Triple Threat: HIV, Substance Use and Mental Health

April 15, 2008
Washington, D.C.

H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse Mental Health Services Administration
U.S. Department of Health & Human Services

“A hopeful society acts boldly to fight disease like HIV/AIDS, which can be prevented, and treated, and defeated.... We will also lead a nationwide effort...and come closer to the day when there are no new infections in America.”

January 31, 2006

President George W. Bush
SAMHSA’S Vision & Mission

Vision
A life in the community for everyone

Mission
Building resiliency and facilitating recovery

Key Treatment Issues

• Reaching Those in Need
• Increasing Burden on the Public Sector
• Implementing Evidence-Based and Culturally-Appropriate Practices
• Building and Sustaining a Qualified Workforce
• Measuring Performance and Improving Quality
• Repairing the World of the Substance Abuser or Alcoholic
Past Month Use of Specific Illicit Drugs among Persons Aged 12 or Older:
2006

- Illicit Drugs: 20.4
- Marijuana: 14.8
- Psychotherapeutics: 7.0
- Cocaine: 2.4
- Hallucinogens: 1.0
- Inhalants: 0.8
- Heroin: 0.3

Past Year Methamphetamine Use among Persons Aged 12+, by Age:
2002-2006

Percent Using in Past Year

- 12 or Older: 0.7
- 12 to 17: 0.7
- 18 to 25: 2.0
- 26 or Older: 0.5

* Difference between this estimate and the 2006 estimate is statistically significant at the .05 level.
The Challenge

Past Year Perceived Need for and Effort Made to Receive Treatment among Persons Aged 12+ Needing But Not Receiving Specialty Treatment for Illicit Drug or Alcohol Use: 2006

Did Not Feel They Needed Treatment (20,114,000)

95.5%

Felt They Needed Treatment and Did Not Make an Effort (625,000)

1.5%

Felt They Needed Treatment and Did Make an Effort (314,000)

21.1 Million Needing But Not Receiving Treatment for Illicit Drug or Alcohol Use

The HIV/AIDS Challenge

Number of HIV Infected in the U.S. at end of 2003:

1,039,000 to 1,185,000

Number unaware of their HIV infection (U.S.) at end of 2003:

252,000 to 312,000 (24% - 27%)

Estimated rates (per 100,000 population) for adults & adolescents living with HIV infection (not AIDS) or with AIDS, 2006 – U.S. & dependent areas

Source: CDC 2006 HIV/AIDS Surveillance Report

Estimated rates (per 100,000 population) for children <13 years of age living with HIV infection (not AIDS) or with AIDS, 2006—U.S. & dependent areas

Source: CDC 2006 HIV/AIDS Surveillance Report
Black, or African Americans, accounted for almost half of the estimated number of HIV/AIDS diagnoses made during 2006.

Transmission Categories of Adults & Adolescents with HIV/AIDS Diagnosed during 2006

*Sexual contact with a person known to have, or be at high risk for, HIV infection.

Transmission Category for Persons with a new HIV Diagnosis in 2006

- **Males**
  - Male-to-Male Sexual Contact: 16%
  - Injection Drug Use (IDU): <1%
  - Male-to-Male Sexual Contact & IDU: 12%
  - High-Risk Heterosexual Contact*: 5%
  - Other: 67%
  
- **Females**
  - Male-to-Male Sexual Contact: 19%
  - Injection Drug Use (IDU): 1%
  - Male-to-Male Sexual Contact & IDU: 1%
  - High-Risk Heterosexual Contact*: 80%
  - Other: 1%

*Sexual contact with a person known to have, or be at high risk for, HIV infection.


Proportion of HIV/AIDS Cases Among Adults & Adolescents by Transmission Category 2002 - 2006

- **Male-to-Male Sexual Contact**
- **Injection Drug Use (IDU)**
- **Male-to-Male Sexual Contact & IDU**
- **High-Risk Heterosexual Contact***
- **Other**

*Sexual contact with a person known to have, or be at high risk for, HIV infection.

Other includes hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified.

District of Columbia vs. National HIV/AIDS Statistics

- There was a **36.2% reduction in mortality** of those living with AIDS between 2003 and 2006 in the District of Columbia, compared to a 17% reduction of deaths of those living with AIDS nationally (2002-2006).
- The number of newly reported HIV (not AIDS) and AIDS cases in the District peaked in 2002 and has **declined** each year since.
  - Nationally, from 2003 through 2006, the estimated number of HIV/AIDS cases in the 33 states with confidential name-based HIV infection reporting remained stable.
- The largest decrease in DC cases by mode of transmission was among HIV (not AIDS) cases attributed to IDU. The number of cases decreased from 70 cases in 2001 to 36 cases in 2006, **almost a 50% reduction**.


