider of comprehensive health services in America, the Veterans Health Administration has created an action agenda for implementing all relevant recommendations in the *Final Report* of the President's New Freedom Commission on Mental Health. An internal Steering Committee, along with participants from various Federal partners, already has embarked upon this challenging undertaking. The action agenda will drive a sustained effort over time to orient the Veterans Health Administration toward the expectation of recovery and veteran-centered care with a commitment to the provision of evidence-based services.

Action

Launch a user-friendly, consumer-oriented web site

Personal health information systems can help consumers manage their own care while gaining computer literacy skills. To this end, CMHS will explore investing in the development of a user-friendly, consumer-oriented web site—such as the San Diego Network of Care for Mental Health—in 25 geographically diverse locations around the country. The San Diego web site was featured as a model program in the *Final Report* of the President's New Freedom Commission. It provides information on mental illnesses and community resources, and gives individuals and family members the ability to create personal health records on a secure server. Consumers can control personal health records, and the privacy of such records is protected according to the regulations of the Health Insurance Portability and Accountability Act (HIPAA). The Federal funding will serve as seed money to the local jurisdictions, which will fund ongoing development and support of this vital resource to place mental health information and services as close as the nearest Internet connection. Information technology accessibility for all individuals with disabilities is mandated by Section 508 of the Rehabilitation Act and is a cornerstone of the President's New Freedom Initiative.

Action

Promote ADA compliance, support and work to eliminate institutionalization, and help eliminate discrimination

The Office of Civil Rights (OCR) in the HHS Office of the Secretary, together with the SAMHSA/CMHS New Freedom Initiative technical assistance center, will continue *Olmstead* voluntary compliance initiatives, including providing technical assistance to States, disseminating

information about *Olmstead* compliance, and promoting Americans with Disabilities Act (ADA) compliance and community care. In keeping with its compliance responsibilities, OCR also will continue to investigate complaints and conduct compliance reviews to protect and enhance the rights of people with mental illnesses under Section 504 of the Rehabilitation Act and the ADA, with particular emphasis on Title II ADA most integrated setting complaints (i.e., *Olmstead* complaints) and will protect the rights of people with mental illnesses under the HIPAA Privacy Rule to prevent inappropriate disclosures of mental health information to employers.

Selected Current Federal Activities in Support of This Goal

ACTIVITY National Mental Health Information Center

SAMHSA's National Mental Health Information Center serves as a focal point for mental health information and referral to services. This service includes a toll-free call center staffed by English- and Spanish-speaking specialists trained to respond to inquiries about mental health issues and treatments, and to refer callers to appropriate State and local mental health organizations and resources. The Information Center also operates a web site that offers materials targeted to consumers, families, and professionals. See www.mentalhealth.samhsa.gov.

ACTIVITY National Runaway Switchboard and Clearinghouse on Families and Youth

ACF operates the National Runaway Switchboard, providing 24-hours-a-day, 7-days-a-week counseling and referral to youth in crisis, runaway youth, and homeless youth, many of whom are at risk for suicide and other mental health issues. ACF also funds the National Clearinghouse on Families and Youth to provide information and referrals for youth at risk.

ACTIVITY Depression Health Disparities Collaborative

The Depression Health Disparities Collaborative, funded by HRSA, facilitates development of learning opportunities for treating depression as a chronic disease. HRSA will use the infrastructure of the Health Disparities Collaboratives to ensure appropriate treatment protocols for primary health care practices in selected Community Health Centers.

ACTIVITY Collaborative Care Models for People Who Are Chronically Homeless

The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) is contributing to the evaluation of 12 SAMHSA- and HRSA-funded service delivery grants to improve access to both behavioral and primary care services for individuals who are chronically homeless. The evaluation is examining clinical outcomes for the collaborative models.

ACTIVITY Initiative for Ending Chronic Homelessness Through Employment and Housing

DOL and HUD jointly fund the Initiative for Ending Chronic Homelessness Through Employment and Housing. The agencies awarded five cooperative agreements to evaluate whether partnerships between employment and permanent housing services result in a higher employment rate for people with disabilities, including people with mental disorders.

ACTIVITY Reducing Transportation Barriers

The HHS' Office of Disability (OD), the Federal Transportation Administration, ED, and DOL are addressing transportation barriers by supporting coordinated State planning efforts that result in action plans to help people with disabilities, including those with serious mental illnesses, have access to available transportation that promotes full community integration.

ACTIVITY Strategic Prevention Framework

SAMHSA's Strategic Prevention Framework is an approach to prevention and early intervention based on the public health model that promotes resilience and facilitates recovery by addressing risk and protective factors. The Strategic Prevention Framework undergirds and aligns all of SAMHSA's prevention and early intervention activities.

ACTIVITY Prevention and Early Intervention Grant Program

SAMHSA's Prevention and Early Intervention Grant Program is a Targeted Capacity Expansion (TCE) grant designed to develop mental health promotion and early intervention services targeted to infants, toddlers, preschool, and school-aged children, and/or to adolescents in mental health care settings and other programs that serve children and adolescents.

ACTIVITY HIPAA Education Card

SAMHSA is developing a HIPAA Education Card to help consumers understand their privacy rights as they relate to HIPAA.

ACTIVITY Application of HIPAA Privacy Rule to Mental Health Issues

The HHS OCR has met with mental health groups to discuss the Privacy Rule under HIPAA and its application to mental health issues and has provided guidance on protecting the privacy of mental health information.

ACTIVITY Resolution of Olmstead Cases

HHS' OCR has resolved more than 100 *Olmstead* compliance cases to prevent unnecessary institutionalization and help individuals return to their communities; has collaborated with DOJ to develop and implement an alternative dispute resolution program for *Olmstead* complaints filed with OCR; and has provided technical assistance to approximately 40 States on *Olmstead* planning.

PRINCIPLE B **...ers of care that ...tate health and ...blic and private ...th treatment and**

The State of Success

In a transformed mental health system:

- A diagnosis of a serious mental illness or a serious emotional disturbance sets in motion a well-planned, coordinated array of treatments and support services that may involve multiple agencies in a single plan of care. These plans of care give consumers, parents of children with serious emotional disturbances, clinicians, and other providers a genuine opportunity to construct and maintain meaningful, productive, and healing partnerships. Consumers and family members participate directly in planning, delivering, and evaluating community-based treatment and support services and formulating policies that direct these activities.
- Mental health services are accessible to all and responsive to the cultural differences of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values.
- The mental health workforce provides evidence-based practices; is ethnically, culturally, and linguistically competent; and reflects the diversity of the individuals it serves.
- Faith-based organizations and leaders are knowledgeable about the effectiveness of mental health services and encourage individuals and families to seek help from mental health service providers where needed. They continue to provide direct services, such as pastoral counseling that helps engage individuals who might otherwise not seek help.
- Rural mental health and public health professionals collaborate to provide evidence-based care.
- Individuals of all ages who are at risk for mental disorders are (with their or their parents'/guardian's consent) appropriately screened for the presence of mental illnesses, emotional disturbances, and substance use disorders in primary care settings; in specialty mental health and substance abuse treatment settings; and in settings where individuals are at high risk for co-occurring disorders, such as the juvenile and criminal justice systems, the child welfare system, and the homeless service system. Mental health services and substance abuse treatment are coordinated or integrated within a program or across a network of services.

Initial Action Steps

Action — *Include issues critical to mental health services in health care reform*

To help integrate discussions of mental health and physical health concerns, the HHS Office of the Secretary, together with agencies across the Department, will ensure that issues critical to mental health services are considered as a part of any dialogue on health care reform.

Action — *Launch the Federal Executive Steering Committee on Mental Health*

The Federal government must take a leadership role to promote and model the type of collaborative efforts required for system transformation at the State and local levels. To this end, HHS will lead an intra- and inter-agency Federal Executive Steering Committee to guide the work of mental health system transformation. The Department will:

- Select as members high-level representatives from agencies across HHS—including the:
  - Administration on Aging (AOA),
  - Administration for Children and Families (ACF),
  - Agency for Healthcare Research and Quality (AHRQ),
  - Centers for Disease Control and Prevention (CDC),
  - Centers for Medicare and Medicaid Services (CMS),
  - Health Resources and Services Administration (HRSA),
  - Indian Health Services (IHS),
  - National Institutes of Health (NIH),
  - Substance Abuse and Mental Health Services Administration (SAMHSA), and
  - Within the HHS Office of the Secretary, the
    - Assistant Secretary for Planning and Evaluation (ASPE),
    - Office for Civil Rights (OCR),
    - Office on Disability (OD), and
    - Office of Public Health and Science (OPHS).

  The Federal Executive Steering Committee will also have as members other Federal departments and agencies that include the:
  - U.S. Departments of
    - Housing and Urban Development (HUD),
    - Veterans Affairs (VA),
    - Education (ED),
    - Justice (DOJ),
    - Labor (DOL),
  - Social Security Administration (SSA), and
  - White House Office of Faith-based and Community Initiatives.

- Charge this group with mobilizing the participating Federal agencies to obtain the "buy-in" necessary to implement proposed reform and reduction of barriers suggested by the New Freedom Initiative and recommended by the President's New Freedom Commission on Mental Health. The Federal Executive Steering Committee will provide ongoing stewardship of the work to promote access and effective services for adults with mental illnesses and children with emotional disturbances in all spheres of community life. Service demonstrations and pilot projects can reveal how funding and other barriers can be eliminated and how consumer choice can be enhanced.
- Require the entire Executive Steering Committee and selected Task Forces it appoints to meet regularly. These Task Forces will oversee vital pieces of the transformation agenda and will include groups on workforce development, rural issues, children, eliminating disparities, and evidence-based practices, among others. The work of these Task Forces, where known, is spelled out throughout this *Federal Mental Health Action Agenda*. In carrying out its specific charge, each Task Force will consider all elements key to community integration for children, adults, and older adults with mental disorders, including housing, employment, transportation, education, and assistive technology.
- Require the Federal Executive Steering Committee to submit a report to the Department every 2 years that details (1) barriers identified, (2) strategies employed to remove these barriers, and (3) measurable outcomes that have resulted.

Action

Build on and expand criminal and juvenile justice and mental health collaborations

Building on the excellent collaboration between SAMHSA, DOI, and DOJ's Office of Justice Programs (OJP) to date, a new initiative will encompass a DOJ/HHS Cooperative Agenda that includes:

- The Serious and Violent Offender Re-entry Program;
- The Mentally Ill Offender Treatment and Crime Reduction Act of 2004;
- Efforts to address the mental health needs of victims of crime, including victims of mass violence and terrorism, and utilization of community-based grief centers; and
- Increased use of evidence-based practices.

OJP and SAMHSA will also continue to develop and support a range of successful criminal justice diversion programs, including crisis intervention teams for police, jail-based diversion, court-based diversion programs such as mental health courts and juvenile justice diversion; and reintegration practices for youth.

Action

Support the Interagency Autism Coordinating Committee

The Interagency Autism Coordinating Committee was created within HHS to coordinate autism research, education, and services efforts. Under the leadership of NIMH, the Committee's primary

mission is to facilitate the efficient and effective exchange of information on autism activities among the member agencies and to coordinate autism-related programs and initiatives. NIH, SAMHSA, other HHS agencies, and ED are committee members. Public members of the committee help bring to HHS the concerns and interests of members of the autism community.

Action

Review standards and set guidelines for culturally competent care

HHS will convene a group of representative behavioral health accrediting, licensing, training, and provider organizations and payers to review and adopt standards, and to develop guidelines and strategies to implement culturally competent care.

- At minimum, this interagency, public-private sector workgroup will include:
  - AHRQ,
  - CMS,
  - HRSA,
  - IHS,
  - NIMH,
  - SAMHSA,
  - Consumers of behavioral health care services, and
  - Accrediting bodies for services and workforce training.
- The public-private workgroup will develop a plan to:
  - Review existing standards, practice and research to ascertain the hallmarks of culturally competent services.
  - Propose additional research to identify key indicators of care that improve quality, access, utilization, effectiveness, and consumer satisfaction for racial and ethnic minorities.
  - Create an operational set of standards, benchmarks, and performance measures for culturally competent services, and disseminate this information to accrediting agencies, providers, trainers, and payers.
  - Encourage all parties to adopt and implement such expectations in their standards for services and training.

Action

Create a National Strategic Workforce Development Plan to reduce mental health disparities

A Task Force of the Federal Executive Steering Committee will oversee creation of a national strategic plan to develop a mental health workforce better able to deliver culturally competent, evidence-based, 21st century health care. The creation of a significantly more competent, capable workforce that includes mental health consumers and family members is fundamental to transformation of the mental health service delivery system and is particularly critical to address and eliminate the disparities in mental health care experienced by racial and ethnic minorities in this country.

The goal of this effort will be to expand and improve the capacity of the mental health workforce to meet the needs of racial and ethnic minority consumers, children, and families; to address the concerns of rural mental health consumers and family members; to make consistent and appropriate use of evidence-based mental health prevention and service interventions; and to work at the interface of primary care and behavioral health care settings.

The Task Force will convene selected leaders in both public and private behavioral health care to create and manage a national strategic planning process. At minimum, these leaders will represent:

- HHS (SAMHSA, HRSA, ACF, ASPE, OCR, and OD), ED, DOJ, and DOL;
- Graduate and undergraduate training programs;
- Behavioral health care providers;
- National ethnic minority mental health organizations;
- Rural mental health organizations;
- Consumers;
- Families; and
- The faith community.

This leadership group will review all relevant existing studies to understand the capacity of the current mental health workforce to provide high-quality, culturally competent services to racial and ethnic minority consumers; to meet the needs of rural consumers and family members; to understand and use evidence-based practices; and to work at the interface of primary care and behavioral health care settings. The results of this review will inform development of the strategic plan to expand and improve the Nation's mental health services workforce.

Action *Initiate a project to examine cultural competence in health care education and training programs*

The President's Commission recommended that all federally funded health and mental health training programs explicitly include cultural competence in their curricula and training experiences. To this end, SAMHSA will initiate a project to examine all current behavioral health care education and training programs that receive Federal funds to help determine the extent to which they:

- Recruit and retain racial and ethnic minority and bilingual trainees.
- Ensure that diversity of the community is reflected among trainees and in the training experience.
- Emphasize the development of cultural and linguistic competence in clinical practice.
- Prepare trainees to work in rural, frontier, and underserved areas.
- Develop and include curricula that address the impact of culture, race, ethnicity, and geography on mental health, mental illnesses, and emotional disturbances; on help-seeking behaviors; and on service use.

- Encourage training and research on multicultural populations and the needs of rural consumers.
- Engage minority consumers and families in workforce development and training.
- Educate trainees about evidence-based mental health interventions.
- Prepare trainees to work in multidisciplinary, integrated treatment settings and systems, particularly at the interface of primary care and behavioral health care treatment.

Action *Advance efforts to integrate mental health and primary care services for racial and ethnic minorities*

HRSA and SAMHSA will collaborate to improve access to mental health assessment and treatment for individuals with limited English proficiency and for individuals living in remote, rural, or hard-to-access areas in urban communities. The Agencies will urge State and local agencies to co-locate and integrate behavioral health services within other key systems, such as primary care or faith-based service organizations.

SAMHSA will convene a conference on the interface of mental health care and primary care for diverse populations. SAMHSA, HRSA, AHRQ, and the OPHS Office of Minority Health will collaborate to develop a national action agenda that includes leadership development and financing models to advance the integration of mental health services and primary health care for underserved populations, with an emphasis on racial and ethnic minorities.

Action *Participate in the HHS "Close the Gap Initiative"*

A Task Force of the Federal Executive Steering Committee will work closely with the HHS Secretary's Health Disparities Council to ensure that eliminating disparities in mental health services is part of the Department's overall "Close the Gap Initiative" and is a priority for the Health Disparities Council as it shapes and coordinates Department-wide activities.

Action *Develop a National Rural Mental Health Plan*

A Task Force of the Federal Executive Steering Committee will work with the HHS Secretary's Rural Task Force to identify and convene key leaders in both the public and private behavioral health care sectors, and will provide leadership and logistical support to develop a national rural mental health plan. At minimum, leaders will include representatives of HHS (SAMHSA and HRSA), the U.S. Department of Agriculture, and rural providers, consumers, and family members. This leadership group will contract with a qualified provider to:

- Circulate the report of the HHS Rural Task Force.
- Develop a plan for action by both the public and private sectors involved in the delivery of behavioral health care services.
- Publish a report of the workgroup's findings and recommendations that address:

- The type and degree of integration of mental health and physical health care;
- Alternative insurance mechanisms, e.g., pool purchasing;
- Incentives;
- The impact of non-Federal match requirements for grants;
- Workforce enhancement programs to address the unique requirements of rural and remote geographical areas; and
- The effectiveness of mental health services delivered by distant providers using telehealth technologies.

Action

Promote strategies to appropriately serve children at-risk for mental health problems in high risk service systems.

The Federal Action Agenda does not recommend mandatory nor universal screening of children for mental health problems. Parents are the decision-makers in the care for their children and if screening appears to be an appropriate action, parental consent must be obtained before it occurs. For these children, early detection through screening may help parents identify emotional or behavioral problems and assist them in getting appropriate services and supports before problems worsen and have longer-term consequences. Therefore, HHS agencies—including SAMHSA, ACF and its Administration on Developmental Disabilities, AHRQ, OD, and HRSA—together with ED and DOJ will gather and review current screening instruments to determine which are the most developmentally, culturally, and environmentally appropriate for children. Mental health consumers, parents, family members, and youth will participate in this review.

Serious emotional disturbance in childhood can be an important precursor to the development of serious mental illnesses as an adult. Supporting the mental health of children and adolescents with serious emotional disturbance and their parents/guardians is seen as a strategic investment that will create long-term benefits for individuals, systems, and society. Children at risk for development of mental disorders and serious emotional disturbances are seen in numerous service systems, including schools, primary health care clinics, child care programs, the child welfare system, and the juvenile justice system.

This Federal review group will make a commitment to assess the feasibility of implementing one or a combination of these instruments in specific service systems where children identified to be at risk for mental disorders present for care and where providers can work with parents to link children to appropriate services and interventions, as needed. The goal is to recognize emotional and behavioral problems at an early stage so preventive interventions can help forestall future disease and disability and reduce the need for extensive treatment.

Action

Develop a demonstration project for children in foster care

ACF, SAMHSA, and NIMH will collaborate to develop and test approaches to target and meet the mental health needs of very young children who enter the foster care system, a high-risk population with documented poor outcomes. Service and research demonstration grants for foster care early intervention approaches will be developed to support States and communities in implementing and testing effective screening, assessment, and intervention approaches for young children in foster care and their families.

Action

Foster joint responsibility and implementation strategies for children, youth, adults, and older adults with co-occurring disorders

Federal agencies will clarify roles, policies, and funding to fully implement action steps detailed in SAMHSA's *Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and Mental Disorders.* This includes identifying, disseminating, and providing technical assistance on:

- Effective assessment tools and best practices to identify children/adolescents and their parents in the child welfare and juvenile justice systems who have, or are at risk for, emotional disturbances, mental illnesses, or co-occurring mental and substance use disorders.
- Effective approaches, strategies, and best practice examples of service integration models and juvenile justice diversion models.

Further, Federal agencies will identify, disseminate, and provide technical assistance on:

- Effective screening and assessment tools and best practices to identify adults and older adults who have mental illnesses or co-occurring mental and substance use disorders, in both primary care and specialty care settings, and in the criminal justice system.
- Effective approaches, strategies, and best practice examples of service integration models.

Action

Focus on children in the juvenile justice and child welfare systems

SAMHSA will encourage applicants for the Comprehensive Community Mental Health Services Program for Children and Their Families to focus on youth in the juvenile justice and child welfare systems, and to increase the application of evidence-based practices and promising community-based approaches for these youth by designating them as a priority population in the Request for Applications (RFA). These strategies will be shared with the DOJ Office of Juvenile Justice and Delinquency Prevention and ACF for development of future joint funding initiatives.

Action *Include mental health in Community Health Center Consumer Assessments*

Based on findings of the U.S. Preventive Services Task Force and the Institute of Medicine Report *From Neurons to Neighborhoods: The Science of Early Childhood Development* (2000), SAMHSA, HRSA, and the CDC will collaborate to facilitate serving adults and older adults identified to be at risk for depression and, with prior parental consent, children and adolescents identified to be at risk for mental, emotional, and behavioral problems in federally funded Community Health Centers and to coordinate followup treatment with community mental health agencies or other appropriate providers.

Selected Current Federal Activities in Support of This Goal

ACTIVITY Family Voices

HRSA's Maternal and Child Health Bureau and HHS' CDC support Family Voices, a national grassroots network of families and friends who advocates for health care services that are family-centered, community-based, comprehensive, coordinated, and culturally competent for all children and youth with special health care needs.

ACTIVITY Circles of Care

The SAMHSA-funded Circles of Care Grant Program provides technical assistance to tribal governments and urban Indian programs to plan and assess the feasibility of implementing a culturally appropriate behavioral health care system for American Indian and Alaska Native children. Intra-agency agreements with the IHS and NIMH in HHS support technical assistance for program development and a cross-site evaluation.

ACTIVITY National Center for Cultural Competence

HRSA, SAMHSA, and ACF provide funding support to a National Center for Cultural Competence at Georgetown University that helps programs assess, plan, implement, and evaluate culturally competent approaches to health and mental health, particularly for children and their families.

ACTIVITY Rural Workforce Shortages Study

The Western Interstate Commission on Higher Education (WICHE) and the HRSA Office of Rural Health Policy support a contract to study the existing workforce shortages specific to rural communities and to make recommendations that address the findings.

ACTIVITY Tribal Youth Program Mental Health Initiative

Under the DOJ Tribal Youth Program Mental Health Initiative, American Indian and Alaska Native tribal communities receive grants to provide diagnosis and treatment for tribal youth with mental and substance use problems.

ACTIVITY Rural Access to Care for Bureau of Primary Health Care (BPHC) Grantees

A memorandum of understanding between SAMHSA and the HRSA BPHC funds training and technical assistance to improve access to mental health and substance abuse care in rural areas served by BPHC grantees.

ACTIVITY Rural Outreach Grants

The Rural Health Care Services Outreach Grant Program, funded by the HRSA Office of Rural Health Policy, includes 29 projects that deliver mental health or substance abuse services. Many of these projects integrate mental health services with primary care.

ACTIVITY Safe Start

DOJ's Safe Start initiative seeks to prevent and reduce the impact of family and community violence on young children (birth to age 6) by creating more comprehensive service delivery systems. Program sites must demonstrate collaborative partnerships among health, mental health and substance abuse, education, social services, and law enforcement agencies.

ACTIVITY Mental Health in Schools

Mental Health in Schools is a project funded by the HRSA Maternal and Child Health Bureau and SAMHSA's CMHS to support two national training and technical assistance centers. These centers, at the University of California, Los Angeles, and the University of Maryland School of Medicine, help school systems and providers strengthen their ability to address psychosocial and mental health problems in schools. As stated throughout this document, any steps to screen or assess children may only be done with the informed consent of parents/guardians.

ACTIVITY Safe Schools/Healthy Students

ED, DOJ, and HHS established the Safe Schools/Healthy Students Interdepartmental Grant Program. Local Education Agencies that receive grants establish formal partnerships with mental health service systems and law enforcement agencies to promote the healthy development of children and youth and to reduce school violence. These grants do not call for mandatory nor universal screening of school children.

PRINCIPLE Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing unnecessary and burdensome regulatory barriers.

The State of Success

In a transformed mental health system:

- The mental health service system relies on multiple sources of financing with the flexibility to pay for effective mental health treatments and services.
- Regulations and funding guidelines relevant to people with mental illnesses and emotional disturbances for housing, vocational rehabilitation, criminal and juvenile justice, disability payments, and education are clarified and coordinated to improve access and accountability for effective services. The burden of coordinating care rests with the system, not with individuals or families.
- Emerging technologies—including computers and video cameras, e-mail, and telephone consultations—overcome geographical and sociocultural distances to provide comprehensive care for individuals in underserved, rural, and remote communities.
- Reimbursement policies of both public and private payers are flexible enough to allow coordination of both traditional clinical care and e-health visits, and to ensure that services delivered through new technologies are suggested and sustained.
- Secure and private electronic medical records enhance communication between informed consumers and health care professionals and improve their discussions about treatment options.

Implementation Action Steps

Action *Educate employers and benefits managers on the practicability of paying for mental health services*

A multidisciplinary group of mental health consumers, corporate benefit managers, health care consultants, pharmacy benefit managers, and Employee Assistance professionals will be invited to form an Employer Toolkit Workgroup to review the recommendations of the New Freedom Commission on Mental Health and to suggest a comprehensive approach for employers in selecting and purchasing mental health services. A toolkit for employers to use will contain several items, including a Solution Brief outlining the issues, guidelines for selecting a mental health vendor, recommendations for evaluating performance of mental health vendors, disability programs, and pharmacy vendors. The toolkit will provide guidance for the structure and operations of these various programs, including sample policies and procedures.

Action — *Evaluate and report the impact of mental health parity*

SAMHSA will continue to study and report on the experiences of California, Vermont, and other States that implement mental health parity legislation.

Action — *Initiate Medicaid Demonstration Projects*

Medicaid is the largest single funder of public mental health services in this country, with Medicare a significant payer, as well. As such, CMS is a critical player in the federal response to mental health system transformation. Current Medicaid policies may act as disincentives to the development of community-based services for children, adults, and older adults with mental disorders. Thus, if authorized and funded by Congress, CMS is committed to supporting demonstration projects that will test the feasibility of alternative approaches. These include the following:

- Supported employment. To help individuals with mental illnesses gain and maintain employment, which can be critical to their recovery, CMS is exploring creation of a supported employment demonstration project. Supported employment is considered a mental health evidence-based practice.
- Respite Care Services. If authorized by Congress, CMS will support a demonstration of respite care services for caregivers of adults with disabilities or long-term illnesses, including psychiatric disabilities, and respite care for caregivers of children with substantial disabilities. Respite services that provide temporary relief for caregivers can help individuals with disabilities remain in their homes and communities.
- Community Based Alternatives for Children. If authorized by Congress, CMS will support States in the Demonstration of Community Based Alternatives to Psychiatric Residential Treatment Facilities for Children. The demonstration will allow CMS to determine the effectiveness and efficiency of extending home- and community-based services waivers as an alternative to residential treatment for children, thereby allowing them to receive treatment in their own homes, surrounded and supported by their families.
- Self-Determination. CMS and SAMHSA will develop a strategic action plan and consider supporting one or more demonstration projects to further efforts to promote self-determination and consumer direction in mental health service systems. These efforts—including such approaches as person-centered planning, vouchers, and consumer-operated services—have been found to be effective for people with physical disabilities and developmental disabilities, as well as for older adults. In 2004, SAMHSA collaborated with CMS to convene a Consumer Direction Initiative Summit to identify the specific needs of mental health consumers, identify potential barriers, develop a vision, and recommend next steps toward a self-directed behavioral health care system.

- Money Follows the Individual. If authorized by Congress, CMS will support a demonstration project to create a system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred service setting as the individual's needs and preferences change. To the participant, the movement of funds will be seamless.

Action

Convene Directors of State Mental Health, State Medicaid, and Regional Medicare Programs

SAMHSA and CMS recognize that it is essential their agencies work together on behalf of children, adults, and older adults with psychiatric disabilities. To model this commitment, they will continue to convene meetings of the Directors of State Mental Health, State Medicaid, and Regional Medicare programs, as well as groups of other key stakeholders (e.g., employers, benefits managers, and other public and private purchasers), to discuss how to fund and deliver evidence-based practices and community-based care to adults with serious mental illnesses and children with serious emotional disturbances. Meeting summaries will be developed and provided as guidance to the field on the use of current steps and/or new, creative methods of financing that can be used to meet the need for full community integration of individuals with mental disorders.

Action

Help parents avoid relinquishing custody and obtain mental health services for their children

HHS will lead an effort among Federal agencies to initiate a multifaceted approach across systems with the goals of ending this tragic practice and increasing families' access to home- and community-based services and systems of care for their children with serious emotional disturbances. At a minimum, this effort will include the provision of technical assistance and dissemination of information to families and States on the State Children's Health Insurance Program (SCHIP) and on Medicaid options, such as the provision of home- and community-based services for children with mental or physical disabilities as authorized by the Tax Equity and Fiscal Responsibility Act (TEFRA), the Home and Community-Based Services Waiver, the Rehabilitation Option, and proposed Medicaid demonstration projects, including respite services for caregivers and alternatives to psychiatric residential treatment for children with serious emotional disturbances. In addition, HHS and its ACF will clarify Federal law, Title IV-E, and develop model legislation clarifying the responsibility of State Child Welfare Agencies and prohibiting custody relinquishment to access mental health services.

Action

Support the Ticket to Work program

As part of its overall support for the Ticket to Work and Work Incentives Improvement Act of 1999, CMS will release a solicitation to provide health care and other support services to

individuals, including those with serious mental illnesses, who may be at risk of losing employment and independence. This solicitation will be for the Demonstration to Maintain Independence and Employment.

Additionally, under the Ticket to Work and Work Incentives Improvement Act, CMS will provide assistance to States through a Medicaid Infrastructure Grant Program. The Ticket to Work Act addresses many of the work disincentives faced by people receiving Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), such as loss of cash benefits and medical coverage. The Medicaid Infrastructure Grant program for 2004 includes a provision that will allow States to propose the use of funding to lessen or remove the primary barriers to employment for adults with disabilities through a comprehensive, coordinated approach between Medicaid and non-Medicaid programs.

The major objectives of this program, called Comprehensive Employment Opportunities Infrastructure Development, are (1) protection of health care coverage, (2) availability of key supportive services, and (3) increased coordination of programs and policies. While the proposals submitted by States will vary, CMS expects that States participating in this program will use the funds to remove barriers to work for people with disabilities, including people with mental disorders, by creating health systems change through the Medicaid program or by bridging Medicaid and other programs to further remove barriers.

Action — *Address reimbursement in primary care*

HHS will convene a high level forum of key federal agencies (including CMS, HRSA, and SAMHSA), primary care providers, managed care organizations, mental health consumers, family members, and insurers to develop and implement an action agenda that will (1) address the barriers to providing coverage for screening, linkage, consultation, and management of mental health services in the primary health care sector, and (2) develop model benefits design and strategies for reimbursement.

Action — *Develop a strategy to implement innovative technology in the mental health field*

SAMHSA will convene a consensus development workgroup, including HHS Office of the National Coordinator for Health Information Technology (ONCHIT), HRSA's Office for the Advancement of Telehealth, public mental health and private-sector experts, consumers, and family members, to:

- Review the current status of telemedicine, information technology, Internet technology, and electronic decision support tools in health care;
- Examine the current status of implementation of these tools in mental health; and
- Prepare key recommendations for immediate next steps in technology support for mental health services.

Action ***Explore creation of a Capital Investment Fund for Technology***

SAMHSA will explore the creation of a Capital Investment Fund for Technology. The Capital Investment Fund will be used to work with States to design and implement an electronic health record and information system consistent with the Institute of Medicine Report, *Patient Safety: Achieving a New Standard of Care* (2004), and with successful models of person-centered, comprehensive electronic health record systems, such as the U.S. Department of Veterans Affairs health record system, highlighted in the Commission's *Final Report*.

The electronic health record and information system will incorporate an individualized plan of care and will be consistent with proposed Comprehensive State Mental Health Plans. The system will include state-of-the-art treatment guidelines and clinical reminders that enhance using standardized, evidence-based, and promising practices to foster recovery and resiliency for children, adults, and older adults with mental disorders. System administrators will incorporate these innovations into the electronic medical records systems that providers use in clinics, offices, hospitals, and acute care and long-term care settings.

Consumers and family members can use the system to evaluate the quality of care provided; participate in online support groups; evaluate best practices; learn about the most recent treatment breakthroughs; interface with a wide range of services and programs, including appointment scheduling and reminders and medication refills; and determine how to best use resources they manage. Consumers and families must be assured that their privacy and the confidentiality of their health information are well protected.

Selected Current Federal Activities in Support of This Goal

ACTIVITY Evaluation of Parity in the Federal Employees Health Benefits Program

HHS, led by ASPE, has partnered with the U.S. Office of Personnel Management (OPM) to evaluate the impact of providing parity for mental health and substance abuse services to the approximately 8.5 million beneficiaries enrolled in the Federal Employees Health Benefits Program. HHS and OPM evaluated the impact of parity on benefit design and management, access to and use of mental health and substance abuse services, beneficiary plan, and OPM costs, quality of mental health and substance abuse services, and provider awareness.

ACTIVITY Guidance on Meeting Title VI English Proficiency Requirement

The HHS OCR has published guidance for recipients of HHS funds about how to meet their obligations under Title VI of the Civil Rights Act to provide meaningful access to people with limited English proficiency, including those who are trying to gain access to mental health services.

ACTIVITY Effectiveness of Telepsychiatry

AHRQ in HHS is testing the effectiveness of mental health service delivery using videoconferencing equipment (telepsychiatry) versus "same-room" (traditional) treatment for veterans with post-traumatic stress syndrome (PTSD). Clinical and process outcomes will be assessed.

ACTIVITY Development of Core Data Standards and Information Infrastructure

The SAMHSA/CMHS Evolution of Healthcare Reform Models Phase II project will complete Decision Support 2000+ work on core data standards and will develop an Internet-based IT system to collect and process data. Decision Support 2000+ is an integrated set of mental health data standards and an information infrastructure designed to help all stakeholders answer key questions and make critical decisions that will improve the quality of care.

ACTIVITY National Health Information Infrastructure

In support of the HHS Secretary's National Health Information Infrastructure (NHII) policy priority, ASPE has begun to accelerate the development and adoption of technology and national standards necessary for the NHII, including Electronic Health Record Systems and their use by the health care and public health systems. ASPE is coordinating its work across HHS and with other Federal agencies.

PRINCIPLE D **Consider how mental health research findings can be used most effectively to influence the delivery of services.**

The State of Success

In a transformed mental health system:

- Research is used to develop new evidence-based practices to prevent and treat mental illnesses; these discoveries are put into practice at the earliest opportunity. New findings on recovery and resilience help individuals with mental disorders live, work, learn, and participate fully in their communities.
- Evidence-based practices are identified, disseminated, and applied routinely in mental health care. Reimbursement policies of both public- and private-sector payers support broad implementation of evidence-based practices.
- Research findings help eliminate disparities in access to quality care among racial and ethnic groups, educate consumers about the efficacy, effectiveness, and limitations of psychotropic medications, enhance the evidence base on the impact of trauma on specific populations, and promote the delivery of acute care and crisis intervention services.

Initial Action Steps

Action *Accelerate research to reduce the burden of mental illnesses*

Building on the discoveries rapidly emerging from the decoding of the human genome and from new, more powerful imaging techniques, NIMH will reorganize and streamline research to produce new interventions. The ultimate goal will be to prevent or cure mental illnesses.

Action *Foster a research partnership*

SAMHSA will foster a public-private partnership to review the major mental health intervention research of the past 5 years. The review will:

- Identify areas that show particular promise for promoting recovery and resilience under field conditions;
- Outline specific projects and initiatives to further develop these key areas; and
- Engage in ongoing dialogue with major research institutes, academic centers, and practitioners.

Action *Expand the Science-to-Services Agenda*

SAMHSA and NIH have begun a formal "Science-to-Services" agenda to further develop and expand evidence-based practices in the field. This is an ongoing, reciprocal relationship in which science informs services, and the experiences of service providers identify priority areas for further research. CMHS and NIMH are spearheading this effort in the area of mental health. To expand these efforts, a Task Force of the Federal Executive Steering Committee will work with SAMHSA, NIH, AHRQ, and CMS to identify evidence-based and promising practices that warrant further research, those ready for field implementation, and those that can and should be funded at the State and local levels. The Task Force will consider all three legs of the research-to-practice stool—science, services, and funding—and will establish guidance to the field about the practical application of research findings.

Action *Conduct research to understand co-occurring disorders*

The high rate of comorbidity of mental and substance use disorders warrants further exploration. NIDA and NIMH at NIH will support basic and clinical research to further clarify mechanisms of comorbidity, including research on genetic and environmental mechanisms. This information will lead to more informed prevention and treatment measures.

Action — *Harness research to improve care*

NIDA will join with several agencies—including NIMH, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), AHRQ, HRSA, and SAMHSA—to support a conference to help develop a health services research agenda to improve care for mental illnesses, substance use disorders, and physical disorders. This initiative will help ensure that evidence-based practices for co-occurring disorders are adopted and implemented in real-world settings in a timely manner. It will also address issues such as the organization, management, and economics of service delivery for co-occurring disorders across the lifespan in a variety of populations and settings.

Action — *Support research to develop new medications*

NIDA and NIMH will support research designed to develop new medications to treat common neurobiological and behavioral substrates of co-occurring mental and substance use disorders. This could include medications targeting compulsive behavior patterns, stress reduction, and co-morbid psychosis and tobacco addiction.

Action — *Expand the National Registry of Evidence-based Programs and Practices to include mental health*

SAMHSA's CMHS will expand and improve its National Registry of Evidence-based Programs and Practices (NREPP) to:

- Identify a procedure through which the status of evidence-based practices can be reviewed and summarized for the public and private mental health fields.
- Summarize action steps currently being taken in parallel fields, such as primary care, to implement evidence-based practices.
- Review the activities of the Practice Guideline Coalition and NREPP and make recommendations for how they might be integrated and implemented in the mental health field.
- Recommend a procedure through which consensus might be developed across key mental health groups, consumers, and family members regarding implementation of evidence-based practices.

Action — *Develop new toolkits on specific evidence-based mental health practices*

SAMHSA will expand its National Evidence-Based Practices Project with the addition of new toolkits. Toolkit topics may include:

- Children's services,
- Supportive housing,
- Older adults,
- Trauma and violence,

- Collaborative models in primary care,
- Consumer-operated service approaches, and
- Supported education.

The toolkits will include materials for administrators, clinicians, consumers, and family members on the implementation of evidence-based practices and will be tested in pilot States and developed in collaboration with private partners.

Action — *Develop the knowledge base in understudied areas*

Within HHS, NIMH, AHRQ, CMHS, HRSA, CDC, and the OCR will:

- Synthesize available knowledge about clinical and rehabilitation practice in each of four understudied areas, including information on:
  - The gap that exists in the quality of and access to mental health care for racial and ethnic minorities.
  - The long-term positive and negative effects of psychotropic medications for maintenance treatment of mental disorders, particularly for children with serious emotional disturbances.
  - The impact of trauma and violence on the mental health of specific populations such as women, children, and victims of violent crime—including terrorism.
  - The availability and effectiveness of acute inpatient and other short-term, 24-hour services, especially for those in crisis who need the safety and intensive treatment of such settings.
- Convene workgroups in each of the areas to identify the next intervention projects that should be undertaken.
- Develop detailed specifications for the proposed studies.
- Seek funding for the proposed projects from appropriate Federal and private sources.

Action — *Conduct research to reduce mental health disparities*

NIMH is expanding its support to programs that conduct research to reduce health disparities by issuing a new program announcement (2004) for the development of Advanced Centers for Mental Health Disparities Research. The purpose of this initiative is to promote the enhancement of established research core infrastructures and investigator-initiated research to understand and ameliorate mental health disparities. Research projects may include, but are not limited to, studies of mental health disparities among American Indians/Alaska Natives, Asian Americans, African

Americans, Hispanics, and Native Hawaiians and Pacific Islanders. Studies of ethnic subpopulations within these broad categories also are encouraged. The Institute will also continue its support for the Disparities in Mental Health Services Research Program, the Socio-Cultural Research Program, the Office of Special Populations, and the Office of Rural Mental Health.

Action *Review the literature and develop new studies on mental illness/general health*

To gain a better understanding of the impact of mental illnesses and emotional disturbances on general health and, conversely, the impact of physical illnesses on a person's mental health, AHRQ, CDC, and NIH will:

- Evaluate current surveillance systems for the co-existence of mental and physical health and illness metrics and make recommendations regarding appropriate measures to be included in these systems to enhance the ability to monitor the co-occurrence of physical and mental illness on an ongoing basis.
- Conduct a comprehensive review of the scientific literature to determine what is known about the relationship between mental and physical health.
- Review the literature regarding strategies to promote general health in people with mental illnesses through improved nutrition, physical activity, and tobacco cessation.
- Design a portfolio of new studies to examine the impact of mental health and illnesses on physical health and illnesses and, conversely, to examine the impact of physical health and illnesses on mental health and illnesses. These studies will take into account developmental issues across the lifespan.

Action *Conduct mental health services research in diverse populations and settings*

NIMH will conduct an extensive range of mental health services research aimed at improving services in settings and populations that represent real, diverse clinical populations in real, diverse settings. NIMH will work with CMHS to obtain feedback on such evidence-based service innovations.

Action *Test new treatments for co-occurring disorders in community settings*

Through the National Institute on Drug Abuse's (NIDA's) National Drug Abuse Treatment Clinical Trials Network, new treatment protocols will be tested in community settings that address people who have co-occurring mental and substance use disorders.

Action *Disseminate findings of the Juvenile Justice and Mental Health Project*

SAMHSA's Juvenile Justice and Mental Health Project will examine existing juvenile justice diversion and reintegration practices for youth with serious emotional disturbances and co-occurring substance use disorders in various jurisdictions across the Nation. SAMHSA will support dissemination of the Project's findings through Policy Academies that share findings with States and local jurisdictions, and explore the feasibility of implementing effective program models for youth in their regions.

Selected Current Federal Activities in Support of This Goal

ACTIVITY Developing Science-Based Interventions for Major Mental Disorders

NIMH maintains large research portfolios focused on the development of new and better science-based interventions for major mental disorders, including new pharmacological and psychosocial interventions; interventions for children, adolescents, adults, and older adults; and services research. For example, NIH sponsors large, multi-site clinical trials on bipolar disorder, schizophrenia, Alzheimer's disease, and treatment-resistant depression, as well as research on trauma/post-traumatic stress disorder.

ACTIVITY National Evidence-Based Practices Project

The National Evidence-Based Practices Project is a collaborative effort being undertaken by SAMHSA, the Robert Wood Johnson Foundation, National Alliance for the Mentally Ill (NAMI), and State and local mental health organizations in eight States. These States are evaluating toolkits developed in six mental health evidence-based practices: medications, illness self-management, Assertive Community Treatment, family psychoeducation, supported employment, and integrated treatment for co-occurring mental and substance use disorders.

ACTIVITY Rural Mental Health Research

The NIMH Office of Rural Mental Health directs, plans, coordinates, and supports research on the delivery of mental health services in rural areas.

ACTIVITY Outreach Partnership Program

The NIH/NIMH Outreach Partnership Program (formerly the Constituency Outreach and Education Program) develops partnerships with nonprofit organizations and the individuals and families they serve in all 50 States and the District of Columbia to help close the gap between mental health research and practice, and to help reduce the stigma of mental illness.

ACTIVITY Anti-Stigma Research and Strategies

NIMH is developing a program of research aimed at better understanding stigma and designing science-based interventions to reduce the stigma of mental illness. NIMH also is working with SAMHSA to develop research on the role of the media to reduce the stigma of mental illness. CMHS is pilot testing anti-stigma messages and strategies in partnership with eight States. The findings from this evaluation will be available to inform further program development and research needs.

ACTIVITY Complexities of Co-Occurring Conditions Meeting

NIMH, NIAAA, NIDA, HRSA, AHRQ, and SAMHSA sponsored a major meeting to speed modern evidence-based treatment knowledge to clinicians and service organizations. The meeting was called "Complexities of Co-occurring Conditions: Harnessing Services Research to Improve Care for Mental, Substance Use, and Medical/Physical Disorders."

ACTIVITY National Child Traumatic Stress Initiative

The National Child Traumatic Stress Initiative, funded by SAMHSA, is providing Federal support for a national effort to improve treatment and services for child trauma, to expand availability and accessibility of effective community services, and to promote better understanding of clinical and research issues relevant to providing effective interventions for children and adolescents exposed to traumatic events.

ACTIVITY Women, Co-occurring Disorders, and Violence Study

SAMHSA's Women, Co-occurring Disorders, and Violence Study was designed to develop, implement, and evaluate integrated systems of care for women with mental illnesses and co-occurring substance use disorders who have experienced violence and their children. Nine sites are evaluating the effectiveness of comprehensive, integrated service models for women who have co-occurring disorders and histories of physical and/or sexual abuse; four sites are evaluating trauma-informed services for their children.

ACTIVITY National Comorbidity Study

NIMH is supporting a 10-year followup of the National Comorbidity Survey, a representative national sampling of 6,000 people ages 15-54 designed to estimate the prevalence and correlates of mental and substance use disorders. The current survey focuses on the relationship between mental disorders and the subsequent onset and course of substance use disorders. As such, it may suggest modifiable risk factors that could be targets for preventive interventions.

ACTIVITY Preparing Preschool Children for Success

HHS and ED have launched a 5-year research effort to find the best ways to prepare preschool children for later success in school. In the initiative's first year, eight institutions across the

country will receive $7.4 million in research grants to test preschool curricula, Internet-based teacher training, and the importance of parental involvement for improving children's readiness to enter school.

ACTIVITY **Mental Health Response to Mass Violence and Terrorism Victims**

DOJ and SAMHSA have developed a training manual and field guide to address the mental health response to mass violence and terrorism victims.

ACTIVITY **Model of Behavioral Response to Uncertain and Stressful Situations**

CDC is applying a public health framework to model the impact of social factors, mental health, and how people appraise risk and safety regarding terrorism and disasters on behavioral response to uncertain and stressful situations (e.g., compliance with public health recommendations).

ACTIVITY **Mental Health Risk Factors Associated with Violence**

CDC collects data and supports research to better understand the mental health risk factors associated with violence.

PRINCIPLE E **Follow the principles of Federalism, and ensure that [the Commission's] recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.**

The State of Success

In a transformed mental health system:

- Each State's Comprehensive State Mental Health Plan is constructed with the active involvement of all State and regional entities responsible for housing, health, transportation, employment, education, justice, and entitlements, and addresses the full range of the treatment and support services that mental health consumers and family members want and need.
- States are held accountable for improved outcomes and, in turn, are granted greater flexibility in combining resources to develop innovative and efficient services.
- States receive the technical assistance and training they need to implement innovative strategies designed to promote full community integration for children with serious emotional disturbances and adults with serious mental illnesses.
- Elimination of seclusion and restraint becomes a policy and practice directive.

Initial Action Steps

Action — *Award State Mental Health Transformation Grants*

Much of the work of system transformation will take place at the State and local levels. This is why the Commission has vested in States one of the most critical elements of system transformation: creation of state-specific Comprehensive State Mental Health Plans. As outlined by the Commission, each State plan should:

- Increase the flexibility of resource use at the State and local levels, encouraging innovative uses of Federal funding and flexibility in setting eligibility requirements.
- Hold State and local levels of government accountable for results, not just to Federal funding agencies, but also to consumers and families
- Expand the options and the array of mental health services and supports along a continuum, and ensure their integration into a seamless system of care in which "any door is the right door" to get help.
- Leverage additional resources from systems that also interact with children and their parents, adults, and older adults who have mental disorders, such as housing, health, transportation, employment, education, entitlements, substance abuse treatment, child welfare, and corrections.

President Bush's Fiscal Year 2005 proposed budget contained $44 million and Congress appropriated $20 million to help States develop comprehensive plans. SAMHSA's CMHS will design, implement, and evaluate a 3-year State Mental Health Transformation Grant program to support State efforts to develop a Comprehensive Mental Health Plan. These grants are expected to support State mental health services infrastructures and to promote implementation of science-based mental health interventions. SAMHSA will help grantees identify prototype State plans and provide technical assistance to customize these plans for specific State needs.

In the first year, States will be required to conduct statewide planning and infrastructure development efforts across multiple service systems to better meet the complex needs of adults with serious mental illnesses and children with serious emotional disturbances and their families. Consumers and family members will be actively involved in these statewide planning efforts. Specific infrastructure development activities include policy development to support best practices, organizational development to support integrated service delivery, financial planning and leveraging of resources, workforce training and development, quality assurance mechanisms, and management information systems and data infrastructure development.

With an optimally effective State infrastructure and plan in place, Federal, State, and local resources can be used and leveraged in the most effective ways to eliminate fragmentation and improve mental health services. Over time, the goal would be to award a grant to each State. A

coordinating center will be funded to provide technical assistance and other resources to help States accomplish the objectives of this program.

Action *Provide technical assistance to help States develop Comprehensive State Mental Health Plans*

CMHS will be contracting with a number of national mental health organizations to provide technical assistance to States in the development of activities and plans to implement the New Freedom Commission recommendations. Written analysis of onsite training and technical assistance will be delivered on a range of policy issues that impact the development of a comprehensive State mental health system.

Action *Award Child and Adolescent State Infrastructure Grants*

SAMHSA will continue to support Child and Adolescent State Infrastructure Grants to help States increase their system infrastructure to support mental health and/or substance abuse services and programs for children, adolescents, and youth in transition, who have serious emotional disturbances, substance use disorders, and/or co-occurring disorders, and their families. A comparable amount of annual funding is projected for subsequent years. These 5-year grants will focus on strengthening State capacity to transform the service delivery system to meet the needs of this population of youth and their parents and other family members, including cross-system coordination and collaboration, financing, increased access to services, workforce development, data management and accountability, implementation of evidence-based interventions, individualized care planning, service integration, family and youth involvement, and sustainability of system reforms. These grants will complement and help prepare States for SAMHSA's State Mental Health Transformation Grants and the development of their Comprehensive State Mental Health Plans, which include cross-system planning for children who have serious emotional disturbances.

Action *Track State mental health system transformation activities*

CMHS will maintain an information database on transformation activities in the States. An annual database on State transformation activities will be created and the results will be posted on the National Association of State Mental Health Program Director's web site. CMHS will also use results from a demonstration data collection to measure resources expended by other State agencies on people with mental illness. Descriptive results will be reported, and trends will be monitored to examine changes over time. As comprehensive State mental health transformation plans are implemented, CMHS will expand the scope of the Decision Support 2000+ System and the Uniform Reporting System to incorporate performance measures that extend beyond the State mental health agencies.

Action *Establish a foundation for the Samaritan Initiative*

Based on experience with the $35 million Collaborative Initiative to Help End Chronic Homelessness, the President proposed the Samaritan Initiative at $200 million in his Fiscal Year 2005 budget. This initiative would provide funding for permanent supportive housing for people who experience chronic homelessness.

Action *Establish the Reentry Initiative for ex-prisoners with psychiatric disabilities*

HUD's 2006 budget request includes $25 million as a part of a prevention initiative for prisoners returning to the community, many of whom are struggling with serious mental illnesses. HUD will collaborate with DOL and DOJ in this effort.

In addition, DOL will compile data on people served and types of services provided to people with psychiatric disabilities who are incarcerated. Information will be solicited from SAMHSA and DOJ's Bureau of Prisons, National Bureau of Corrections, and relevant foundations and associations. DOL's Employment and Training Administration, VETS, and the Faith-Based Office will support One-Stop Centers to identify resources and effective practices. Policy recommendations will be developed to address service gaps systematically and strategically.

Action *Award Seclusion and Restraint State Incentive Grants*

SAMHSA will continue to support grants designed to enhance State capacity to provide staff training to implement alternatives to seclusion and restraint in mental health care settings. This program also supports a Resource Center, which acts as a central repository on effective practices to reduce and eliminate seclusion and restraint and provides technical assistance to the grantees.

Action *Develop statewide systems of care for children with mental disorders*

HRSA's State Maternal and Child Health Early Childhood Comprehensive Systems Grants will bring in other Federal partners to plan for and develop statewide systems of care to support the healthy social and emotional development of children. These grants enable States to plan, develop, and implement comprehensive, collaborative systems to improve childhood outcomes. In particular, grants support the development of a State plan that addresses access to health insurance and regular primary care services, mental health and social-emotional development interventions, early child care and educational supports, and parent education and family support. These are 2-year planning grants followed by multi-year implementation grants.

Action

Provide technical assistance to States on systems of care for children and their families

Through its technical assistance contracts and/or grants, SAMHSA, in collaboration with HRSA, will provide technical assistance to support State efforts to plan, finance, and implement a coordinated approach to providing mental health screening, early intervention, services, and supports to young children identified to be at risk for mental disorders and their parents/guardians. Technical assistance will include training and materials on development of a collaborative State plan, as well as examples of successful State and community approaches and evidence-based interventions. SAMHSA and HRSA will collaborate with other Federal technical assistance and training efforts.

Action

Convene State leadership to develop Statewide plans to serve children with serious emotional disturbances

ED and HHS will convene representatives of State education, public health, and mental health leadership to set the stage for the inclusion of children's services in the Comprehensive State Mental Health Plan; to develop a prototype State education, public health, and mental health collaborative plan; and to establish support for State-level infrastructures for school-based mental health. These plans will address the need for informed parental consent for screening children for mental health issues.

Action

Expand the Partnerships for Youth Transition Grant Program

SAMHSA will collaborate with ED, ACF, and other relevant Federal agencies and departments, including DOL, to expand its Partnerships for Youth Transition Grants Program aimed at developing effective models for youth with serious emotional disturbances who are transitioning from the child to the adult systems. Through this grant program, States develop, implement, stabilize, and document models of comprehensive programs to support transition to adulthood and independent living for youth with serious emotional disturbances. Funding and partnerships from other Federal agencies will expand the number of States and communities to be funded, strengthen the cross-system linkages necessary for successful independent living and transition to adult system supports, and address systems barriers to serving this vulnerable population.

Action

Provide technical assistance on Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

SAMHSA, CMS, and HRSA will conduct a technical assistance forum for State Medicaid Directors, State Mental Health Directors, and Community Health Centers on implementation of the EPSDT program. Assistance will be available on model screening instruments, strategies for creating

partnerships across child-serving agencies to ensure access to appropriate care, and mechanisms for managing costs and State Medicaid match.

Action *Facilitate linkages among DOL/SSA's Joint Disability Pro... Initiative, SAMHSA, and related State and local mental...*

DOL's Employment Training Administration will incorporate information on the employment of people with psychiatric disabilities, resources, effective practices, information on SAMHSA's programs and resources, and State and local mental health systems' programs into its training for more than 100 Disability Program Navigator staff hired in pilot States. Linkages will be developed between local One-Stop Centers and State and local mental health systems.

Action *Disseminate information on mental health issues through DOL grant initiatives and programs*

DOL will disseminate mental health information through its many grants and programs including: Work Incentive Grants, Customized Employment Grants, Homeless Veterans' Reintegration Program, Veterans' Workforce Investment Program, Incarcerated Veterans' Transition Program, Youth Offender Demonstration Program, Serious and Violent Re-entry Initiative, Ready4Work Grants, High School/High Tech Grants, and Chronically Homeless Grants.

Selected Current Federal Activities in Support of This Goal

ACTIVITY **New Freedom Initiative Technical Assistance Center**

The SAMHSA/CMHS New Freedom Initiative technical assistance center supports State collaborative efforts to develop community integration plans for individuals with mental illnesses and emotional disturbances residing in, or at risk for, placement in State facilities.

ACTIVITY **Technical Assistance Center to Improve State and Local Systems**

SAMHSA/CMHS-funded Technical Assistance Centers help improve State and local mental health systems by providing information, publications, and referrals to consumers, family members, service providers, administrators, researchers, advocates, and the general public.

ACTIVITY **Comprehensive Community Mental Health Services Program for Children and Their Families**

The CMHS Comprehensive Community Mental Health Services Program for Children and Their Families provides cooperative agreements to States, tribes, and territories to develop systems of care for children with serious emotional disturbances and their families. Ninety-two communities in 47 States and 2 territories have received funding to develop these comprehensive systems

of care. Individualized plans of care that integrate services across child-serving systems are a key goal of this program. ACF, HRSA, ED, and the Office of Juvenile Justice are partners with SAMHSA in this program.

ACTIVITY Intergovernmental Young Adult State Planning Initiative

The HHS Office on Disability's Intergovernmental Young Adult State Planning Initiative, co-sponsored with other HHS agencies and Federal departments (Education, Labor, Transportation, and SSA), helps States develop and implement infrastructure-based coordinated action plans to address the health, human services, employment, education, housing, and transportation needs of young adults (ages 16 to 30) with disabilities, including those with mental illnesses and comorbid disabilities.

ACTIVITY Collaboration to End Chronic Homelessness for People with Mental and Substance Use Disorders

HRSA, HUD, VA, the Interagency Council on Homelessness, and SAMHSA jointly fund a $35 million collaborative initiative to end chronic homelessness among people with mental and substance use disorders.

ACTIVITY Toolkit on Interagency Management Information Systems

CMHS is developing a toolkit for States and communities on interagency management information systems to better track services for children and families across agencies, to reduce duplication of information gathering, to increase access to services, and to provide accountability.

ACTIVITY Protection and Advocacy for Individuals with Mental Illness (PAIMI) Program

CMHS will continue to support and improve the PAIMI program. To facilitate continuous quality improvement, CMHS will conduct an Evaluability Assessment of the PAIMI program, which will form the foundation of a plan for the full, independent evaluation of the PAIMI program.

ACTIVITY Restraint and Seclusion Demonstration Grant

The CMHS-funded Restraint and Seclusion Demonstration Grant is a 3-year program to develop best practice models to reduce staff use of seclusion and restraint procedures in facilities for children and youth.

ACTIVITY Children's Justice Act Grants

Children's Justice Act Grants funded by ACF provide funds to help States develop, establish, and operate programs designed to improve (1) the handling of child abuse and neglect cases, (2) the handling of suspected child abuse or neglect-related fatalities, and (3) the investigation and prosecution of child abuse and neglect cases.

ACTIVITY Co-occurring State Incentive Grant Program

The SAMHSA-funded Co-occurring State Incentive Grant (COSIG) program provides funds to States to increase their capacity to provide effective treatment and services for people with co-occurring mental and substance use disorders. The emphasis is on building or enhancing service system infrastructures to offer integrated treatment.

CONCLUSION

The Time for Action Is Now

Transformation of the mental health system in America is a monumental task, but one that cannot be delayed. This *Federal Mental Health Action Agenda* makes clear that the system must be redirected toward its primary goal—helping adults with serious mental illnesses and children with serious emotional disturbances achieve recovery to live, work, learn, and participate fully in their communities. This vision requires nothing short of a complete transformation of administrative policies, funding mechanisms, and the hearts and minds of everyone who has a stake in our nation's health care system. The time for action is now.

This *Federal Mental Health Action Agenda* represents the first "to do list" of a multi-year effort to alter the form and function of the mental health system from the top down and from the bottom up. This *Action Agenda* represents the Federal response to Executive Order 13263 and is informed by the New Freedom Commission's vision of a transformed mental health service system. However, transformation is a shared responsibility.

Shared Responsibility

Federal agencies can act as leaders and as facilitators, promoting shared responsibility for change at the Federal, State, and local levels, and in the private sector, in such areas as public education, research, service system capacity, and technology development. States, however, will be the very center of gravity for system transformation; many have already begun this critical work. Their leadership in planning, financing, service delivery, and evaluation of consumer and family-driven services will significantly advance the transformation agenda. Finally, an emphasis on individual recovery and resilience will transform not only service delivery systems, but also hearts, minds, and lives for future generations.

Unprecedented Federal Commitment

With this *Federal Mental Health Action Agenda*, the U.S. Department of Health and Human Services (HHS) and its Federal partners make an unprecedented commitment to collaborate on behalf of adults with serious mental illnesses and children with serious emotional disturbances to:

- Send the message that mental illnesses and emotional disturbances are treatable and that recovery is possible.
- Act immediately to reduce the number of suicides in the Nation through full implementation of the National Strategy for Suicide Prevention.
- Help States develop the infrastructure necessary to formulate and implement Comprehensive State Mental Health Plans that include the capacity to create individualized plans of care that promote resilience and recovery.

- Develop a plan to promote a mental health workforce better qualified to practice culturally competent mental health care based on evidence-based practices.
- Improve the interface of primary care and mental health services.
- Initiate a national effort focused on the mental health needs of children and promote early intervention for children identified to be at risk for mental disorders. Prevention and early intervention can help forestall or prevent disease and disability.
- Expand the "Science-to-Services" agenda and develop new evidence-based practices toolkits.
- Increase the employment of people with psychiatric disabilities.
- Design and initiate an electronic health record and information system that will help providers and consumers better manage mental health care and that will protect the privacy and confidentiality of consumers' health information.

Full Participation Now

The reason to begin is both simple and profound—people with mental disorders have a vital role to play in our families, our neighborhoods, our communities, and our country. Their ability to participate fully can no longer be derailed by outdated science, outmoded financing, and unspoken discrimination. They demand better, and they deserve better. Putting children and their parents, adults, and older adults with mental disorders at the heart of the health care system must be accomplished now.

APPENDIX A

Executive Order 13263

Federal Register
Vol. 67, No. 86
Friday, May 3, 2002

Presidential Documents

Title 3—

The President

Executive Order 13263 of April 20, 2002

President's New Freedom Commission on Mental Health

By the authority vested in me as President by the Constitution and the laws of the United States of America, and to improve America's mental health service delivery system for individuals with serious mental illness and children with serious emotional disturbances, it is hereby ordered as follows:

Section 1. *Establishment.* There is hereby established the President's New Freedom Commission on Mental Health (Commission).

Sec. 2. *Membership.* (a) The Commission's membership shall be composed of:

(i) Not more than fifteen members appointed by the President, including providers, payers, administrators, and consumers of mental health services and family members of consumers; and

(ii) Not more than seven ex officio members, four of whom shall be designated by the Secretary of Health and Human Services, and the remaining three of whom shall be designated—one each—by the Secretaries of the Departments of Labor, Education, and Veterans Affairs.

(b) The President shall designate a Chair from among the fifteen members of the Commission appointed by the President.

Sec. 3. *Mission.* The mission of the Commission shall be to conduct a comprehensive study of the United States mental health service delivery system, including public and private sector providers, and to advise the President on methods of improving the system. The Commission's goal shall be to recommend improvements to enable adults with serious mental illness and children with serious emotional disturbances to live, work, learn, and participate fully in their communities. In carrying out its mission, the Commission shall, at a minimum:

(a) Review the current quality and effectiveness of public and private providers and Federal, State, and local government involvement in the delivery of services to individuals with serious mental illnesses and children with serious emotional disturbances, and identify unmet needs and barriers to services.

(b) Identify innovative mental health treatments, services, and technologies that are demonstrably effective and can be widely replicated in different settings.

(c) Formulate policy options that could be implemented by public and private providers, and Federal, State, and local governments to integrate the use of effective treatments and services, improve coordination among service providers, and improve community integration for adults with serious mental illnesses and children with serious emotional disturbances.

Sec. 4. *Principles.* In conducting its mission, the Commission shall adhere to the following principles:

(a) The Commission shall focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self care, interpersonal relationships, and community participation.

(b) The Commission shall focus on community-level models of care that efficiently coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.

(c) The Commission shall focus on those policies that maximize the utility of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers;

(d) The Commission shall consider how mental health research findings can be used most effectively to influence the delivery of services; and

(e) The Commission shall follow the principles of Federalism, and ensure that its recommendations promote innovation, flexibility and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.

Sec. 5. *Administration.* (a) The Department of Health and Human Services, to the extent permitted by law, shall provide funding and administrative support for the Commission.

(b) To the extent funds are available and as authorized by law for persons serving intermittently in Government service (5 U.S.C. 5701–5707), members of the Commission appointed from among private citizens of the United States may be allowed travel expenses while engaged in the work of the Commission, including per diem in lieu of subsistence. All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(c) The Commission shall have a staff headed by an Executive Director, who shall be selected by the President. To the extent permitted by law, office space, analytical support, and additional staff support for the Commission shall be provided by executive branch departments and agencies.

(d) Insofar as the Federal Advisory Committee Act, as amended, may apply to the Commission, any functions of the President under that Act, except for those in section 6 of that Act, shall be performed by the Department of Health and Human Services, in accordance with the guidelines that have been issued by the Administrator of General Services.

Sec. 6. *Reports.* The Commission shall submit reports to the President as follows:

(a) *Interim Report.* Within 6 months from the date of this order, an interim report shall describe the extent of unmet needs and barriers to care within the mental health system and provide examples of community-based care models with success in coordination of services and providing desired outcomes.

(b) *Final Report.* The final report will set forth the Commission's recommendations, in accordance with its mission as stated in section 3 of this order. The submission date shall be determined by the Chair in consultation with the President.

Sec. 7. *Termination.* The Commission shall terminate 1 year from the date of this order, unless extended by the President prior to that date.

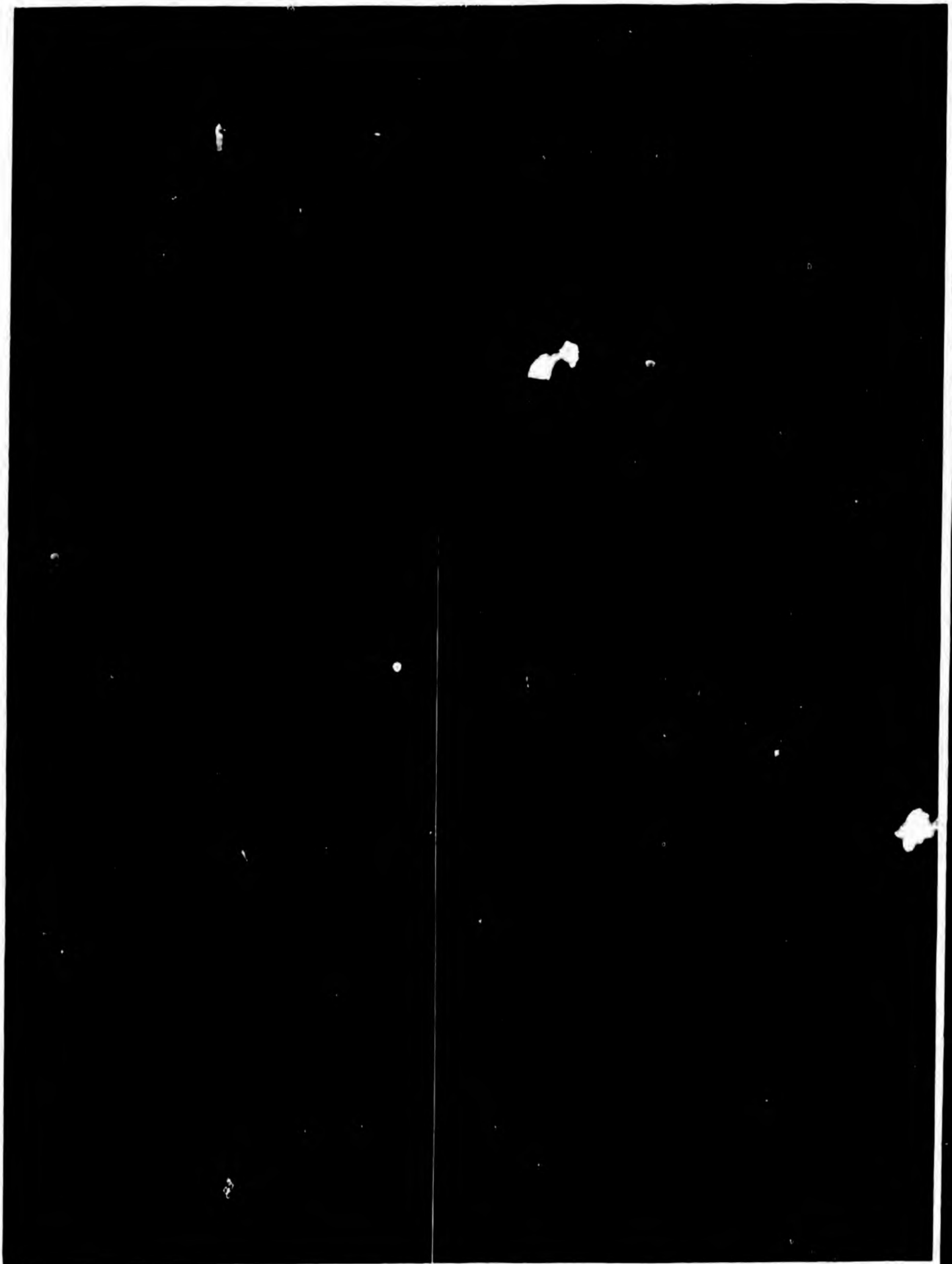
THE WHITE HOUSE,
April 29, 2002.

APPENDIX B

Acronym List

ACF	Administration for Children and Families
ADA	Americans with Disabilities Act
AHRQ	Agency for Healthcare Research and Quality
AOA	Administration on Aging
ASPE	Office of the Assistant Secretary for Planning and Evaluation
BPHC	Bureau of Primary Health Care
CDC	Centers for Disease Control and Prevention
CMHS	Center for Mental Health Services
CMS	Centers for Medicare and Medicaid Services
COSIG	Co-occurring State Incentive Grant
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
ED	U.S. Department of Education
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
HELP	Hotline Evaluation and Linkage Program
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
IDEA	Individuals with Disabilities Education Act
IHS	Indian Health Service
NAMI	National Alliance for the Mentally Ill
NHII	National Health Information Infrastructure
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NREPP	National Registry of Evidence-based Programs and Practices
OCR	Office for Civil Rights
OD	Office on Disability
ODEP	Office of Disability Employment Policy
ONCHIT	Office of the National Coordinator for Health Information Technology
OJJ	Office of Juvenile Justice
OJP	Office of Justice Programs
OPHS	Office of Public Health and Science
OPM	U.S. Office of Personnel Management
ORR	Office of Refugee Resettlement
PAIMI	Protection and Advocacy for Individuals with Mental Illness

PTSD	Post-Traumatic Stress Disorder
RFA	Request for Applications
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHIP	State Children's Health Insurance Program
SPRC	Suicide Prevention Resource Center
SSA	Social Security Administration
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
TCE	Targeted Capacity Expansion
TEFRA	Tax Equity and Fiscal Responsibility Act
VA	Department of Veterans Affairs
WICHE	Western Interstate Commission on Higher Education



Keeping Alaskans Out of the Cold



STATE OF ALASKA
REPORT TO GOVERNOR FRANK MURKOWSKI
RECOMMENDED STRATEGIES TO ADDRESS HOMELESSNESS

OCTOBER 2005

Clare House provides temporary, emergency 24-hour shelter and case management for women and women with children.

The Office of
Governor Frank H. Murkowski

Homelessness is a wrenching problem that confronts an estimated 14,000 Alaskans a year, according to this report.

My goals in establishing the Interagency Council on Homeless were to find ways to address the problem, encourage public discussion, and increase Alaskans' understanding of the complexities surrounding homelessness.

The Interagency Council looked at the many causes of homelessness in Alaska. It is no surprise that the primary reason is a change in economic status and the inability to pay increased housing cost.

The council recognized that many government and nongovernment organizations, including community and faith-based groups, are involved in helping. Yet, with all this effort, the problem persists. As a result of their efforts, the council made a number of recommendations for action that can help move toward the elimination of homelessness in Alaska.

My belief is that the best way to help someone meet the basic necessities of life is to have opportunities for job training and hence permanent employment. That is why my priority is creating employment opportunities for Alaskans by stimulating private sector investment through development of Alaska's natural resources.

I am grateful to the Lieutenant Governor, the commissioners, and other executives who served on the panel and produced this report. I thank in particular all of the citizens who participated, presented testimony, and made recommendations to the council.

I encourage Alaskans to read this report to gain insight into the complex problems surrounding homelessness in Alaska and look forward to further work on the recommendations.

Sincerely yours,

Frank H. Murkowski
Governor

Alaska Housing
FINANCE CORPORATION

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October 13, 2005

Governor Frank Murkowski
Office of the Governor
PO Box 110001
Juneau, Alaska 99811-0001

Dear Governor Murkowski

On behalf of the interagency Alaska Council on Homelessness, I am pleased to transmit to you this report and recommended strategies for addressing homelessness in Alaska. As you know, the members of the council include eight department commissioners, the executive director of the Alaska Mental Health Trust, and two ex-officio members: the Lieutenant Governor and the director of the Alaska HUD office. It was my honor to serve as the chair.

Over the past 17 months, we held a number of public meetings, discussions and hearings to develop this information. Council members were well qualified for the assignment. Each is knowledgeable about the complexities of the state's homeless problem, and each addressed it from a different perspective, based on his or her professional background.

We all agreed that homelessness is a costly and serious problem. It has the potential to become critical in times of a major economic downturn or, conversely, in times of another boom like the state experienced during the 1970s. Council members also agreed that the most cost effective strategy for the state is to prevent homelessness and thereby avoid dealing with its many consequences.

Although dozens of recommendations for a state strategy were discussed, council members agreed to pare the list to a realistic handful considered affordable and ones that could be acted upon relatively quickly. You will find in this report the following recommendations:

1. Support programs that assist low income families to preserve, maintain and weatherize homes and multi-family housing, so the families can continue living in their homes and not become homeless.

2. Expand renter education programs statewide so that new renters, including young people first leaving home and rural residents relocating to urban communities, have an understanding of their obligations as a renter and of the consequences of not paying rent on time or neglecting maintenance needs.

3. Create a working group of representatives from the departments of Health and Social Services, Public Safety and Corrections, the Alaska Mental Health Trust, and local community partners and stakeholders to identify policies and procedures that would provide individuals a well coordinated transition from institutionalization to independent living. Currently, about 5,000 Alaskans are released each year from a state hospital, a correctional facility or a foster care setting into homelessness status.

4. Increase the inventory of affordable housing and thereby ease the burden on community-funded shelter services by reducing homelessness. Accomplish this objective by bringing together a working group comprised of policy makers, local partners, and representatives of housing builders, financiers and providers, land use planners, Native corporations, and community and faith-based organizations to identify housing priorities and regions of the state most in need. The working group would be available to provide counsel and recommendations to the state executive and legislative branches of government.

5. Appoint a steering committee to assist the Governor and Legislature to establish an affordable housing trust that would help the state fund programs that increase the inventory of affordable housing and accomplish the recommendations to end homelessness, identified in this report.

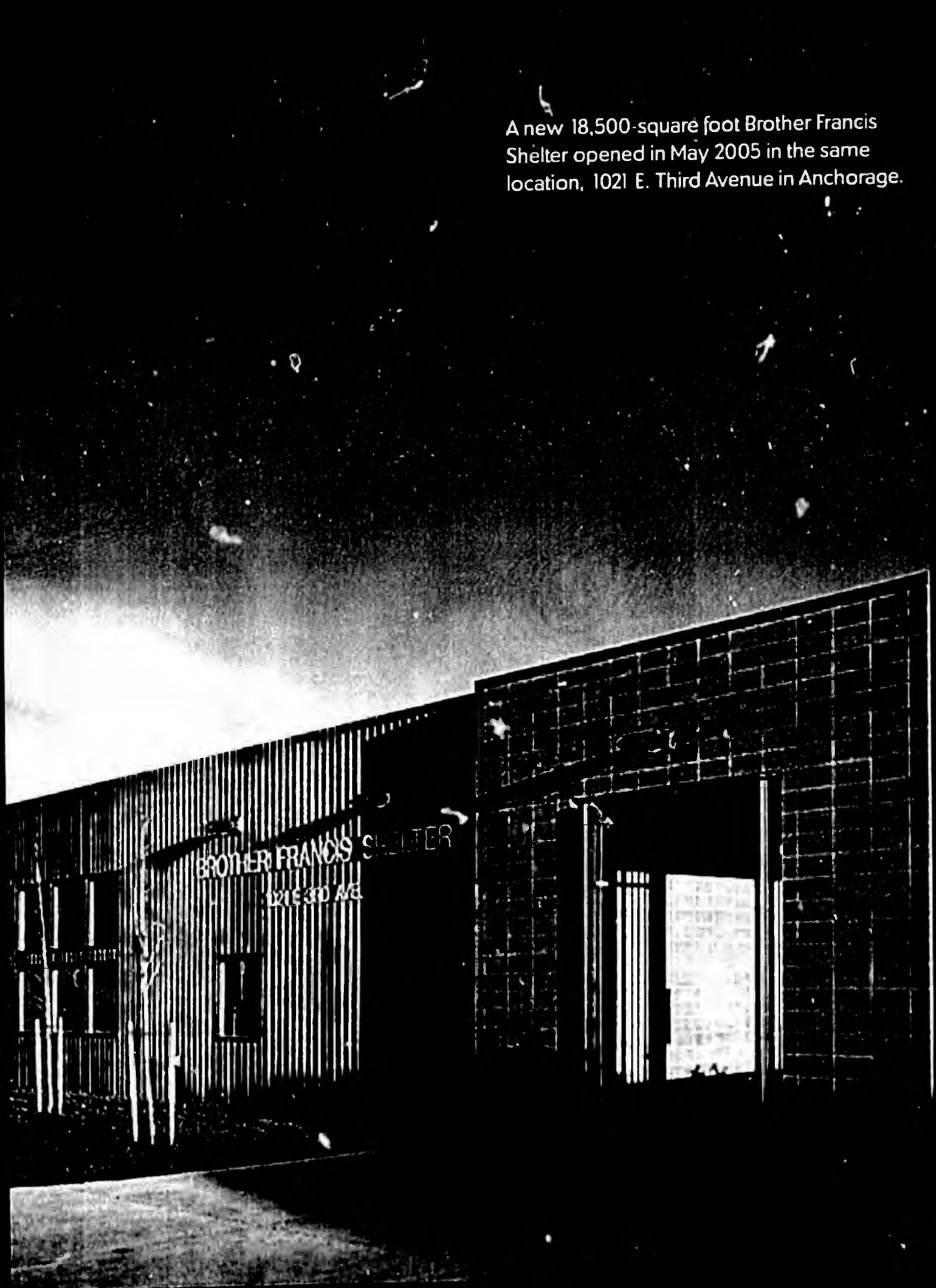
With delivery of this report, the Interagency Council on Homelessness considers its assignment completed, and unless otherwise directed, dissolves. As the administration evaluates these recommendations and contemplates implementation, those of us who served stand ready to provide counsel and assistance, and to serve on working groups that may be formed.

Thank you for the opportunity to serve on the council. It has been a rewarding and enlightening experience for all of us. We hope that the recommendations in the report are of help to you as your administration continues to address the complex problem of Alaska's homeless population.

Sincerely,

Daniel R. Fauske

Dan Fauske
Chair



A new 18,500-square foot Brother Francis Shelter opened in May 2005 in the same location, 1021 E. Third Avenue in Anchorage.

Introduction

It is estimated that 14,000 people experience homelessness in Alaska at some time each year. That's the equivalent of all the people in communities such as Ketchikan or Kodiak or the Bethel region living without housing. Homelessness is a complex problem surrounded by many issues in addition to housing. It is one of the most challenging domestic matters facing Alaska and the nation.

The costs of homelessness in Alaska are enormous – both in terms of human suffering and economic impact. Annually, more than $14 million are spent on homeless services in Alaska, and include assistance with housing, health, education, social services and public safety. A 2003 study of chronic homelessness in Fairbanks, conducted by the University of Alaska Center for Alcohol and Addiction Studies, revealed that more than $40,000 per person was spent in public intervention over a 20-month period.

Statewide strategies to address homelessness were first developed through the Alaska Coalition on Housing & Homelessness. Established in 1989, the Coalition is a partnership of faith-based and community organizations, public agencies and concerned citizens. Urban communities also have established similar networks of local partnerships, and mayoral task forces in several Alaskan communities have studied homelessness over the past 15 years. Despite these efforts, homelessness has continued to grow throughout Alaska.

Faith-based and community organizations over the years have fulfilled a critical role in providing assistance to Alaskans in need. In recognition of this, Gov. Murkowski in 2002 called upon Lt. Gov. Loren Leman to lead a task force that examined issues and ways in which the various organizations might be able to improve delivery of services and how the government might reduce hurdles that hinder this delivery. "This task force surveyed current needs in Alaska and determined that the concern voiced most often was the lack of adequate safe and affordable housing." (Alaska Faith Based and Community Initiatives Task Force Report, February 2004.)

In April 2004, Governor Murkowski furthered his commitment to address the needs of Alaskans by joining 44 other states in appointing an interagency council on homelessness. The Alaska Council on the Homeless is comprised of eight state commissioners (from the departments of Health and Social Services; Corrections; Public Safety; Transportation and Public Facilities; Education and Early Development; Labor and Workforce Development; Military and Veterans Affairs and Commerce, Community and Economic Development) and representatives from the Governor's office, Lt. Governor's office, the Alaska Mental Health Trust Authority (AMHTA) and the U.S. Dept. of Housing & Urban Development (HUD). The governor designated the CEO of the Alaska Housing Finance Corporation, Dan Fauske, to chair the Council and to provide the resources and staff time necessary for the Council to assess the problem and develop strategies.

A two-tiered strategy was adopted by the Council. First, the Council looked internally at the role state government should take. Following that, the Council explored ways to bring together other partners and stakeholders to identify actions that the state, federal, and local governments, along with non-profits, faith-based and private organizations, could take to end homelessness in Alaska.

The Council held a series of six meetings and formal public hearings to gather information and to formulate strategies. All meetings included the opportunity for public comment. Active participation

was also sought from a number of identified partners, including the U.S. Dept. of Veterans Affairs, the Social Security Administration, Alaska Coalition on Housing & Homelessness, Alaska Policy Academy team on Homeless Families and Youth, the Anchorage Mayor's Task Force on Homelessness and representatives of the faith and community-based providers. Meaningful insights were also shared by people who had personally experienced homelessness.

This report examines homelessness in Alaska and offers potential strategies for further consideration. The report, along with other state and local planning documents, will assist stakeholders and policy makers to create a comprehensive statewide action plan to end homelessness.

Covenant House staff and friends from Homeward Bound at a vigil for homeless youth.

Overview of Homelessness in Alaska

How does homelessness impact the state?

Homelessness is a costly problem that threads its way throughout state systems. While only a few discrete programs are specifically related to homelessness, the needs of homeless people, families and children intersect among numerous state services. For example, homeless children will often require financial, nutritional and medical support from the Department of Health and Social Services or from state-sponsored social service partners. Additionally, these children will intersect with the Department of Education and Early Development (DEED). Not only does homelessness affect school performance, but it may also cause a reduction or channeling of federal funds for purposes outside the classroom. For example, schools are penalized for poor academic performance, and additional costs are borne by school districts to provide specialized tutoring and to transport homeless children to their home schools, no matter where they currently live in the district. During the 2004-2005 school year, the DEED reported 3,023 children were homeless or residing in inadequate housing at some time during the school term.

More than 3,000 Alaska children were homeless or in inadequate housing during the school term.

State and state-supported agencies address other needs of homeless families, as well. Without adequate housing, family stability becomes precarious. Work, child care and transportation may become tenuous, due to the uncertainty of where the family will be living from one day to the next. State job reemployment services assist these families in rebuilding economic stability, while government supported shelters and case managers are often called upon for transitional support purposes. Homeless families are a priority for public and subsidized housing, and often seek help with securing permanent housing from AHFC or regional housing authorities.

A stay at Alaska Psychiatric Institute costs $732 per day; a trip to a detox center costs $270 per day; incarceration costs $111 per day. By contrast, a supportive housing program costs $70 per day.

The impact of chronic homelessness upon state services is also significant. The underlying issues that result in chronic homelessness lead to crisis and public safety interventions that are especially costly to the State. The cost for a stay at Alaska Psychiatric Institute (API) is $732 per day. A trip to detox is $270 per day and incarceration is $111 per day. Prevention of homelessness is cost-effective. By contrast, placement in a supportive housing program is estimated to be only $70 per day, and can provide early intervention to avoid these additional human and financial costs. Placements in supportive housing may also lead to reductions in the secondary costs of homelessness to the many state, federal and community-based resources.

An estimated 14,000 Alaskans experience homelessness at some point each year.

How is homelessness defined?

The definition of homelessness varies among different federal funding sources. The definition from the McKinney-Vento Act is the most inclusive, and is used in determining eligibility for various health and education programs. The U.S. Department of Housing & Urban Development (HUD) provides a different and more restrictive definition. HUD defines homeless as: "an individual or family who lacks a fixed, regular, and adequate nighttime residence and an individual who has a primary nighttime residence that is

(a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);

(b) an institution where the person is within one week of discharge with no identified residence or resources to obtain a residence; or

(c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings."

The HUD definition is not a perfect fit because it does not address several specific issues surrounding homelessness, such as homeless students or overcrowding caused by shared housing. However, the best available data on homelessness according to HUD's definition of those who are homeless is gathered annually for HUD's Continuum of Care process. Consequently, unless otherwise noted, the data presented in this report utilizes HUD's definition and should be treated as a conservative estimate of number and characteristics of the population.

How many homeless are there?

At least 3,500 Alaskans are identified as homeless, based upon point-in-time surveys regularly conducted by AHFC twice each year. This total represents only those who happened to interact with a homeless enumerator on that particular survey day. In communities where shelters or other related services are unavailable, homeless persons are not likely to be counted. According to a study by the Urban Institute, (Martha R. Burt, Oct. 1, 2001) "during a year's time, four or five times as many people experience homelessness as are homeless on any particular day." Annual service reports from Alaska providers support this estimate, thus indicating that in the course of a year, approximately 14,000 Alaskans experience a period of homelessness.

What are their characteristics?

28 percent of Alaska's homeless are families with children.

32 percent of Alaska's homeless are "chronically homeless."

Homeless Alaska Natives and African-Americans are over-represented compared to their proportion of the population.

There are many subpopulations among those who experience homelessness. These subpopulations include single men and women of all ages, single mothers with children, single fathers with children, two-parent or "blended" families with children, disabled persons, runaway or abandoned youth, victims of domestic violence and veterans. Over the last two years, the AHFC Homeless Survey reveals that approximately 28 percent of the reported households were families with children. Homelessness for many of these families may be the result of a sudden economic downturn from causes such as illness, injury, divorce or job loss. According to the Summer 2001 AHFC Homeless Survey, 32 percent of the homeless were "Chronically Homeless." HUD defines the chronically homeless as "single individuals with a disabling condition who have been homeless for a year or more, or

Homeward Bound's Mission is to provide the homeless chronic alcoholic with the tools needed to travel the journey home.

who have experienced at least four episodes of homelessness within three years." In at least 50 percent of the chronic homeless cases, the "disabling" condition was mental illness and/or substance abuse.

Alaska Natives are over-represented among Alaska's homeless. They represent 36 percent of the homeless counted over the last 10 years of the survey, but are only 19 percent of the state's population. African-Americans are also over-represented, accounting for 8 percent of the homeless reported compared to 5 percent for the overall population in Alaska.

According to shelter providers around the state, some of the most difficult people to house are those recently released from institutions with no resources or family support and essentially nowhere to go. In a survey of inmates conducted in January 2005 by the Alaska Department of Corrections, 373 - 35 percent of the 1,067 respondents stated they either had no place identified to reside upon release, or they were certain they would enter a homeless shelter and/or live on the streets. Reports from Alaska Psychiatric Institute also indicate a 5-10 percent discharge rate each month to homelessness.

What services are currently in place?

Alaska has 1,229 emergency shelter beds, 817 transitional housing beds, 450 targeted permanent supportive housing beds.

The fundamental components of a "continuum of care" for homelessness include prevention, outreach/assessment/intake, supportive services, emergency shelter, transitional housing and permanent housing. Alaska's current HUD-defined "Continuum of Care" inventory consists of 1,229 emergency shelter beds (including 376 secure beds for domestic violence victims), 817 transitional housing beds, and 450 permanent supportive housing beds that specifically target homeless persons.

A critical component for housing retention is the provision of supportive services that reinforce housing stability and break the cycle of homelessness for people with complex problems. Testimony from formerly homeless people overwhelmingly confirmed the value of case management, particularly during the early stages of a housing crisis when someone to help "navigate the system" is vital. Existing "housing first" programs report that private landlords are more willing to accept persons with clouded housing histories when a case manager is available to call should problems arise. The Council also recognized employment assistance, transportation, and child care as other essential elements for housing retention.

How are homeless services currently funded?

$14 million is spent on homeless services in Alaska annually.

A combination of private and public funds is used to assist Alaska's homeless. Annually, Alaska spends more than $14 million for services ranging from housing, health, education, social services and public safety, as tabulated from the 2001 Continuum of Care applications for Anchorage and the remainder of the state. Many of the emergency shelters and food pantries serving the general public were developed by faith-based organizations such as the Salvation Army, Catholic Social Services, Lutheran Social Services and St. Vincent de Paul. These agencies generally rely on private donations and government support to keep their doors open. Pitted against a community's need for public safety, education and transportation, these shelters struggle every year to keep a line in their local government budget.

Numerous federal programs also contribute funding for services to the homeless. HUD's Emergency Shelter Grant provided $83,573 for Anchorage and $119,198 for the remainder of the state for the federal fiscal year (FFY) 2001. Federal funding for domestic violence shelters, under the Victims of Crime Act, totaled $867,100 in FFY03.

Federal funding plays a greater role in longer-term homeless assistance, most notably through the Stewart B. McKinney Act. Under this act, a combination of formula and competitive awards is made each year by the federal government to assist the homeless in Alaska. Formula awards include funds to the Alaska Department of Education and Early Development to provide continuity in the education of homeless children. In July 2001, 12 agencies throughout the state competed under HUD's Continuum of Care process to renew 17 projects that were

Clare House serves as a temporary haven through which homeless women and children are assisted on their paths toward independence and self-respect.

originally funded in the mid- to late 1990s. These projects ranged from transitional housing for victims of domestic violence to scattered-site housing for homeless persons with mental disabilities. The most recent FFY04 award totaled $3,574,089. To meet HUD's matching requirements, AHFC has annually awarded about $1 million to Continuum of Care grantees.

As the recipient of a number of federal formula funds, the State of Alaska is in a position to make a concerted effort to address homelessness. Federal funds awarded through block grants all come with provisions that allow states wide discretion to determine priority programs and beneficiaries, including homeless persons. The State can also play a key role in ensuring that federal grant funding which specifically targets homeless persons such as PATH (Projects for Assistance in Transition from Homelessness), Healthcare for the Homeless and Homeless Education are used in association with other State and local homeless programs to maximize benefits.

A growing concern among agencies in the homeless service sector is securing funding for operating and program expenses. Most of the private foundations operating in Alaska and many of the federal programs limit their awards to capital (building) projects or one-time program start-ups. The harsh reality of homelessness is that people in this situation are not in a position to pay for the services they need. Without a united effort from all sectors, Alaska cannot expect to break the cycle of homelessness.

Clare House served 452 clients in FFY04; 60 percent were children.

Strategies to End Homelessness

Major strategies emerged, including education, early crisis intervention, housing preservation and increase of affordable housing stock.

The Council conducted two fact-finding meetings and held a public hearing to examine the causes of homelessness. A list of 21 needs and issues was extracted from reports and plans generated by such groups as the Alaska Coalition on Housing & Homelessness, the Faith-Based & Community Initiatives Task Force, Continuum of Care applications and the Mental Health Trust Authority.

Throughout the planning process, Council discussions centered on the role the State of Alaska should or could play in ending homelessness. Council members were provided with strategies and recommendations contained in plans from other states and in local plans to assess best practices. In addition, the Council reviewed the draft plan created by the Alaska Policy Academy Team on Homeless Families and Youth, as well as the recently completed "Ten-Year Plan on Homelessness" for the Municipality of Anchorage. The Council also heard a presentation from the Chair of the Mayor's Task Force on Homelessness and the executive director of the Faith-Based and Community Initiatives, Alaska Department of Health and Social Services. Also, a public hearing was conducted on April 26, 2005, so people could respond to a draft report that proposed recommendations to address homelessness, and, in some cases, to offer additional recommendations.

After assessing all the information, the Council narrowed its focus to a few central themes. Three major areas emerged as cha[illegible] points to ending homelessness:

1. Sufficient affordable housing;
2. Well-coordinated transition from institutionalization to independent living and
3. Homeless prevention and housing retention.

Affordable Housing

16,000 new affordable housing units are needed.

National research has shown that the supply of affordable housing is directly related to the incidence of homelessness.

According to AHFC's 2005 Consolidated Housing and Community Development Plan and the 2005 Alaska Housing Needs Assessment, about 300 to 350 units of affordable housing are added annually in Alaska. But an estimated 16,000 new housing units are currently needed to meet population growth, relieve overcrowding and replace substandard housing. An annual average of 1,000 housing units are weatherized, repaired or modified for accessibility, but more than 20,000 units currently are in need of major repair. An estimated additional 25,000 units require weatherization improvements and/or accessibility modifications.

20,000 units are in need of major repair, and 25,000 units require weatherization improvements and/or accessibility modifications.

Alaska also faces challenges on the other side of the housing affordability equation – affordable rents. Alaska has relied upon a variety of federal and state programs to lower rental costs to make housing more affordable. Unfortunately, "affordable" rents are often more than the amount very low-income Alaskans can manage and various federal rental subsidy programs, as well as funds for public and Indian housing, are being significantly reduced.

Thirty-four states already have created housing trusts to supplement current funding for affordable housing development and rental subsidy programs. These states fund their trusts through unclaimed property funds, general fund appropriations and other methods. Nationwide, state housing trust funds commit $400 million annually to provide 50,000 units of affordable housing. On average, each housing trust fund dollar leverages eight additional dollars of housing funding.

Many state housing trust funds target specific purposes. Three states have homeless trust funds specifically addressing the needs of the homeless. These include the Georgia Trust Fund for the Homeless, Nebraska Homeless Assistance Trust Fund and Wisconsin's Interest Bearing Trust Account.

One successful multi-faceted housing trust fund is the Burlington (Vermont) Housing Trust Fund. During its ten-year history, this fund has supported the construction or rehabilitation of 750 units of low-income housing; the continuous operation, building maintenance and improvement of Way Station, a 36-bed shelter for the homeless; and the operation of Project HOME – a program that links people who have extra living space with those who are seeking affordable housing.

One important component of the Burlington Housing Trust Fund activities has been its funding support of the Burlington Community Land Trust projects providing low-income housing alternatives. Between 1984 and 2002, the Burlington Community Land Trust developed 259 affordable single-family homes and condominiums. All of these homes were sold to first-time homebuyers subject to durable controls over their occupancy and resale. These controls are designed to maintain availability and affordability for low-income households far into the future.

Over the past five years, AHFC has funded affordable rental housing development totaling more than 950 units at a total development cost of $170 million. During this same period, state funding of $15 million has leveraged $155 million in federal funds – a ten-fold leveraging. That leveraging came from low-income housing tax credits and mortgage financing and it made affordable housing projects feasible. Projects included 500 units set aside for households at or below 50 percent of median family income, with an additional 250 units set aside for households at or below 60 percent of median family income. The Council recognizes the importance of leveraging federal and other funds through commitment of state funds, and knows that such leveraging is critical to increasing affordable housing stock across the state.

AHFC has funded more than 950 units of affordable rental housing over the past five years.

AHFC has also proposed a federal legislative agenda involving modifications to the federal tax code that would increase funds for affordable housing. A number of housing authorities from other states support this initiative. The federal agenda can be accessed through the Reference Guide, which can be found at the end of the report.

Council Recommendation: Develop a State Affordable Housing Trust

The Council recommends the Governor and Legislature establish an affordable housing trust. A steering committee should be formed, representing public and private interests, to research options and develop a housing trust framework to present for the Governor's approval, which will maintain the affordability of housing. The steering committee should examine the various resources statewide and nationwide currently available to develop and operate affordable rental housing and ownership programs; develop a mission statement and performance measures for the housing trust; establish policies and procedures; determine the financing mechanism of the trust; and develop enabling legislation to be considered during the next legislative session.

Elsie entered the Homeward Bound program after spending most of her adult life on the streets of Anchorage. She graduated from the program this year and now enjoys her own apartment. She was recently reunited with her brother Ben, a counselor from Sitka, for the first time in 30 years.

Institutional Services Discharge

A growing body of research is showing significant cost savings when public funds are invested in a well-coordinated transition from institutionalization to independent living. Those leaving a state hospital, a correctional facility or a foster care setting are likely to have little or no income and lack significant social skills to make a positive transition into society. Without support from family or friends, these individuals may be vulnerable to homelessness. Often this risk is increased by lack of adequate support, or expectations to secure housing, employment, medical and mental health services and legal assistance. Some of these individuals require substantial and long-term support to achieve a successful and lasting transition. It is estimated that more than 4,700 Alaskans are released from institutional care into homelessness every year.

It is estimated that more than 4,700 Alaskans are released from institutional care into homelessness every year.

Council Recommendation: Institutional Services Discharge

The Council recommends the State of Alaska adopt policies to reduce the likelihood of homelessness upon discharge from institutions by creating a working group comprised of representatives from the departments of Health and Social Services, Public Safety and Corrections, the Alaska Mental Health Trust, and local community partners and stakeholders. This group would evaluate the barriers to effective discharge planning and make recommendations for modifications to policies that would reduce the risk of homelessness.

Homeless Prevention/ Housing Retention

Emergency shelters are expensive and problematic for local communities. The Council unanimously agreed that one of the best ways to reduce the need for shelters is to keep homelessness from happening. From the presentations and discussions on this topic, three major strategies emerged: education, early crisis intervention, housing preservation and increase of affordable housing stock. The Council also recognized the need for adequate supports in transportation, job opportunities and, in some cases, supportive services to assure housing stability.

Renter Education

According to testimony, young people first leaving home and rural residents relocating to urban centers often have a difficult time retaining housing. They are not fully prepared for, nor do they understand the consequences of not paying rent on time or neglecting the maintenance needs of their units. To mitigate this problem, several providers around the state, such as Catholic Social Services in Anchorage and St.Vincent de Paul in Juneau, have developed successful renter education programs that cover such topics as budgeting, housing search techniques, understanding and negotiating a lease, maintenance do's-and-don'ts and skills

Homeward Bound has served 212 program participants since April 1997. Participants have repaid $330,670 in debt previously considered unrecoverable.

for dealing with guests and roommates. AHFC currently provides free day-long seminars throughout the state to educate prospective home buyers about various aspects of buying and caring for a new home. This program could be modified easily to provide information pertinent to renters. Several other states such as Minnesota, Wisconsin, Virginia and Michigan provide renter education courses through their Cooperative Extension Service.

Council Recommendation: Expand Renter Education

The Council recommends the expansion of renter education opportunities in Alaska through existing delivery systems and educational programs, such as the Department of Education and Early Development, the University of Alaska Cooperative Extension Service, AHFC and community and faith-based groups.

Housing Preservation and Increasing Inventory of Affordable Housing

Other critical elements of homeless prevention are the preservation of existing housing stock and increasing the inventory of affordable housing. Programs that assist low-income homeowners make needed repairs or modifications, improve energy efficiency, or create additional affordable housing can ease the burden on community-funded shelter services by reducing homelessness. Additionally, support for maintenance and weatherization programs aids in reducing the rising costs of utilities and extend the life of existing homes.

Council Recommendation Long-Term: Appoint a Working Group to Continue the Discussion on Homelessness and its Solutions

The Council recommends the Governor bring together policy makers, partners from within our communities, and other stakeholders as a working group to address ongoing housing issues mentioned in this report, including the goal of expanding the affordable housing inventory and preserving existing housing stock. This working group should include housing builders, housing financiers, current housing providers, land use planners, Alaska Native corporations, and faith-based and community organizations.

The working group's primary charge should be to address community and statewide barriers and solutions to ending homelessness. It should work closely with the housing trust to encourage investments in affordable housing in areas most in need. Documents created from state and local planning efforts to address homelessness, community "best practices" and resources can be shared and used to craft an ongoing action plan that produces measurable results, and achieves the goal of ending homelessness in Alaska.

Alaska Council on the Homeless

Members

Dan Fauske, CEO/Executive Director, Chair
Alaska Housing Finance Corporation

Lt. Governor Loren Leman

Mark Antrim, Commissioner
Department of Corrections

Mike Barton, Commissioner
Eric Taylor, Manager of Statewide Plan & Transit
Department of Transportation & Public Facilities

Colleen Bickford, Anchorage Field Office Director
U.S. Department of Housing & Urban Development

Major General Craig Campbell,
Adjutant General/Commissioner
Jerry Beale, Deputy Director
Department of Military & Veterans Affairs

Dennis DeWitt, Special Assistant
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Karleen Jackson, Commissioner
Department of Health & Social Services

Jeff Jesse, Executive Director
Alaska Mental Health Trust Authority

Greg O'Claray, Commissioner
Department of Labor & Workforce Development

Roger Sampson, Commissioner
Department of Education & Early Development

William Tandeske, Commissioner
Department of Public Safety

Alaska Council on the Homeless
(l to r) Eric Taylor, Mark Antrim, William Tandeske, Jeff Jesse, Karleen Jackson, Colleen Bickford, Dennis DeWitt, Loren Leman, Dan Fauske, Roger Sampson and Jerry Beale.

Reference Guide

Links to the following information can be found at www.ahfc.us/homeless/homeless.cfm#reference.

A. 2004 Gaps Analysis for the Continuum of Care, Balance of State

B. 2005 Policy Academy for Improving Access to Mainstream Services for Families with Children Experiencing Homelessness Action Plan

C. Alaska Mental Health Trust Authority Strategic Plan on Housing

D. Alaska Wage/Rent Disparity Chart

E. Consolidated Housing and Community Development Plan for the State of Alaska, 2005 - 2010

F. "Costs of Serving Homeless Individuals in Nine Cities," Corporation for Supportive Housing, November 2004.

G. Continuum of Care Housing Activity Charts

H. Continuum of Care Service Activity Chart

I. Fair Market Rent Chart

J. Faith-Based & Community Initiatives Task Force

K. Governor's Administrative Order No. 214 forming the Alaska Council on Homeless

L. Homeless Funding Matrix

M. AHFC Homeless Surveys

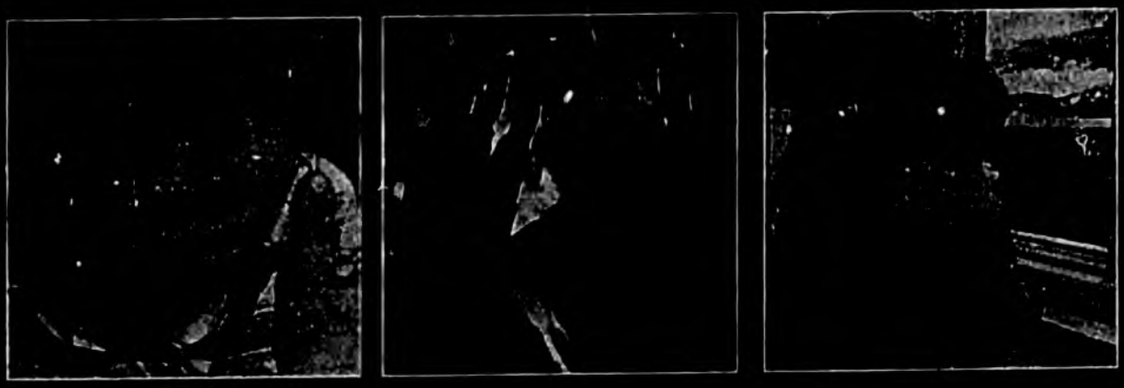
N. Alaska Council on the Homeless minutes and public hearing proceedings

O. Municipality of Anchorage Ten Year Plan on Homelessness

P. "Innovative Services for Alaska's Homeless Persons with Mental Illness," Bernard Segal, PH.D., Center for Alcohol and Addiction Studies, University of Alaska, 2003.

Q. AHFC federal legislative agenda for affordable housing

R. "Keeping Alaskans Out of the Cold," State of Alaska, Report to Governor Frank Murkowski, Recommended Strategies to Address Homelessness, October 2005.



The TRUST

The Alaska Mental Health Trust Authority

Jeff Jessee

Tel:

Fax:

The Office of
Governor Frank H. Murkowski

February 2006

Dear Alaskan,

Congratulations to The Alaska Mental Health Trust Authority (The Trust) on completing ten years of working to improve the lives of their beneficiaries. This annual report highlights many successful projects over the first ten years that prove that working together we can make significant improvements that enhance the lives of Alaskan's.

Fiscal year 2005 continued to be an exciting time for The Trust as we worked together on our shared visions. My "Bring the Kids Home" initiative, in partnership with The Trust, made progress toward providing mental health services for young Alaskans in state—closer to their families and loved ones. We are also working on the other Trust focus areas including appropriate housing and working toward solving housing issues over the long term for the homeless. The Justice for Persons with Disabilities focus area, working with the Court System and Department of Corrections, continues to show progress in expanding alternatives to incarceration, increasing treatment availability, protecting victims' rights, and improving transitions after incarceration to deter recidivism.

As Governor, I want every Alaskan to have the best quality of life our state can offer. I am committed to making this happen and I commend The Trust and all those who partner with them for their efforts and their success.

Sincerely yours,

Frank H. Murkowski
Governor

A decade of achievement.

A decade of learning.

A decade of growth.

A decade of leadership.

A decade of partnerships.

A decade of trust.

A DECADE OF TRUST

Vision and Mission

The Alaska Mental Health Trust Authority administers the Mental Health Trust established in perpetuity. It has a fiduciary responsibility to its beneficiaries to enhance and protect the Trust and to provide leadership in advocacy, planning, implementing and funding of a comprehensive integrated mental health program to improve the lives and circumstances of beneficiaries.

To Governor Murkowski, Members of the Alaska Legislature and the Alaska Public:

Ten years ago I was appointed to serve on the Mental Health Trust Authority Board of Trustees. I joined six other appointees, sitting around a table entrusted with a legislative mandate to preserve The Trust and serve our beneficiaries to the best of our abilities. What a journey it has been.

The Trust Authority history dates back further than 10 years. This year we also recognize the 50th anniversary of the Mental Health Trust Enabling Act of 1956, a plan to bring Alaskans home from institutions in the Lower 48. More of that history appears in this report.

We spent our first years organizing how we would handle The Trust and stay true to the vision of enhancing and protecting The Trust and to providing leadership toward a comprehensive integrated mental health program for Alaska. We realized that treatment wasn't enough, that our beneficiaries needed a holistic approach. They needed housing, health care, job training and other of life's necessities. Without all of these elements in place, many people could not live up to their full potential. So, our strength became how we dealt with the whole picture.

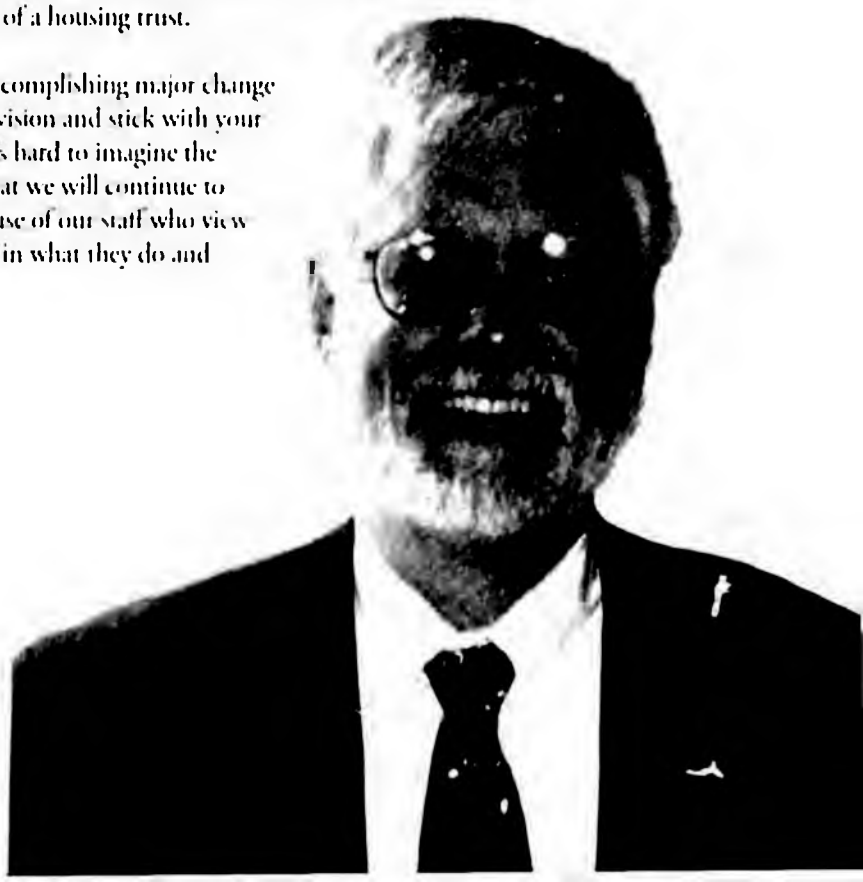
Our experience over the last 10 years led us to work outside the boundaries of traditional state organizations. The Trust has made partnering the cornerstone for accomplishing its mission. Our partnerships have allowed us to leverage dollars with foundations, grants, and other organizations. Together with our partners we've become stronger and more effective.

These leadership and partnering practices led The Trust to direct the majority of its funding for the next three to five years into four major focus areas (Housing, Disability Justice, Beneficiary Initiatives, and Bring the Kids Home) and to work with our partner advisory groups to develop joint advocacy priorities. The FY2006 legislative session advocacy priorities include expanding adult dental Medicaid services, the maintenance of Medicaid services for beneficiaries, and support for the creation of a housing trust.

During the past 10 years Trustees have learned that accomplishing major change is difficult and you must [illegible] in the wisdom of your vision and stick with your plans. The Trust has truly accomplished just that. It's hard to imagine the progress we will make in the next 10 years. I know that we will continue to grow not only because of the Board's vision, but because of our staff who view their work as more than just a job. They truly believe in what they do and for that, I, and the rest of the board are thankful.

It has been a privilege.

John Pugh
FY2005 Chair



John Pugh
Chair, Board of Trustees
Chair - Comprehensive Integrated Mental Health Plan

William Doolittle, MD.
Vice Chair, Board of Trustees

Phil Younker, Sr.
Trustee

Caren Robinson
Chair - Legislative Adhoc Committee

Nelson G. Page
Chair - Finance Committee

John E. Malone
Chair - Program & Planning Committee

Tom Hawkins
Chair - Resource Management Committee

The Alaska Mental Health Trust marked its 50th anniversary in 2005. Many people are surprised to learn that The Trust has been part of the mental health landscape for a half century. Its legacy dates back to the transition from a territory to a state and when Congress passed the Alaska Mental Health Enabling Act of 1956. The Act transferred the responsibility for providing mental health services from the federal government to the Territory of Alaska and ultimately the State of Alaska.

The intent was to bring Alaskans home. Prior to statehood, the federal government sent people who experienced mental disabilities to live in an institution in Portland, Oregon. The Enabling Act created the Alaska Mental Health Trust that was to be funded from income generated by one million acres of prime land selected from the federal government. Those lands would be managed to generate income for a comprehensive integrated mental health program.

It didn't happen the way the Congress intended. Although the state legislature was responsible for managing these lands to fund mental health services, it did not do so. The state transferred the most valuable parcels of land to private individuals and the government. By the 1980s only about 45 percent of the land trust remained unencumbered and in state ownership.

In 1982 a private citizen, Vern Weiss from Nenana, filed a class action suit against the state that ultimately prevailed in the State Supreme Court. The court ordered restoration of the original trust. In 1994 a final settlement reconstructed The Trust with 565,000 acres of original Trust land, 395,000 acres of replacement land, and $200 million dollars. The settlement established an independent Board of Trustees appointed by the governor and confirmed by the legislature to oversee the assets of The Trust and spend the income on behalf of the beneficiaries.

Once the seven Trustees were appointed they began setting a course to optimize The Trust assets on behalf of its beneficiaries. The mission was to oversee the prudent management of the $200 million and the one million acres of land and to work to improve the lives of beneficiaries. In the first six months, The Trust signed a memorandum of understanding with the Department of Natural Resources to manage Trust lands. During that same time, the Trust fund cash was transferred to the Alaska Permanent Fund Corporation for investment.

In 1994, a final settlement reconstructed The Trust with 365,000 acres of original Trust land, 395,000 acres of replacement land and $200 million. It established an independent Board of Trustees appointed by the governor and confirmed by the legislature.

The first Board of Trustees on the day of the swearing in. Front row: Nelson Page and Tom Hawkins. Back row: Not pictured is John Malone. Phil Younker, Jr., John Pugh, Caren Robinson.

A DECADE OF TRUST

The creation of a statewide Comprehensive Integrated Mental Health Plan was a central task set out for The Trust. This Plan was to provide policy direction, intended to promote a continuum of care and service that fosters individual well-being, personal safety, economic security, and life with dignity for all Alaskans. The Plan guides the programs and services provided to Alaskans who are beneficiaries of the Alaska Mental Health Trust and is developed by the Department of Health and Social Services in conjunction with The Trust.

The structure of The Trust settlement empowered four Governor-appointed boards to advise on and advocate for the plan of services for Trust beneficiaries: The Alaska Mental Health Board, Governor's Council on Disabilities and Special Education, Alaska Commission on Aging and the Governor's Advisory Board on Alcoholism and Drug Abuse. A central role for The Trust was to ensure that everyone agreed on what the problems are, the number of people affected, and the impact and solutions to these problems.

Beneficiaries of The Trust are people with mental illness, developmental disabilities, chronic alcoholism, and Alzheimer's disease and related disorders. However, The Trust feels that its role must go beyond its direct beneficiaries and also support prevention and early intervention services for persons at risk of becoming beneficiaries.

1995

The seven founding Trustees were appointed by the Governor and confirmed by the Legislature.

Land Office opened in December 1994.

THE TRUST BOARD OF TRUSTEES:
(L to R) Jim Hayden, William Donlink, M.D., Phil A. Younker, Sr., Caren Robinson, Nelson G. Page, John Page, John E. Malone

Harborview

Supporting the original intention of the Enabling Act to bring residents home to Alaska, The Trust took that notion a step further with its first major project: closing Harborview in Valdez and moving residents to their home communities. Haborview housed Alaska's most profoundly disabled citizens, and at its height cared for 180 residents.

All the data had shown that people do better in their own communities, near their own families. However, first the communities needed the services to support those Harborview residents. Working with the State, The Trust funded Harborview services while the State used its funding to implement new community services. In 1997, the last resident left for home. Follow-up studies since Harborview's closing demonstrate that Alaskans do lead fuller and richer lives near their homes and families.

Alaska Psychiatric Institute

At the same time The Trust worked on the Harborview project, it worked with the State and began due diligence to replace the aging Alaska Psychiatric Institute (API) with a smaller, more appropriate facility. However, for a smaller facility to work, short-term crisis admissions would need to be reduced enabling API to focus on its role as Alaska's longer term psychiatric hospital. Working with a congressional earmark, a psychiatric emergency system was developed in Anchorage to reduce demands on API. With those community services in place, a smaller less expensive building has just been completed to replace the original API.

A DECADE OF TRUST

Finding out about our beneficiaries

As The Trust began to establish its operating procedures and make headway toward its mission and vision, it was time to survey its beneficiaries and learn more about their needs.

- Under health, The Trust learned that beneficiary resources were too low to meet their basic health needs, such as getting eyeglasses, dental work or hearing aids.
- Under Safety, beneficiaries noted that about 37 percent had been to jail and that half of that number felt they should have received medical care instead. Emotional, physical, and sexual abuse were also listed as major problems.
- Half of the study participants said they needed additional help to fund services not covered by Medicaid or Medicare.
- According to the survey, 66 percent of the respondents were unemployed and 24 percent were employed full time or part time year-round.
- A survey during that same year revealed that more than 25 percent of all inmates and 38 percent of female inmates qualify as Trust beneficiaries, most suffering from mental illness. This made the Department of Corrections the largest mental health provider in Alaska. Further, women inmates didn't have equal access to mental health services.

With this information in hand, it became clear that The Trust needed to take a holistic approach with its beneficiaries. Addressing jobs, adequate housing, proper health care, and other elements will ensure that beneficiaries are living with dignity.

Beneficiaries participate in [illegible] the REAL [illegible] [illegible] [illegible] [illegible] the Trust.

1996

Provided leadership in developing the State's Comprehensive Integrated Mental Health Program through the adoption [illegible]

[illegible]

1997

[illegible]

[illegible]

Experts agree that alcohol abuse in is the number one social and health problem in Alaska. To address this concern, Trustees have worked closely with the state administration, the Governor's Advisory Board on Alcohol and Drug Abuse, and communities to fund strategies to address problems related to substance abuse. These have included treatment programs for inmates in Corrections, encouragement of local-option laws, the use of the State's involuntary commitment laws, a detox facility in Fairbanks, and many other projects. However, a coordinated statewide effort by all Alaskans will be needed to make significant progress on this problem

Over the past several years the State refinanced many state grants using the Medicaid program. While the federal money is important, Medicaid's medical model and dependency-promoting structure is sometimes a poor fit for Alaska. As we have recently experienced, over dependence on this funding source makes Alaska subject to the budgetary whims of the federal government. At the same time, Medicaid is at the core of the funding mechanism for Alaska's mental health program and must be protected and strategically expanded to meet Alaskan needs.

Trustees understood from the beginning that due to the remoteness, cultural variations, and poor economies of scale, rural Trust beneficiaries received limited levels of service. The first action was to sensitize State leaders and Trustees by visiting rural communities. The only way you can truly understand the successes and challenges in rural communities is to spend at least one night there.

Each year since 1998, Trustees, staff and board members from the Trust-related boards, State administrators, legislators, and legislative aides have traveled together to visit different regions of Alaska and meet with community members to understand rural issues.

In addition, the out-of-state placement of hundreds of Alaskan children, the continued over-involvement of beneficiaries with the criminal justice system, the lack of affordable, safe, accessible housing, and the desire of the beneficiaries to do as much as possible for themselves continue to be the major challenges facing The Trust.

[illegible]

A DECADE OF TRUST

Future

Over the last 10 years, The Trust has learned to work outside the boundaries of traditional public organizations to fully meet the mandates of The Trust's unique statutory mission. One method used provides active support for many of the grantees, to better ensure the success of projects. Leadership techniques are also used that mobilize stakeholders to clarify what matters most, in what balance, and with which tradeoffs.

The Trust often acts as a convener and works with stakeholders to plan and prioritize for the future. Partnering has become the cornerstone of the work in which The Trust is involved. The Trust rarely funds projects on its own, rather it creates partnerships with other entities, partnerships that then become stronger than the sum of their parts. These leadership and partnering practices led The Trust to direct the majority of its funding for the next 3 to 5 years into four major focus areas and to work with its partner advisory groups to develop joint advocacy priorities.

1998

Assisted with the development of the first Women's Substance Abuse Treatment Program for women in Alaska's prisons.

Negotiated a $900,000 land exchange with the City and Borough of Juneau setting the stage for redevelopment of the Trust's valuable waterfront land in Juneau [Subport].

1999

Sponsored the first Rural Outreach Trip.

Converted the Fort Knox mill site lease to a regional mill site lease, thereby allowing off site ore to be processed at the mill. Rents increased by 400% from $30,000 per year to $150,000 per year.

Susie LaBelle, an Alaska Native leader, became a Trustee in 1998. It was her suggestion that state leaders and Trustees travel to rural communities to better learn their needs.

A DECADE OF TRUST

2000

Held the first Mental Health Trust Mover Awards to recognize individuals and organizations who have helped improve the lives of Trust beneficiaries.

Negotiated the first placer gold lease on Trust Lands.

2001

Final redevelopment strategy completed for the API / McLaughlin parcel.

Resolved public-use conflict associated with a popular recreation parcel in Fairbanks (Chena River Wayside) by agreeing to sell the parcel to the State for about $700,000.

The Trust spent much of 2005 preparing and planning activities in four focus areas for 2006.

Disability Justice

Beneficiaries of the Mental Health Trust are at increased risk of involvement within the criminal justice system both as defendants and as victims. Trust beneficiaries who have committed no crime are incarcerated nearly 4,000 times each year because appropriate service alternatives are unavailable to provide for their safety and treatment.

Because of their disorders, individuals with mental disabilities are at greater likelihood of becoming involved in the criminal justice system. Once involved, they are at greater risk of repeated cycling through the system.

A long-term partnership with the Alaska Court System began FY2001 to assist Alaska's Courts to become more capable of providing an accessible forum for justly resolving cases involving Trust beneficiaries and better equipped the courts to achieve positive outcomes for the beneficiaries and the communities.

Bring the Kids Home

Between 1998 – 2004, the children's behavioral health system in Alaska had become increasingly reliant on out-of-state residential psychiatric treatment center (RPTC) care for treatment of severely emotionally disturbed youth. Out-of-state placements in RPTC care grew by nearly 800%. At any given time, approximately 350-400 children were being served in out-of-state placements. In 2004, these statistics caused Trustees to pick this as a focus area and earmark over $2 million each year to begin in July 1, 2005, for addressing the "Bring the Kids Home" issue, in partnership with the Dept. of Health & Social Services.

The goals of the project are to:

- Build/develop and sustain the community-based and residential capacity.
- Develop an integrated, seamless service system in Alaska.
- Significantly reduce the existing numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.

Affordable, Safe, Accessible Housing

Alaska Mental Health Trust beneficiaries have many unmet housing needs. Safe, decent, affordable, accessible, and appropriate housing is often the key for beneficiaries in maintaining a healthy lifestyle and it is an important component of The Trust's holistic approach and living with dignity. The statewide shortage of affordable, safe, accessible, and appropriate housing disproportionately affects Trust beneficiaries. Some beneficiaries will require supportive living situations or accommodations to meet special needs. The goal of the Trust's Housing initiative is to increase the availability of a continuum of housing options that are best suited to Trust beneficiary needs and desires that improves/sustains their quality of life.

Affordable Housing

Supportive housing is a cost-effective approach to addressing beneficiary needs.

Service	Cost per day
Hospital	$1,600
API	$732
Nursing Home	$400
Detox	$270
Jail/Prison	$114
Supportive Housing	$70

Source: OMB API, DOC, Oltheuse Center ~AHFC data

Trust Beneficiary Group Initiatives

There is a growing interest among Trust beneficiaries and their family members to use services provided by fellow consumers/clients and family members. These services create a sense of empowerment and choice that often helps in promoting quality sustainable services and recovery.

The state has existing models for consumer-controlled services that may be adapted or replicated by beneficiaries. The initiative will examine how this service and the mutual understanding between individuals may also improve outcomes and be part of the cost effective services provided to beneficiaries.

FY06 Legislative Priorities

The FY06 advocacy priorities include expanding adult dental Medicaid services, the maintenance of Medicaid services for beneficiaries, and the establishment of a housing trust.

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For the second consecutive year, the cash assets of the trust benefited from a healthy stock market. Investments with the Alaska Permanent Fund Corporation (APFC) increased from $333,152,000 at the end of FY2004 to $363,826,000 at the end of FY2005.

Income from these investments was $30,811,000 for FY2005 and $42,322,000 for FY2004. Statutory net income determined by APFC (which does not include unrealized gains) was $21,008,000 for FY2005 and $18,811,000 for FY2004. This market rebound has offset the market losses of the three prior years and has validated our four-year Budget Reserve financial model. The budget reserve is set at 400 percent of the annual payout to allow disbursement during market downturns.

The remainder of the Budget Reserve is managed by the Treasury Division of the Department of Revenue (DOR). This portion of the Budget Reserve earned $778,440 in FY2005. To equalize the two halves of the Budget Reserve, $3.45 million was transferred from the APFC Budget Reserve to the DOR Budget Reserve.

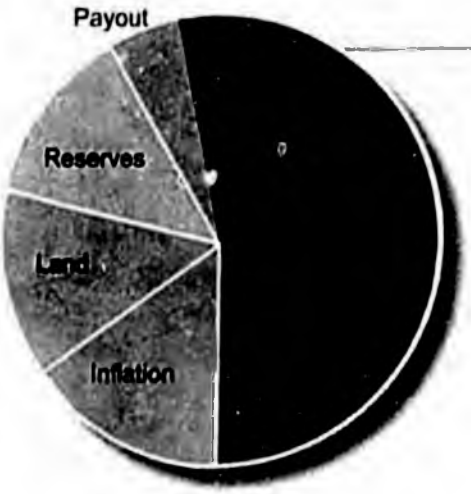
The Trust was able to add approximately $10 million to the Principal account for inflation proofing.

The Trust's payout rate, based on a percentage of market value, which is used to determine the disbursement (or payout) for the mental health budget was increased at the end of FY2004 from 3.5% to 3.75% beginning with the FY2006 budget. At the end of FY2005, the payout rate was further increased to 4.0% beginning with the FY2007 budget. This rate is applied to the amount of the Trust Fund (Principal and Budget Reserve) at the end of a fiscal year to calculate the payout for the subsequent year.

The following performance for FY2005 is available for funding the FY2006 mental health budget:

- Disbursement (payout) rate of 3.75%, for a payout of $14,607,472. This represents an increase of 17.8% over FY2004.
- Resource management revenue allocated as income was $3,009,923.
- Interest on the Income Account at Treasury Division was $923,747.
- Lapsed funds from prior fiscal years were $5,220,114.
- Total funding available for the Mental Health Trust budget in FY2006 is $23,761,255. This is an increase of 14% over FY2005.

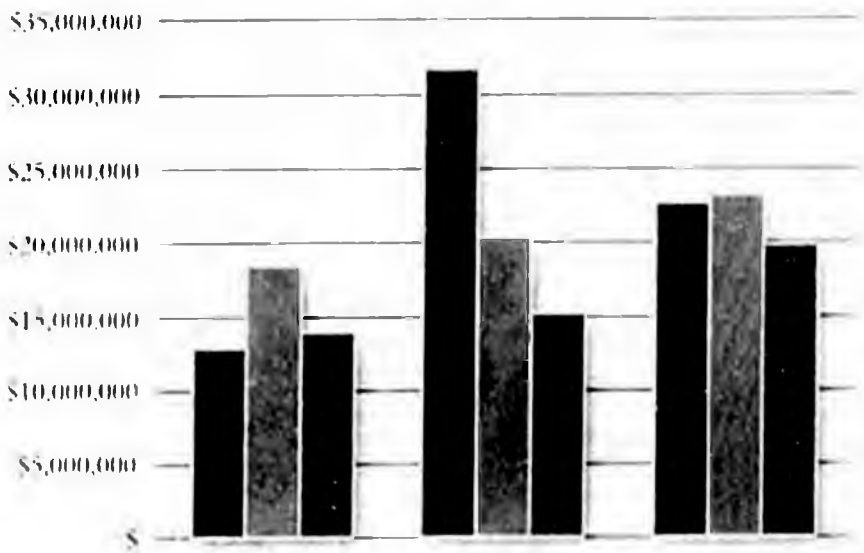
A DECADE OF TRUST



Trust Cash Assets at End of FY2005

Settlement	*58.0%*	*$ 200,000,000*
Inflation	*17.9%*	*$ 61,836,475*
Land	*15.8%*	*$ 54,527,213*
Reserves	*16.9%*	*$ 58,429,886*
Payout	*3.75%*	*$ 14,607,472*

Trust Fund Performance



Trust Fund Performance	*$ 13,778,270*	*$ 41,589,940*	*$ 22,597,100*
Trust Income Available	*$ 18,438,020*	*$ 20,270,950*	*$ 23,163,600*
Trust Funded Projects	*$ 13,916,220*	*$ 15,011,800*	*$ 19,760,160*

2002

Advocated for the successful passage of the statewide alcohol tax increase.

Signed API-McLaughlin panel subdivision plat, setting stage for conveyance of a 16 acre tract to the Department of Health and Social Services as the new API site, sale of a 25 acre tract to Providence Hospital for hospital expansion or University trade purposes and future leasing of Lease Lake One and Providence corner parcel.

2003

Partnered with the Alaska Court System to sustain and expand Alaska therapeutic courts and therapeutic justice practice statewide.

Land Office gross revenue increase to over $16.8 million.

A DECADE OF TRUST

2004

Launched new budgeting method, Budget Recommendation Planning Process that will guide decision-making and funding process for the next five to 10 years.

Completed the purchase of the [illegible] acre site for the new Fairbanks [illegible] Center.

2005

Concentrated on planning activities in four focus areas for 2006: Disability Justice, Bring the Children Home, Affordable, Safe, Accessible Housing, and Trust Beneficiary Group Initiatives.

By Fall 2004 Cook Inlet Oil and Gas lease sale resulted in $[illegible] of bonus bids on [illegible] tracts encompassing 80,000 acres.

The Trust Land Office exceeded its gross revenue projections by 123 percent, with final revenues equaling about $17.6 million compared to a goal of $7.9 million. Much of the revenue was attributable to multi-year transactions, which were not guaranteed to close in FY2005 and so were not included in the FY2005 gross revenue projections. It is important to note that Spendable Income exceeded projections by only 15 percent, with a year-end outcome of about $3.0 million, compared to projections of $2.6 million. Since The Trust Authority relies heavily on the Spendable Income projections of the TLO, it is important that this projection be as accurate as reasonably possible.

FY2005 Land Office Highlights for the Year

The real estate program and Community Enhancement Initiative accounted for over 76 percent (about $13.4 million) of gross revenue. Successful efforts included the sale of about 4,060 acres of waterfront property in Gustavus to The Nature Conservancy and Department of Natural Resources for $3.2 million, the completion of the reconfigured MHTL Subdivision in the U-Med District in Anchorage into Providence-Chester Creek Subdivision and the payoff of Providence Hospital's $3.4 million promissory note for Tract A.

The TLO completed its eighth annual land sale, selling 58 parcels through a sealed bid process with a value of $3,176,570. New subdivisions were completed at West Lake and Twin Island Lake both in the Mat-Su Borough, with full sellout in the 2004 land sale, valued at $776,000.

The Trust acquired ownership of an office building located in East Anchorage. The building, formerly known as the Family Resource Center has been renamed the Trust Authority Building and is the future home of the Alaska Mental Health Trust Authority.

FY2005 timber revenue accounted for over 16 percent (about $2.8 million) of gross revenue, with sales in Wrangell and the combined areas of Signal Mountain, Gravina Island, and Minerva Mountain in Ketchikan. The TLO also signed a contract with Alcan Forest Products LP for the multi-year Leask Lake Timber Sale with revenues anticipated from FY2006 through FY2010.

View from Trust land, [illegible]

Trust land, Kodiak, Alaska

[illegible]

The Cook Inlet Oil & Gas Lease Sale conducted in the fall of 2004 resulted in $780,000 in income to The Trust from bonus bids and first year rental payments. Overall, the oil and gas program accounted for over 6 percent (about $1.1 million) of gross revenue with about 150,000 acres under lease.

The minerals and materials program accounted for almost 2 percent of gross revenue (about $356,000). AngloGold Ashanti was the successful bidder for the competitive mineral lease offering northwest of Salcha (Caribou Creek) resulting in a lease of about 5,060 acres of Trust mineral land. Freegold Ventures LTD USA was the high bidder for 750 acres of Trust mineral land north of Cleary Summit, and the TLO received its second royalty payment of $68,000 from the Fort Knox Gold Mine near Fairbanks.

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The TRUST

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Alaska Mental Health Trust Authority

Senate Finance

FY 07 Budget Priorities

Trust FY07

TRUST Distributable Income	
Land Office Income	$ 2,600,000
Trust Fund Payout ***4.00%*** (up from 3.75%)	$16,028,605
Prior Year Lapse	$ 1,500,000
Interest	$923,750
Total Trust Projected	$21,052,355
Expenditure Recommendations	$12,854,400 Operating $2,250,000 Capital $5,581,000 Direct Grants
Total Recommendations	$20,685,400

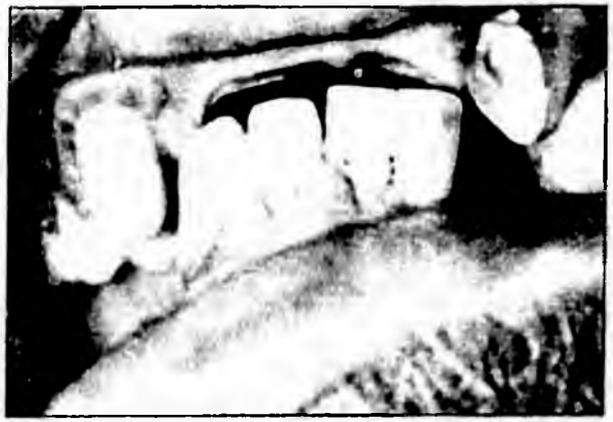
Four Focus Areas

- Bring the Kids Home
- Affordable, Appropriate Housing
- Justice for Persons with Disabilities
- Trust Beneficiary Group Initiatives

Guiding Direction for Trust Program Investment

- Focused on results.
- Investing in policies, programs, services that make a difference.
- Example in Justice Focus Area:
  - Therapeutic Courts
    - Apply sound scientific principles of behavior change – effective use of incentives and sanctions, with treatment and other new technologies.
    - Effectively coordinates the persuasive and coercive power of the court with essential treatment and supports and oversight of treatment and behavioral compliance
    - Results measured in reduction in recidivism rates

Would You Hire Them?



Poor Oral Health = Reduced Employability

HB 105/SB 79

BRING THE KIDS HOME (BTKH)
FY06 – FY12
Trust, DHSS, & Tribal Collaboration

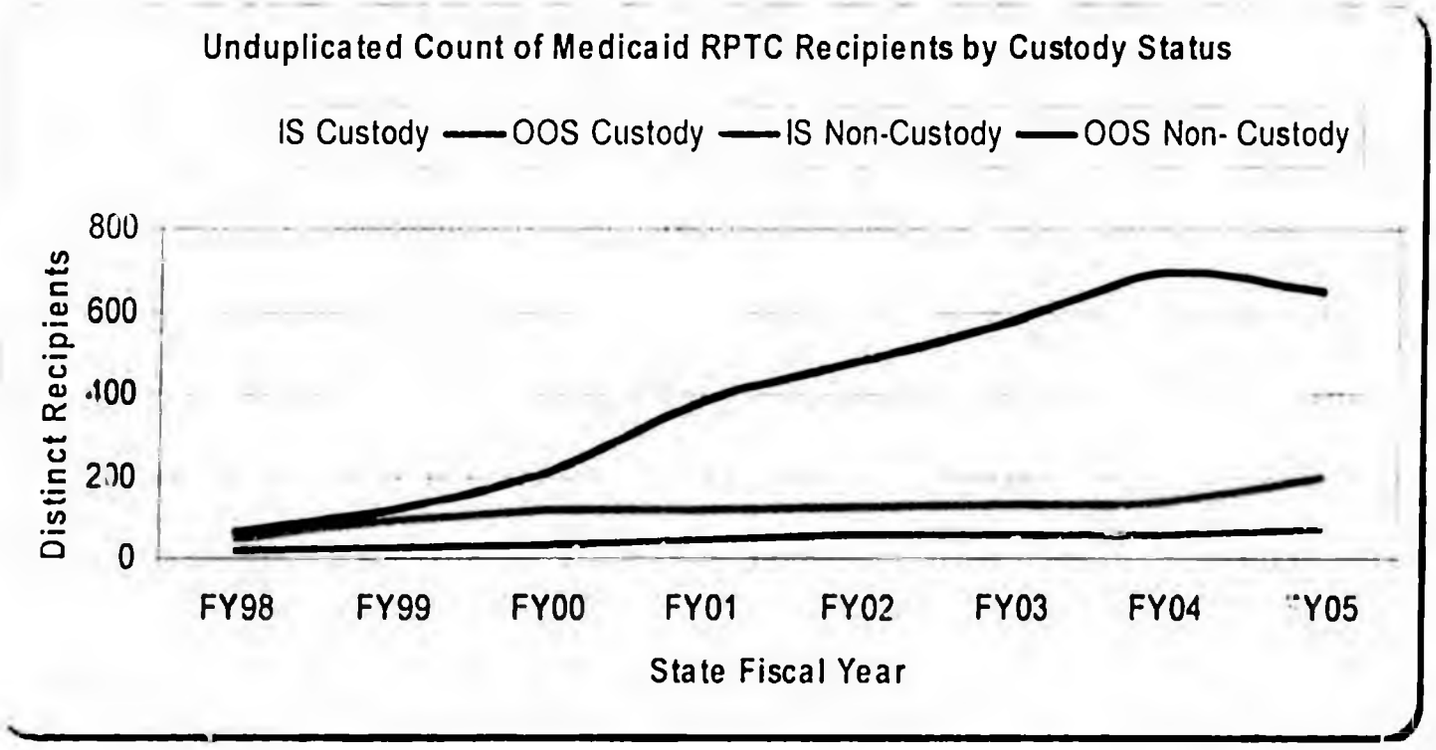
- BTKH model provided by DHSS expertise
- Trust Work Group formed (meets quarterly):
  - Established 7 indicators of progress
  - 20 stakeholders: tribal reps (40% AK Native), family, providers
  - Reviews progress of 4 subcommittees:
    - Care Coordination
    - Home & Community-based services
    - Work force development
    - Data

Seven Indicators of Progress

- *Indicator 1: **Client Shift** – A reduction in the total number of SED children/youth placed out of state by 90 percent by SFY 12. (15 percent per year)*
- *Indicator 2: **Funding Shift** - Ninety percent reduction in Medicaid/General Fund match dollars from out-of-state services to SED children/youth with a corresponding increase in Medicaid/General Fund match dollars for in-state services by SFY 12. (15 percent per year)*
- *Indicator 3: **Length of Stay** – Reduction in the average length of stay for in-state and out-of-state residential institutions by 50 percent by SFY12. (8.3% per year.)*
- *Indicator 4: **Service Capacity** – Increase in the number of children /youth receiving home and community based services in communities or regions of meaningful ties by 60 percent by SFY 12. (10 percent per year)*
- *Indicator 5: **Recidivism** - Decrease in the number of children/youth returning to residential care by 75% by SFY 12. Defined as children/youth returning within one year to the same or higher level of residential care. (12.5% per year)*
- *Indicator 6: **Client Satisfaction** – Via annual reporting. 85 percent of children and families report satisfaction with services rendered.*
- *Indicator 7. **Client Improvement** - 85% of children and youth show functional improvement in one or more life domain areas at discharge and one year after discharge.*

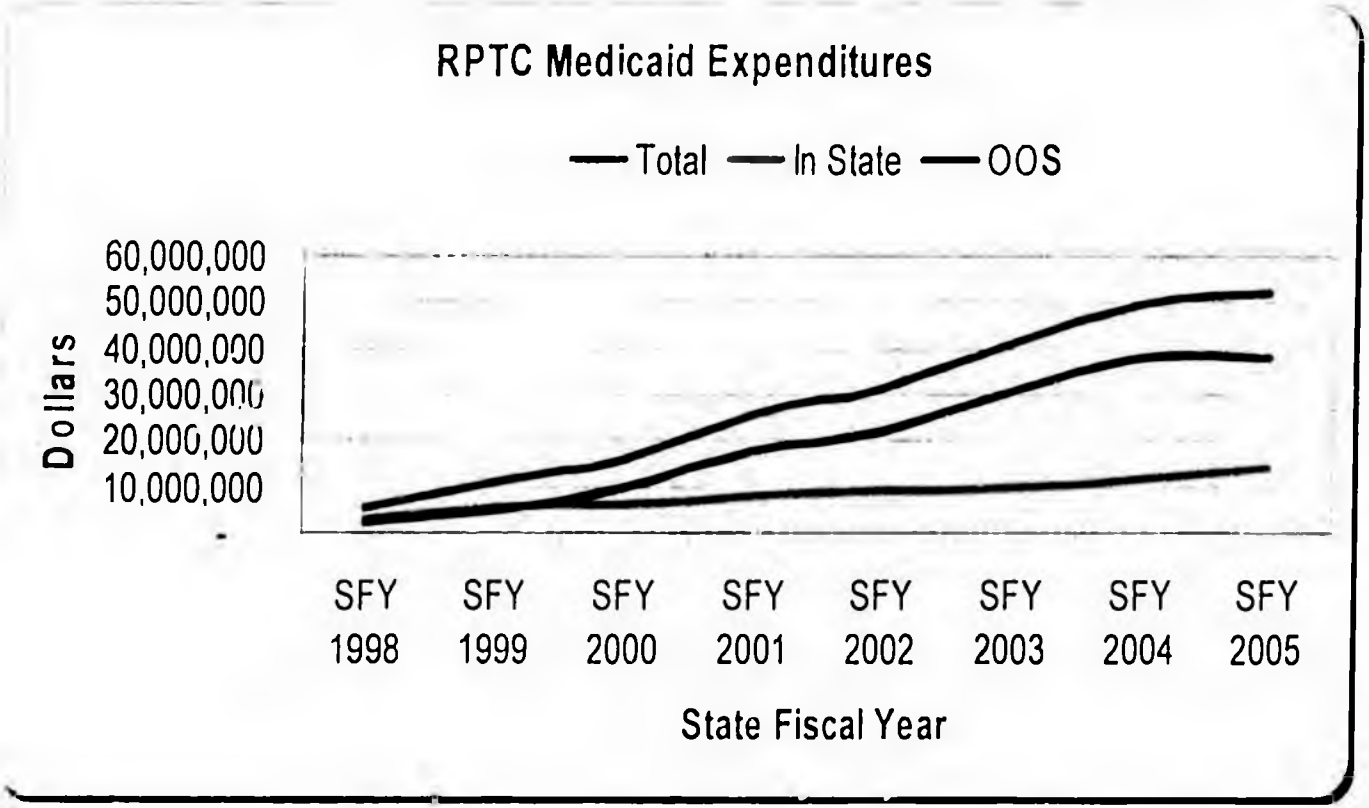
Indicator 1: ***Client Shift***

Number of youth out of state is declining. Increases have been largely experienced in non-custody youth.



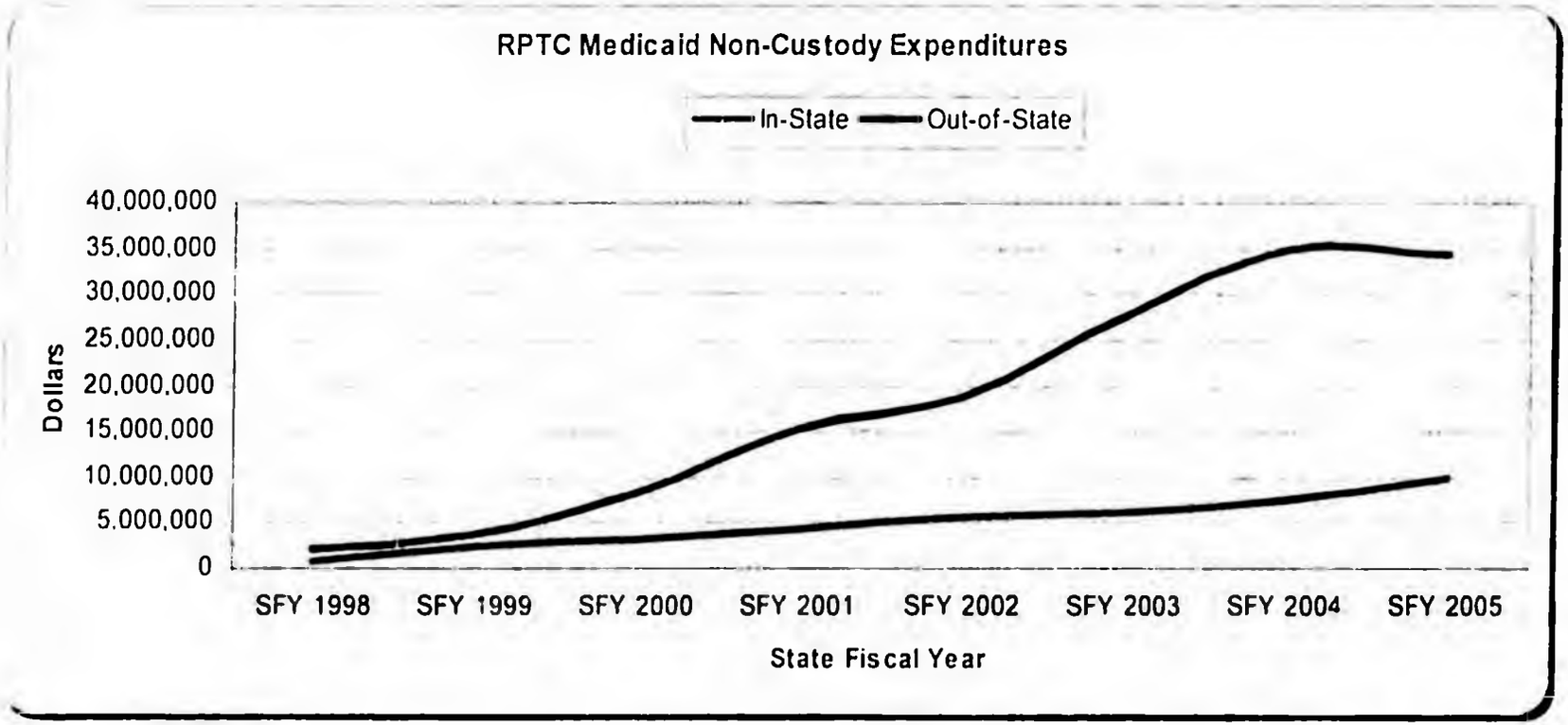
Indicator 2: ***Funding Shift***

Medicaid expenditures out of state are declining with a corresponding increase in state.



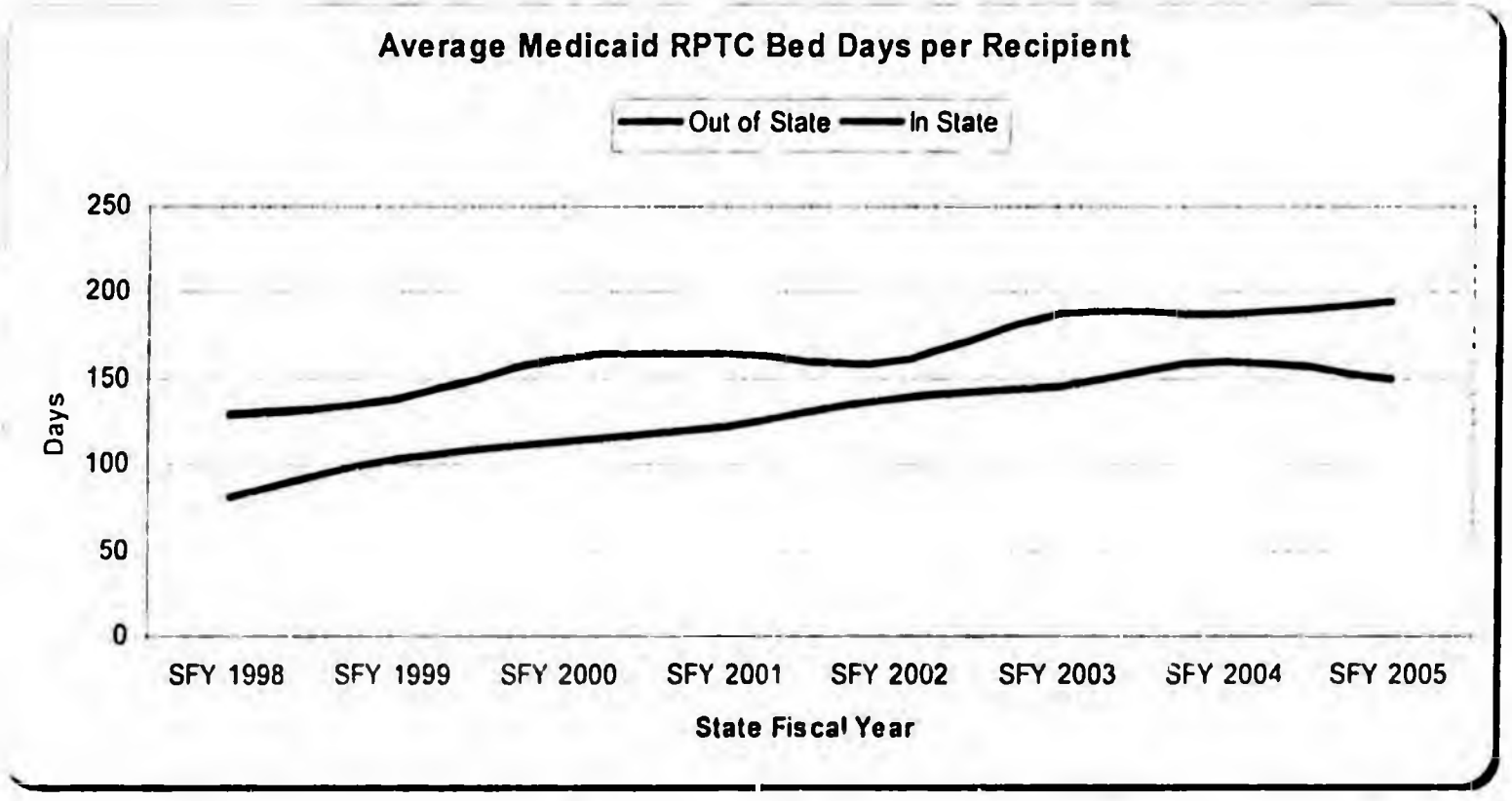
Indicator 2: **Funding Shift**

Again, large increases have been related to non-custody youth.



Indicator 3: **Length of Stay**

Length of stay for out of state youth is increasing, however in state length of stay is decreasing.



Strategies

- Strategy 1: **Theory of change** Articulate and communicate a formal theory of change and continue ongoing communication.
- Strategy 2: **Strong family voice** Develop a strong family and youth voice in policy development, advocacy, family education and support, and quality control/assurance and evaluation.
- Strategy 3: **Examine financing & policy issues**
- Strategy 4: **Performance & QA measures** Ensure that strong performance measurement/continuous quality improvement procedures are in place.
- Strategy 5: **Home & community-based services** Develop a wide range of accessible home and community-based services that reduce the need for kids to enter residential care and ease transition back into the community for those in out of home care.
- Strategy 6: **Work force development** Build the capacity and core competencies of in-state providers to provide services that meet the needs of kids with severe behavioral health disorders.
- Strategy 7: **Assessment & Care Coordination** Develop "gate keeping" policies and practices and implement regional resource committees to divert kids from psychiatric residential care.

Strategy 2: **Strong family voice**
FY06 $25.0 Trust

- Managed by Alaska Mental Health Board
  - Ensures youth & family member involvement in planning
  - Statewide teleconferences with each Work Group quarterly meeting
  - Assists Resource Committees with
    - Provider representative
    - Consumer representative

Strategy 3: **Examine financing & policy issues**

FY06 $1,150.0 Trust in Individualized Services

- **Individualized Services** Assists with non-Medicaid services to keep youth near home
- **Medicaid Rate Review (BRS)** will ensure reimbursement fits each level of care appropriately (BRS – Behavioral Rehabilitation Services)
- **BRS regs change** adds 54 OCS/BRS residential beds
- **School-based Medicaid** provides funding incentives for early intervention services in schools
- **Out of State regulations** will enhance negotiations with out of state providers on funding issues

Strategy 5: **Home & Community-based Services**

FY06 $1,050.0 Trust (Operating)
FY06 $350.0 Trust (Capital)
FY 05 $4,150.0 Denali Commission (Capital)

- FY06 increased in-state service capacity
  - Start up operating provided for expanded capacity for ten grantees
  - Types of care: group, therapeutic foster & transitional care homes; respite beds, etc.
  - 186 additional youth to be served annually
  - Available by spring 2006
  - Another RFP is planned for FY07 reaching more providers
- Some capital dollars are available to increase service capacity
  - $ 674.0 Trust and Denali Commission
  - $1.25 million Denali Commission
- BRS changes will assist in keeping kids in state
  - Recommendations for Rate increases are currently under review and will enhance system capacity
  - Expansion of facility use to non-custody kids will allow 54 new beds

Strategy 6: **Work force development**

FY06 $500.0 Trust (with U of A)
FY06 $140.0 Trust (CoDI)
FY 06 $200.0 DHSS (CoDI)

- Part of a larger Trust initiative
  - U of A SE offering Behavioral Health Certification for BTKH workers
  - UAF Training Academy for continuing training
- Co-occurring Disorders Institute (CoDI)
  - includes BTKH work force training
  - training to BRS residential care providers

Strategy 7: **Assessment & Care Coordination**

FY06 $132.0 Trust

FY 06 $431.5 DHSS

- Regional & Out-of-State Resource Committees
  - New law asserts state "gate-keeping" function for ALL children
  - Committees will partner with local agencies to review each youth placement to encourage in-state and lowest level of care
- Utilization Review staff
  - To review RPTC and acute care placements, and refer to lower levels of care
- "InterQual" Level of Care Assessment
  - Ensures consistent review of each youth's situation
  - Currently being piloted at two sites

DHSS Certificate of Need

- CON ensures against overbuilding of highest levels of care
- For BTKH facilities over $1 million
- Establishes formula, based on underserved populations, referral trends
- If >29 beds are proposed, CON requires campus-like setting with secure & non-secure beds
- So far, only North Star Anchorage approved for 60 beds with 20 secure

BTKH Funding FY06 & Proposed FY07

	FY06 Trust		FY07 Trust	FY07 GF/MH	FY07 AHFC	Denali Comm
07 OPERATING						
Develop a Strong Family Voice	25 0		25 0			
BTKH Oversight & Placement Comm Staffing				390 0		
Home & Community-based Services	1 110 0		1 110 0			
OCS BRS Increased Rate and Beds				1,250 0		
Care Coord/Individualized Svs	1 193 0		700 0	2,120 0		
Operating Totals	**2,328.0**		**1,835.0**	**3,760.0**		
07 CAPITAL						
Group Home Development	350 0		150 0		250 0	
BTKH Operating & Capital Total	**2,678.0**		**1,985.0**	3,760.0	**250.0**	
Denali Comm BTKH Facilities (@50%)						**5,500.0**
07 Proposed State Match for BTKH Facil				*5 000 0*		
Work Group Meetings Qtrly (off budget)	40 0		40 0			

Unduplicated Medicaid RPTC Recipients by Ethnicity

	FY03	FY04	FY05
Alaskan Native	280	338	381
American Indian	14	16	18
Asian	5	12	11
Black	39	45	52
Hispanic	24	28	21
Pacific Islander	4	4	6
Unknown	54	46	44
White	432	476	469
Totals	**852**	**965**	**1,002**

Percentage Medicaid RPTC Recipients by Ethnicity

	FY03	FY04	FY05
Alaskan Native	33%	35%	38%
American Indian	2%	2%	2%
Asian	1%	1%	1%
Black	5%	5%	5%
Hispanic	3%	3%	2%
Pacific Islander	0%	0%	1%
Unknown	6%	5%	4%
White	51%	49%	47%
Totals	**100%**	**100%**	**100%**

Recipients by Gender

Unduplicated Count of Medicaid RPTC Recipients

	FY03	FY04	FY05
Female	403	432	424
Male	449	533	578
Totals	**852**	**965**	**1,002**

Unduplicated Percentage of Medicaid RPTC Recipients

	FY03	FY04	FY05
Female	47%	45%	42%
Male	53%	55%	58%
Totals	**100%**	**100%**	**100%**

Additional Resources

- Bring the Kids Home Documents can be found on-line at the DBH webpage at http://www.hss.state.ak.us/dbh/ under System Re-design. Select the Bring the Kids Home Work Group and you will find more materials to inform you about this exciting project.
  - BTKH Data 2005 Update (Preliminary)
  - Annual Report FY 05

Maintenance of Medicaid

- Medicaid funding is critical to beneficiaries of The Trust.
  - Refinanced Grants
  - Waivers avoid more costly care
  - Fairshare replacement
  - Inflation
  - Uninsured population growing

FY 07 GF/MH Budget Recommendations

Not in Governors Budget

- $500.0 Capital funds for Fairbanks Detox
- $5000.0 50% match for Denali Commission
- $500.0 Flexible Long Term Care for Seniors
- $400.0 Integrated Behavioral Health Services for Older Alaskans
- $6360.0 Developmental Disabilities Waitlist Reduction and Base Grant Restoration

Advisors to The Trust

- *Alaska Mental Health Board*
- *Advisory Board on Alcoholism & Drug Abuse*
- *Governor's Council on Disabilities & Special Education*
- *Alaska Commission on Aging*
- *Commissioners of the departments of Health and Social Services, Natural Resources and Revenue.*
- *Alaska Traumatic Brain Injury Board*
- *Suicide Prevention Council*

State of Alaska

DEPARTMENT OF HEALTH & SOCIAL SERVICES

Frank H. Murkowski, Governor

Karleen Jackson
Commissioner
P.O. Box 110601
Juneau, Alaska 99811-0601
FACT SHEET

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January 11, 2006

Bringing — and Keeping — the Kids Home

The Department of Health and Social Services is requesting $3.76 million in new general funds in the Fiscal Year 2007 budget to invest in the Bring the Kids Home initiative. This funding will enhance the two-year effort underway in partnership with the Mental Health Trust Authority to invest $5 million in FY06 and FY07 to bring and keep kids home. Of that amount, the Trust is contributing about $2.2 million. Additionally, the Denali Commission is providing $5.5 million federal funding over two years to help with half of the capital improvement costs to expand in-state capacity.

During the period from 1998 to 2004, the children's behavioral health system in Alaska became increasingly reliant on institutional care – Residential Psychiatric Treatment Center (RPTC) care for treatment of severely emotionally disturbed youth. Out-of-state placements in RPTC care grew by nearly 800 percent during that time. At any given time, approximately 350-400 children are being served in out-of-state placements. Alaska Native children represent 49 percent of children in state custody sent to out-of-state placements and 22 percent of the non-custody children sent to out-of-state placements.

"We've only heard talk about this for the last decade, but the sad fact remained that the state had failed to develop local treatment services. As a result, our young people had to leave their villages and their families to seek services Outside. That's unacceptable."

Governor Murkowski speaking to Alaska Federation of Natives Convention, October 2004

Bring the Kids Home project

The Department of Health and Social Services initiated the Bring the Kids Home project in 2004, in partnership with the Mental Health Trust Authority, the Denali Commission and other stakeholders. The mission is to return children being served in out-of-state facilities back to in-state residential or community-based care. The intent is to reinvest funding now going to out-of-state care to in-state services and build capacity to serve children closer to home.

More

Provided 2/8/06

The following long-term goals guide the direction of the Bring the Kids Home project:

- Build/develop and sustain the community-based and residential capacity to serve children with all intensities of need within the service delivery system in Alaska.
- Develop an integrated, seamless service system in Alaska that will allow children and youth to be served in the most culturally competent, least restrictive setting, as close as possible to home as determined to be safe and appropriate.
- Significantly reduce the existing numbers of children and youth in out-of-state care and ensure that the future use of out-of-state facilities is kept to a minimum.

Bring the Kids Home: Activities for FY05

The scope of this project requires that four levels of the system of care must be addressed concurrently: community, regional, in-state, and out-of-state care.

Community level of care

- Using about $1.1 million from the Mental Health Trust Authority, a Request for Proposals was issued for home and community based capacity enhancements in summer 2005, to provide operational funding for therapeutic alternatives close to home for youth diagnosed as severely emotionally disturbed.
- With Mental Health Trust Authority funding, the department began a planning initiative to define and implement Individualized Service Agreements to ensure youth diagnosed as severely emotionally disturbed are served as close to their community as possible, providing clinically necessary services to prevent institutional care.

Regional level of care

- The department is expanding the role of resource committees to provide gate keeping functions for Alaska children, ensuring that in-state resources at the appropriate level of care are fully utilized as matched with the client's clinical needs, as close to community and family as possible.
- The department contracted with McKesson Corporation in the use of a Level of Care Assessment at two pilot sites, both of which will be implemented in early 2006.

State level of care

- Trust funding helped create three Utilization Review positions in Behavioral Health to ensure that all in-state resources are used prior to a young person being placed in an out-of-state Residential Psychiatric Treatment Center.
- The department is soliciting for further services to assist in the Bring the Kids Home Initiative by the end of FY06, including therapeutic foster homes, home and community based capacity enhancements, and residential psychiatric treatment beds.
- The Dept. of Health and Social Services and the Dept. of Education and Early Development are developing a memorandum of agreement to ensure that the needs of all Alaskan children with intensive behavioral heath issues will be reviewed by regional and out-of-state placement committees.
- Juneau Youth Services and the Southeast Area Regional Health Corporation received $90,000 for planning and design and $1.5 million of capital funding for their proposed 15-bed Residential Treatment Center.

Groundbreaking ceremony for the new Juneau Residential Treatment Center, October 2005

– More –

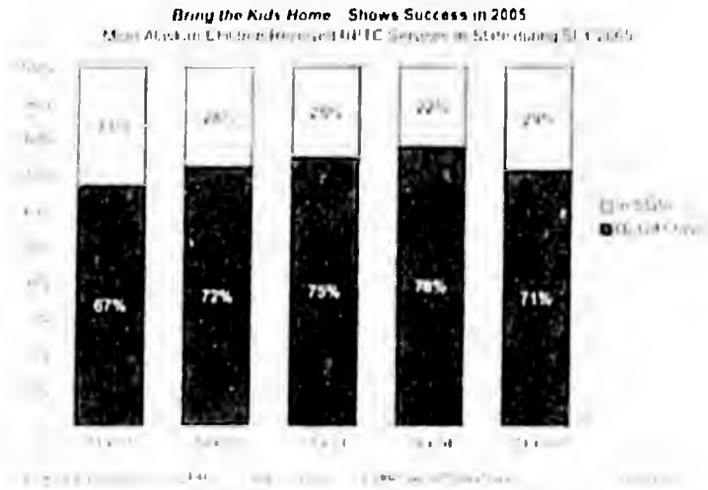
Out-of-State level of care

- The department has been working to amend the regulations for out-of-state placement to give Behavioral Health regulatory authority to manage and authorize out-of-state providers.
- Behavioral Health has negotiated with contractor First Health Services to provide two additional Care Coordinators to monitor length of stay and ensure timely discharge of youth from Residential Psychiatric Treatment Centers.

Bring the Kids Home: Outcomes for FY05

Due to the efforts of the partners in the Bring the Kids Home initiative, with creative collaboration with some urban providers, the numbers of Alaska children placed out-of-state declined in FY05 — for the first time. This is significant and shows that we are making progress.

Between FY98 and FY04 the unduplicated number of youth diagnosed as severely emotionally disturbed receiving out-of-state residential psychiatric treatment care has steadily increased an average 46.7 percent per year. During the same time period the distinct number of in-state residential psychiatric treatment care recipients has remained relatively flat, showing little change. The Residential Psychiatric Treatment Center population as a whole has also shown steady increase from FY98 to FY04, an average annual increase of 24.8 percent.



Between FY04 and FY05:

- The unduplicated number of Out-of-State Residential Psychiatric Treatment Center Medicaid recipients **decreased 5.1 percent** — the first decrease in the Out-of-state Residential Psychiatric Treatment Center population since 1998.

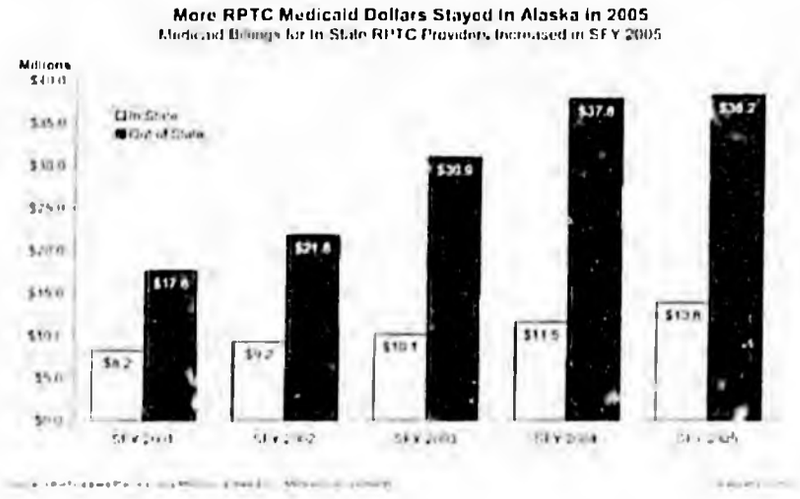
Distinct Counts of Medicaid RPTC Recipients by State Fiscal Year								
	FY 98	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05
Out-of-state	83	149	247	429	536	637	749	711
In State	139	217	221	211	208	215	216	291
Total	222	366	468	640	744	852	965	1,002

- The unduplicated number of In-State Medicaid Residential Psychiatric Treatment Center recipients increased 34.7 percent.
- After years of steady increases, the number of out-of-state Alaska youth not in state custody receiving Medicaid assistance for Residential Psychiatric Treatment decreased 6.6 percent between FY04 and FY05.

Between FY98 and FY04 out-of-state Residential Psychiatric Treatment Center Medicaid expenditures annually increased an average of 59.2 percent and increased overall 1300 percent. During the same time period in-state Residential Psychiatric Treatment Center Medicaid expenditures increased a little more than 300 percent and with smaller average annual increases of 29.6 percent.

Between FY04 and FY05:

- Out-of-State Residential Psychiatric Treatment Center Medicaid expenditures **increased by only 1.1 percent** — the smallest annual increase since 1998.
- In-State Residential Psychiatric Treatment Center Medicaid expenditures **increased by 19.8 percent.**



- Total Residential Psychiatric Treatment Center Medicaid expenditures increased by 5.5 percent — the smallest annual increase since 1998.
- Residential Psychiatric Treatment Center Custody expenditures for the out-of-state youth in custody decreased 1.3 percent from FY04 to FY05. Whereas this may seem minor, this decrease in out-of-state expenditures is significant considering the explosive annual historical increases. In-state expenditures for youth not in state custody increased 34.6 percent during the same time period.

Governor Frank Murkowski's FY07 budget request

Governor Murkowski's FY07 budget includes a request for an additional $3.76 million in state general fund investment for the Bring the Kids Home initiative to build on the successes of the past and to continue to make progress. The proposal focuses on three main areas:

- $390,000 general fund to improve oversight and staffing of the regional placement committees to form the gatekeeping system to review placement of all Alaskan youth.
- $1.25 million general fund to expand lower level residential care beds for children not in state custody. This will allow the state to purchase unused bed capa for in-state use at a lower cost.
- $2.12 million general fund to provide for individualized services for children who remain in Alaska and need community services.

Contact: Sherry Hill, (907) 465-1618, Cell (907) 321-2838
Jeff Kasper, (907) 465-8194, Cell (907) 321-3158

CS FOR HOUSE BILL NO. 105(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 2/11/05
Referred: Finance

Sponsor(s): HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act relating to coverage for adult dental services under Medicaid; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. The uncodified law of the State of Alaska is amended by adding a new section to read:

PURPOSE; INTENT. (a) The purpose of this Act is to increase adult dental care services for an eligible recipient of Medicaid under AS 47.07 to ensure that services critical to a recipient are implemented first, while controlling the overall growth of the costs of the increase in services.

(b) It is the intent of the legislature that the Department of Health and Social Services implement the increase in adult dental care services authorized by this Act through the adoption of regulations consistent with the department's obligation to contain the costs of the increased services in order to provide the services within appropriation limits. It is further the intent of the legislature that the Department of Health and Social Services implement

mechanisms to contain costs, which may include establishing a maximum amount of benefits for each eligible recipient in a fiscal year for the services and specifying the scope of the services.

* **Sec. 2.** AS 47.07 is amended by adding a new section to read:

Sec. 47.07.067. Payment for adult dental services. (a) The department shall pay for adult dental services provided under AS 47.07.030(b) and under regulations adopted by the commissioner in conformity with applicable federal requirements and this chapter. Regulations adopted under this section may include the following:

(1) a maximum amount of benefits for adult dental services for each eligible recipient in a fiscal year; this paragraph does not apply to minimum treatment for the immediate relief of pain and acute infection provided by a licensed dentist; and

(2) specification of the scope of adult dental services.

(b) As used in this section, "minimum treatment" means the application or prescription of a medication or material deemed necessary by the dentist for the palliative treatment of pain or for the reduction of the spread of infection.

* **Sec. 3.** AS 47.07.900(1) is repealed.

* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

* **Sec. 5.** Section 4 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 6.** Except as provided in sec. 5 of this Act, this Act takes effect July 1, 2005.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB105CS(HES)-DHSS-DHCS-01-25-06
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ADULT DENTAL COVERAGE UNDER MEDICAID
RDU: Health Care Services
Component: Medicaid Services

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR
Requester: HOUSE (FIN)
Component No.: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	3,469.4	11,548.1	11,912.5	11,081.4	10,814.9	11,166.7
Miscellaneous						
TOTAL OPERATING	**3,469.4**	**11,548.1**	**11,912.5**	**11,081.4**	**10,814.9**	**11,166.7**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	2,285.1	7,608.7	7,790.9	7,212.5	7,058.8	7,356.6
1003 GF Match	759.3	2,514.4	2,636.6	2,818.9	3,056.1	3,460.1
1004 GF						
1037 GF/Mental Health						
1092 MHTAAR	425.0	1,425.0	1,425.0	1,050.0	700.0	350.0
Other(Specify Type-do not abbreviate)						
TOTAL	**3,469.4**	**11,548.1**	**11,912.5**	**11,081.4**	**10,814.9**	**11,166.7**

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal: [ ]

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Historically Medicaid Dental Benefits for recipients 21 years or older, have been limited to immediate relief of pain and acute infection. Routine preventive or restorative services have not been covered.

Under this bill, Dental Benefits for Adults would be expanded to include preventive and resorative care up to a cap of $1,150 per person annually. Examples of services that could be provided at that level are: one exam, 4 bitewing radiographs, cleaning and about 8 restorations or extractions, or; one exam and an upper or lower full denture.

con't on next page

Prepared by: Janet Clarke, Assistant Commissioner — Phone: 465-1630
Division: Finance and Management Services — Date/Time: 01/24/2006
Approved by: Karleen Jackson, Commissioner — Date: 01/25/2006
Agency: Department of Health and Social Services

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO. HB105CS(HES)-DHSS-DHCS-01-25-06

ANALYSIS CONTINUATION
Analysis Con't

It is estimated that approximately 41,000 individuals would be eligible for the expanded Medicaid Dental Benefits, including adults with disabilities and seniors. Not all eligible individuals will seek dental benefits, and those that do will utilize services at varying rates. Of the 41,000 eligible persons, 50% of Alaska Native adults and 35% of non-Native adults are expected to access dental care - about 15,800 individuals.

Based on the assumptions below on utilization of dental benefits, the weighted average benefit for a full fiscal year is about $730 per recipient.

- Of adult recipients that access dental care it is estimated that:
  - 15% will receive up to $250 in benefits
  - 25% will receive up to $500 in benefits
  - 25% will receive up to $750 in benefits
  - 20% will receive up to $1,000 in benefits
  - 15% will receive the maximum $1,150 in benefits.

The SFY08 estimated expenditure for a full year ($11,548.1) represents the costs for the 15,800 individuals projected to receive the additional benefit at an estimated weighted average cost of $730.

These utilization rates are based on provider capacity (the extent of dental access through tribal and community health center dental programs, and the extent of private dental participation in the Medicaid program) and treatment needs (not all eligible individuals will seek dental benefits, and those that do will utilize services at varying rates.)

Factoring in those individuals who are eligible for 100% federal reimbursement, the federal contribution (through FY 2012) will cover approximately 66% of the costs. State GF will constitute about 25% and Mental Health Trust about 9% of the matching funds.

It is anticipated that the program will be operational the last quarter of FY07 so costs in that year are calculated at approximately 25% of FY08 costs and adjusted higher to allow for pent up demand.

A 3% growth in utilization is included to reflect possible increases in eligible adults and/or an increased percentage of adults accessing the dental services. This utilization is partially offset by projected lower expenses in FY10, FY11 & FY12 under the assumption that adults on the program for several years would eventually have their major treatment needs met and move to a "maintenance" level of care (e.g., routine exam and cleanings but less restorative needs and less dental emergencies).

It is anticipated that this service expansion will reduce dental emergencies, however there will always be adults who avoid the dentist u til there is an acute need. Because the service would not be implemented until the 4th quarter of FY07, claims for emergency dental services will likely remain the same in FY07.

CS FOR SENATE BILL NO. 79(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 2/18/05
Referred: Finance

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act relating to coverage for adult dental services under Medicaid; and providing for an effective date."

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(b) It is the intent of the legislature that the Department of Health and Social Services implement the increase in adult dental care services authorized by this Act through the adoption of regulations consistent with the department's obligation to contain the costs of the increased services in order to provide the services within appropriation limits. It is further the intent of the legislature that the Department of Health and Social Services implement

mechanisms to contain costs, which may include establishing a maximum amount of benefits for each eligible recipient in a fiscal year for the services and specifying the scope of the services.

* Sec. 2. AS 47.07 is amended by adding a new section to read:

Sec. 47.07.067. Payment for adult dental services. (a) The department shall pay for adult dental services provided under AS 47.07.030(b) and under regulations adopted by the commissioner in conformity with applicable federal requirements and this chapter. Regulations adopted under this section may include the following:

(1) a maximum amount of benefits for adult dental services for each eligible recipient in a fiscal year; this paragraph does not apply to minimum treatment for the immediate relief of pain and acute infection provided by a licensed dentist; and

(2) specification of the scope of adult dental services.

(b) As used in this section, "minimum treatment" means the application or prescription of a medication or material deemed necessary by the dentist for the palliative treatment of pain or for the reduction of the spread of infection.

* Sec. 3. AS 47.07.900(1) is repealed.

* Sec. 4. The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory changes.

* Sec. 5. Section 4 of this Act takes effect immediately under AS 01.10.070(c).

* Sec. 6. Except as provided in sec. 5 of this Act, this Act takes effect July 1, 2005.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB079CS(HES)-DHSS-DHCS-01-25-06
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ADULT DENTAL COVERAGE UNDER MEDICAID
RDU: Health Care Services
Component: Medicaid Services

Sponsor: (RLS) BY REQUEST OF THE GOVERNOR

Requester: SENATE (FIN)
Component No.: 2077

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims	3,469.4	11,548.1	11,912.5	11,081.4	10,814.9	11,166.7
Miscellaneous						
TOTAL OPERATING	3,469.4	11,548.1	11,912.5	11,081.4	10,814.9	11,166.7
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE	(Thousands of Dollars)					
1002 Federal Receipts	2,285.1	7,608.7	7,790.9	7,2[illegible]	7,058.8	7,356.6
1003 GF Match	759.3	2,514.4	2,696.6	2,818.9	3,056.1	3,460.1
1004 GF						
1037 GF/Mental Health						
1092 MHTAAR	425.0	1,425.0	1,425.0	1,050.0	700.0	350.0
Other(Specify Type-do not abbreviate)						
TOTAL	3,469.4	11,548.1	11,912.5	11,081.4	10,814.9	11,166.7

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Historically Medicaid Dental Benefits for recipients 21 years or older, have been limited to immediate relief of pain and acute infection. Routine preventive or restorative services have not been covered.

Under this bill, Dental Benefits for Adults would be expanded to include preventive and resorative care up to a cap of $1,150 per person annually. Examples of services that could be provided at that level are: one exam, 4 bitewing radiographs, cleaning and about 8 restorations or extractions, or; one exam and an upper or lower full denture.

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Prepared by: Janet Clarke, Assistant Commissioner — Phone: 465-1630
Division: Finance and Management Services — Date/Time: 01/24/2006
Approved by: Karleen Jackson, Commissioner — Date: 01/25/2006
Agency: Department of Health and Social Services

STATE OF ALASKA
2006 LEGISLATIVE SESSION

BILL NO. SB079CS(HES)-DHSS-DHCS-01-25-06

ANALYSIS CONTINUATION
Analysis Con't

It is estimated that approximately 41,000 individuals would be eligible for the expanded Medicaid Dental Benefits, including adults with disabilities and seniors. Not all eligible individuals will seek dental benefits, and those that do will utilize services at varying rates. Of the 41,000 eligible persons, 50% of Alaska Native adults and 35% of non-Native adults are expected to access dental care - about 15,800 individuals.

Based on the assumptions below on utilization of dental benefits, the weighted average benefit for a full fiscal year is about $730 per recipient.

- Of adult recipients that access dental care it is estimated that:
  - 15% will receive up to $250 in benefits
  - 25% will receive up to $500 in benefits
  - 25% will receive up to $750 in benefits
  - 20% will receive up to $1,000 in benefits
  - 15% will receive the maximum $1,150 in benefits.

The SFY08 estimated expenditure for a full year ($11,548.1) represents the costs for the 15,800 individuals projected to receive the additional benefit at an estimated weighted average cost of $730.

These utilization rates are based on provider capacity (the extent of dental access through tribal and community health center dental programs, and the extent of private dental participation in the Medicaid program) and treatment needs (not all eligible individuals will seek dental benefits, and those that do will utilize services at varying rates.)

Factoring in those individuals who are eligible for 100% federal reimbursement, the federal contribution (through FY 2012) will cover approximately 66% of the costs. State GF will constitute about 25% and Mental Health Trust about 9% of the matching funds.

It is anticipated that the program will be operational the last quarter of FY07 so costs in that year are calculated at approximately 25% of FY08 costs and adjusted higher to allow for pent up demand.

A 3% growth in utilization is included to reflect possible increases in eligible adults and/or an increased percentage of adults accessing the dental services. This utilization is partially offset by projected lower expenses in FY10, FY11 & FY12 under the assumption that adults on the program for several years would eventually have their major treatment needs met and move to a "maintenance" level of care (e.g., routine exam and cleanings but less restorative needs and less dental emergencies).

It is anticipated that this service expansion will reduce dental emergencies, however there will always be adults who avoid the dentist until there is an acute need. Because the service would not be implemented until the 4th quarter of FY07, claims for emergency dental services will likely remain the same in FY07.

Bring the Kids Home (BTKH) Initiative

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year												
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
I. Community Based																
	CMHC Capacity for Individualized Services beyond Medicaid **Grant increases for care management** **Note: This includes "In-Home Su ports"**	1. Increase capacity for lower level of care 2. Evaluate barriers of policy or reimbursement 2. Develop a reimbursement system beyond Medicaid that provide flexibility and incentive for lower levels of care	Proposed Individ Services Resources: MH Trust: *reference the $ at the Resource Committees Resources: GF/MH (Trust proposed) - $1,250,000 (FY07)			2 community wraparound programs 5 kids per program *Measurement connotes number of community based wraparound programs	15 (+5)	30 (+15)	45 (+15)	60 (+15)	75 (+15)	90 (+15)		Future expansion will be driven by capacity of community behavioral health programs		
	School-Based Services	Current Status 1. Department planning committee worked with school officials to define services, and develop work process 2. Regulations for "School Based Behavioral Health Service" has been completed, approved, and implemented				13 communities with school based programs 5 students *Measurement connotes number of communities with school based services	70 (+5)	85 (+15)	100 (+15)	Future expansion will be driven by capacity of community behavioral health programs and individual school districts Economy of scale must be addressed						
	Therapeutic Foster Homes	Current Status 1. Through the Community Based 1915(B) RFP, an additional 9 homes, each serving 1-5 children, was awarded, and will be implemented in '06	Resources *reference the $ at Regional Services				40 beds (+40)	20 beds (+40)	30 beds (+40)	Future expansion will be driven by community need, resources and capacity						

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year											
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	Respite		Resources: *reference the $ at Regional Services							Future expansion will be driven by community need, resources and capacity						
	Crisis Respite	Current Status: 1. Through the Community Based '06RFP, an additional 3 homes (each able to serve 1-2 children) have been awarded, and will be implemented in '06.	Resources: *reference the $ at Regional Services							Future expansion will be driven by community need, resources and capacity						
	Crisis Nursery	Current Status: 1. Through the Community Based '06RFP, an additional program to serve approximately 21 children, will be implemented in '06.	Resources: *reference the $ at Regional Services				5 beds (+5)	10 beds (+5)	15 beds (+5)	Future expansion will be driven by community need, resources and capacity						
II. Regional Level																
	Group Homes	1. Expand beds to increase capacity for placement into lower level of care. 2. Schedule of expansion acknowledges the challenges in start up efforts Current Status: 1. Through the Community Based '06RFP, an additional 5 homes (serving 8 children each) will be implemented in '06.	Resources: - For variety of Home/Community based services *Start up operating* MH Trust: - $1,110,000 (FY06) - $1,110,000 (FY07) GF/MH Trust proposed) - $500,000 - *Capital* MH Trust: - $350,000 (FY06) - $350,000 (FY07) Denali Comm (FY05) - $110,000 (existing) - $1,250,000 (new)		10 beds	10 beds	20 beds (+10)	30 beds (+10)	40 beds (+10)	Future expansion will be driven by ongoing assessment of need, resources and capacity						

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year											
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	OCS: BRS * facilities Behavioral Rehab. Services	Strategies: 1. Expand beds to increase capacity for kids in the custody of the Office of Children Services (OCS) through the various facilities of Behavioral Rehab. Services. 2. Expand beds to increase capacity for kids who are not in state's custody. 3. Increase capacity for services that allow for services at a lower level of care. Current Status: 1. Behavioral Health Regulations have completed public notice, and are in final legal review: this will allow 55 currently unused beds to be accessible to non-custody children. 2. A Rate Review is currently underway to insure that the economic sustainability of residential facilities is maintained.	Resources: GF/MH (Trust proposed) - $1,500,000 Federal '06 request of $5.5 million			350 beds[1] TOTAL current state capacity	397 beds (+47)	442 beds (+45)	487 beds (+45)							Future expansion will be driven by ongoing assessment of need, resources and capacity
	Level I: Day Treatment		Resources: -none designated			2 programs 33 custody slots 0 non-custody										
	Level II: Emergency Stabilization & Assessment		Resources: -See Above			14 programs 99 custody beds 50 non custody	159 beds (+10)	169 beds (+10)	179 beds (+10)							Future expansion will be driven by ongoing assessment of need, resources and capacity
	Level III: Residential Treatment		Resources: -See Above			12 programs 108 custody beds 34 non custody	162 beds (+20)	182 beds (+20)	202 beds (+20)							Future expansion will be driven by ongoing assessment of need, resources and capacity
	Level IV: Residential	Current Status: 1. A joint venture between a nonprofit and native	Resources:			4 programs 18 custody beds	51									

[1] Child and Youth Needs Assessment (CAYNA) Report

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year											
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	Diagnostic Services	health providers has received funding for a 15 bed facility. This will be operational in '06.	-See Above			8 non custody Total: 36 bed	beds (+15)			Future expansion will be driven by ongoing assessment of need, resources and capacity						
	Regional & Out of State Resource Committees	1. Finalize MOA between OCS, DJJ, and DBH 2. Define policy & procedure for custody and non-custody children	1. MOA is finalized. 2. In process Resources for Committees and Individualized Services: -MH Trust: -$$1,193,000 FY '06 -$700,000 * FY 07 GF/MH(Trust proposed): -$700,000 (FY07) - $150,000 (FY07)			*Measurement is a decline of recidivism by 12% per year										
III. State Level																
	Instate RPTC's	Current Status: 1. Certificat of Need process has been completed, adopted, and implemented. 2. A CON for a Level V facility has been approved for 60 beds (20 secure), and will be operational in '06.	Resources: GF/MH start up oper (Trust proposed): - $500,000 (FY07) Federal '06 request of $4.6 million			101 beds 4 programs 36 custody beds 65 non custody	161 (+60)		200 beds	Future expansion will be driven by ongoing assessment of need, resources and capacity						
	Care Coordination	Current Status 1. Contract adjustments with 1st Health Corporation completed, resulting in hiring of 2 additional care coordinators	1. Finalized 1/1/05 Resources: -MH Trust: - $85,000 (FY05) -DBH, 1st Health Contract			*Measurement is a the decline in average LOS for OOS placement, by 8% per year										
IV Out-of-State Level																

Expansion of Services & Facilities

System Level	Proposed Enhancements	Activities/Discussion/Status	Resources	Proposed Implementation Schedule & Timelines by Fiscal Year												
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	Gate keeping	1. State utilization surveyors have been hired. 2. State RPTC placement criteria has been re-written and implemented. 3. Level of Care Assessment has been adopted, and applied to the Acute Care facilities in Anchorage.				*Measurement is the decline in the number of OOS placement										
Average RPTC Placements (Placement, & Targeted Reduction*) by Fiscal Year & Unduplicated Count																
				2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
	Instate RPTC Placements	Assumptions: 1. projection is based on a rate of 10% growth per year		215	114	150	165 (+15)	182 (+17)	200 (+18)	220 (+20)	242 (+22)	266 (+24)	292 (+26)	321 (+29)	353 (+32)	388 (+35)
	Out-Of-State RPTC Placements	Assumptions: 1. projection is based on a rate of 15% reduction per year 2. Assumes that community based services will increase capacity to absorb 10% of these placements a year		399	446	500	450 (-50)	400 (-50)	350 (-50)	300 (-50)	250 (-50)	200 (-50)	150 (-50)	100 (-50)	50 (-50)	0
	Total RPTC Placements	Assumptions: 1. rate of total RPTC placements will decline 2. LOS will decline 3. Community –based services will increase 4. Diversions are at a higher level at the beginning and taper down. The assumption is that later diversions will require higher levels of care.		492	560	650	610	582	550	520	492	466	442	421	403	388

Tom Hawkins

Chair, Resource Management Committee

Tom is Chief Operating Officer for Bristol Bay Native Corporation, an ANCSA regional corporation in western Alaska with 7,500 shareholders, $80 million in assets and 3 million acres of land. He is the former Deputy Commissioner of the State Department of Natural Resources, Director of State Division of Lands, and General Manager for Choggiung Limited in Dillingham. Tom is a member of the Alaska Wilderness Recreation and Tourism Association board, the Alaska Land Managers Forum and the Bureau of Land Management's statewide Resource Advisory Council.

Term expires April 2009

Laraine Derr

Laraine is a Juneau resident who has spent much of her career in public service. She most recently served as Director of the Governor's Boards and Commissions Office. Prior to that, Laraine spent seven years as President and CEO for the Alaska State Hospital and Nursing Home Association. That position gave her direct insight into Alaska's healthcare industry. She also served as Commissioner of Revenue, whose duties include service on the Permanent Fund Board, the Alaska Housing Finance Board, and the advisory board for the Alaska State Retirement System. Her experience also includes serving as head of the School of Business and Public Administration for the University of Alaska Southeast. Laraine serves on a number of boards and commissions and is Chair of the University of Alas College of Fellows, University of Alaska Southeast; she is also a member of the University of Alaska Foundation Board.

Term expires March 2010

Beneficiary Groups

Beneficiaries of The Trust include people with mental illness, people with developmental disabilities, people with chronic alcoholism and people with Alzheimer's disease or related disorders.

Advisors

The commissioners of Health and Social Services, Natural Resources, Revenue, and Corrections by statute are important advisors to the Trustees. Trustees also work closely with four advocacy boards that represent Trust beneficiaries. They are the Advisory Board on Alcoholism and Drug Abuse, Alaska Commission on Aging, Alaska Mental Health Board, and Governor's Council on Disabilities and Special Education.

Jeff Jessee
Chief Executive Officer

Delisa Culpepper
Chief Operating Officer

Marie Trueblood
Chief Financial Officer

Marilyn McMillan
Budget Coordinator

Bill Herman
Trust Program Officer

Nancy Burke
Trust Program Officer

Steve Williams
Trust Program Officer

Erika Wolter
Trust Program Specialist
Liaison

Jody Thomas
Administrative Manager

Lucas Lind
Grants Administrator

Yvette Miller
Administrative Support
Specialist

The Trust
The Alaska Mental Health Trust Authority

550 West 7th Avenue, Suite 1820
Anchorage, AK 99501

907-269-7960

www.mhtrust.org

ABOUT THE TRUSTEES

A DECADE OF TRUST

A seven-member Board of Trustees oversees the Alaska Mental Health Trust. Trustees have a fiduciary responsibility to Trust beneficiaries to enhance and protect the Trust's financial assets. Trustees also ensure the planning, implementation and funding of a comprehensive integrated mental health program to improve the lives of Trust beneficiaries.

Trustees are appointed by the governor and confirmed by the legislature to five-year terms.

John Pugh
Chair, Board of Trustees
Chair, Comprehensive Integrated Mental Health Plan

John is Chancellor of the University of Alaska Southeast in Juneau. He is the former Commissioner of the State Department of Health and Social Services and Director of the Division of Family and Youth Services. John serves on various boards and commissions related to higher education in Alaska and the Northwest. The past two years he has chaired the Northwest Regional Education Laboratory.

Term expires March 2006

William Doolittle, MD
Vice Chair, Board of Trustees

Bill is a retired physician who serves as a medical consultant to the Social Security Administration and the Alaska Division of Vocational Rehabilitation. He retired from the day-to-day practice of medicine in 1997, but maintains his medical certification and is licensed in Alaska. His 43-year career included serving five terms as chief of staff at Fairbanks Memorial Hospital, medical director of the North Pole Fire Department EMS Service, director of the Arctic Medical Research Laboratory and chief of medicine for Bassett Army Hospital at Fort Wainwright. He began his medical training and career in the Army and retired with the rank of lieutenant colonel. He graduated from the University of Vermont with degrees in science and medicine. Currently he serves on the Fairbanks Memorial Hospital Foundation Board of Trustees and the Fairbanks Chronic Inebriate Program Task Group. The task group is a community partnership with representatives from healthcare, law enforcement and the judicial system who are attempting to improve the lives of people dealing with chronic alcoholism.

Term expires [illegible]

Margaret Lowe
Secretary, Treasurer, Board of Trustees
Chair, Rural Outreach Committee

A long-time advocate for children and adults with developmental disabilities, Margaret began her career as a teacher and retired in 1986 from the Anchorage School District after 20 years in the classroom, as a principal and as a program administrator, primarily working in special education. She went on to serve as director of the State Division of Mental Health and Developmental Disabilities and became Commissioner of Health and Social Services in 1993, a post she held at the time of the Trust Settlement. She is active on many boards and commissions throughout the state, including the Association for Retarded Citizens of which she was a charter member in 1967. She is also a past member of the Council for Exceptional Children and the Governor's Council on Mental Retardation, which she helped transition into the Alaska Developmental Disabilities Council. Margaret earned a bachelor of science in education at the University of Minnesota, a master of arts in education at the University of Alaska Fairbanks, and an education specialist certificate in public school administration from the University of Alaska Anchorage.

Term expires April 2010

Nelson G. Page
Chair, Finance Committee

Nelson is a shareholder in the Anchorage law firm of Burr, Pease and Kurtz, where he has practiced law for 22 years. He is a member of the Alaska Bar Association Ethics Committee, and past member of the Bar Association's Board of Bar Examiners Area Discipline Committee and the Alaska Supreme Court's Standing Committee on Civil Rules. His past community service includes four years on the Alaska Mental Health Board, membership on the Anchorage Transportation Commission, and membership on the Board of Directors of the Suicide Prevention and Crisis Intervention Center. Nelson is a graduate of Portland State University and the Georgetown University Law Center.

Term expires March 2007

John E. Malone
Chair, Program & Planning Committee

John is the Land Use and Planning Administrator for the City of Bethel. He has had extensive experience in the mental health community in Alaska, having served as a member of the Alaska Mental Health Board for five years and as State President of the Alaska Alliance for the Mentally Ill for four years. John was chair of the Federal Region X State Presidents Council of the National Alliance for the Mentally Ill and co-chaired the Mental Health Quality Improvement Task Force. He is a former Executive Director of Bethel Community Services, Inc.

Term expires [illegible]

Photo courtesy of Alaska Rainforest Sanctuary Ketchikan, Alaska

Commercial Tourism Opportunities

Information

Maps and answers to general Mental Health Trust Land questions can be found at the Department of Natural Resources Public Information Offices.

DNR Public Information Offices
Northern Region, Fairbanks, (907) 451-2705
Southcentral Region, Anchorage, (907) 269-8400
Southeast Region, Juneau, (907) 465-3400

More specific questions should be directed to the Trust Land Office at (907) 269-8658, or email at **MHTLO@dnr.state.ak.us.**

Questions about the use of revenues should be directed to the Alaska Mental Health Trust Authority Office at (907) 269-7960.

Trust Land Office
718 L Street, Suite 202
Anchorage, AK 99501
Tel: (907) 269-8658; Fax: (907) 269-8905
www.mhtrustland.org

Alaska Mental Health Trust Land Office
718 L Street, Suite 202
Anchorage, AK 99501

The Alaska Mental Health Trust

Trust Land Office

The Trust

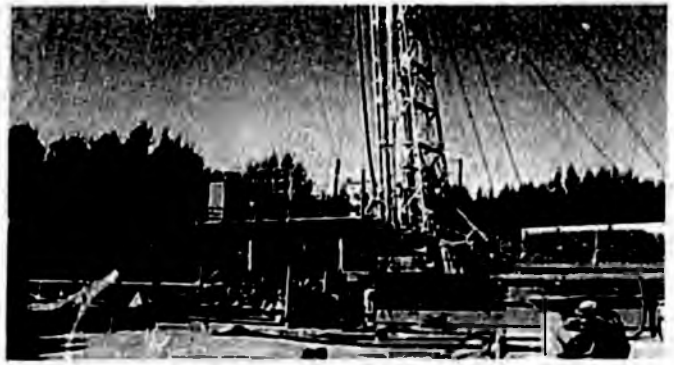
The *Alaska Mental Health Trust* was established by Congress in 1956. The 1956 law included a grant of one million acres of land to be used to generate revenues to meet the expenses of mental health programs in Alaska. In the mid-1980s a citizen lawsuit was filed claiming mismanagement of these lands. In 1994 the Alaska Superior Court and Alaska Legislature took actions, which effectively settled the litigation. The settlement created the Alaska Mental Health Trust Authority whose responsibility is to ensure the creation of a comprehensive integrated mental health program for Alaska.

Trust Beneficiaries

Alaska Mental Health Trust beneficiaries include people with mental illness, people with developmental disabilities, people with chronic alcoholism, and people with Alzheimer's disease or related dementia.

Trust Land Office

The 1994 settlement reconstituted the Alaska Mental Health Trust and the related legislation transferred nearly one million acres of land to the Alaska Mental Health Trust Authority. It also required the creation of a separate unit within the Department of Natural Resources, the Trust Land Office. This office was established to manage the lands under contract to the Alaska Mental Health Trust Authority. Trust Land Office activities are funded from Alaska Mental Health Trust income, not the General Fund.



Oil & Gas Exploration

Trust Land Office Mission

The Trust Land Office manages Mental Health Trust Land to generate income that is used by the Alaska Mental Health Trust Authority to improve the lives and circumstances of Trust beneficiaries.

Trust Land Opportunities

- Real estate opportunities uniquely situated for residential and commercial activities, including opportunities for development related to recreation and tourism.
- A wealth of natural resources including: commercial timber, hard rock minerals, coal, oil and natural gas.
- An enthusiastic Trust Land Office staff, dedicated to generating revenues from Mental Health Trust Land.
- A flexible business-oriented decision making process that encourages creative and sensible projects.
- The knowledge that revenues generated from Mental Health Trust Lands go to improving the lives and circumstances of trust beneficiaries.

Real Estate Development

Timber Opportunities

Trust Land Office Management Guiding Principals

- Be loyal and accountable to the Alaska Mental Heath Trust and its beneficiaries.
- Maximize revenues from Trust Land and resource assets over time.
- Protect and enhance the value and productivity of Trust Land.
- Manage Trust Land prudently, efficiently and with accountability to The Trust and its beneficiaries.
- Encourage a diversity of revenue-producing uses of Trust Land.
- Emphasize innovative solutions.