HIV/AIDS in the District of Columbia

- However, HIV/AIDS remains a major public health challenge in the District of Columbia.
- Late testing is considered to be a major contributor to almost 70% of all AIDS cases progressing from HIV to AIDS in less than 12 months after the initial HIV diagnosis (1997-2006).
  - Nationally, only 39% of AIDS cases are late testers.

HIV/AIDS in the District of Columbia

- Although Black residents account for only 57% of the District’s population, they account for 81% of new reports of HIV cases and approximately 86% of living AIDS cases.
  - Black women constitute only 58% of the District’s female population, but they account for 90% of all new female HIV cases and 93% of living AIDS cases among women.

Transmission Categories of Adults & Adolescents in DC
Reported HIV/AIDS Cases: 2006

Injection Drug Use & HIV/AIDS

According to CDC data on U.S. adolescents and adults – in 2006:

• Approximately 13% of the reported new AIDS cases were related to injection drug use.
• 19% of males and 32% of females living with AIDS were exposed through injection drug use.
• Almost one-third (27.8%) of AIDS deaths were adolescents and adults infected through injection drugs.


Methamphetamine Use & HIV Risk Behaviors

• Methamphetamine reduces inhibitions and judgment, resulting in use of shared needles and sexual practices that may increase the likelihood of HIV transmission.
• Meth may dry mucosa, which may lead to more chafing and abrasions – which could provide an entry for HIV during sexual activity.
• Meth use may cause mental confusion and impair the ability to take medications that have been prescribed for HIV infection or other conditions.

Source: Centers for Disease Control & Prevention
Co-Occurrence of Serious Psychological Distress & Substance Use Disorder in the Past Year among Adults Aged 18 or Older: 2006

![Venn Diagram]

Source: 2006 NSDUH

Drug Use and Mental Health Impacts on Antiretroviral Therapy Adherence & Viral Suppression

- A 2002 study found that adherence to antiretroviral therapy among drug users is influenced by:
  - Active cocaine use
  - Screening positive for depression
  - Using alcohol or drugs to cope with stress
- Overall adherence among active cocaine users was 27% (compared to 68% among those who reported no cocaine use).
- 13% of cocaine users maintained viral suppression (compared to 46% of nonusers).

“The Triple Threat”

- Untreated mental health disorders, particularly depression, and active substance or alcohol use disorders have been associated with poor adherence to treatment.¹
- HIV is a causal factor in depression, and depression is a causal factor in HIV-related morbidity.²
- Cognitive impairment, social disorganization, and reduced motivation, which may be associated with any of these three disorders, may seriously impede an individual’s access to medical care.

² Ciesla & Roberts, 2001

Responding to the Triple Threat

For HIV-infected patients with co-occurring substance use and mental health disorders, services that successfully combine substance use and mental health treatment with HIV care may positively affect the patient’s overall medical care.

Source: New York State Department of Health AIDS Institute
The SAMHSA HIV/AIDS and Hepatitis Targeted Expansion (TCE) grants are administered by each of the 3 Centers, resulting in a comprehensive offering that addresses mental health and substance abuse issues related to HIV/AIDS:

**Center for Substance Abuse Treatment (CSAT):**
- The purpose of the CSAT TCE/HIV grant program (63.1M) is to enhance and expand substance abuse treatment and/or outreach and pretreatment services in conjunction with HIV/AIDS services.
- These grants require that at a minimum, 80% of all clients will be tested for HIV/AIDS.

**Center for Substance Abuse Prevention (CSAP):**
- The purpose of the CSAP TCE/HIV grant program (39.3M) is to assist communities in expanding existing HIV/AIDS and substance abuse prevention services.

**Center for Mental Health Services (CMHS):**
- The purpose of the CMHS HIV/AIDS Minority Mental Health Services grant program (9.2M) is to increase capacity to provide culturally competent mental health treatment services to individuals living with HIV/AIDS.
SAMHSA Grant Awards 2007/2008
District of Columbia

<table>
<thead>
<tr>
<th>Formula Funding</th>
<th>Fiscal Year 2007/2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Prevention and Treatment Block Grant:</td>
<td>$6,595,230</td>
</tr>
<tr>
<td>Community Mental Health Services Block Grant:</td>
<td>$715,759</td>
</tr>
<tr>
<td>Projects for Assistance in Transition from Homelessness (PATH):</td>
<td>$300,000</td>
</tr>
<tr>
<td>Protection and Advocacy Formula Grant:</td>
<td>$413,000</td>
</tr>
<tr>
<td><strong>Subtotal of Formula Funding:</strong></td>
<td><strong>$8,023,989</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discretionary Funding</th>
<th>Fiscal Year 2007/2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health:</td>
<td>$6,846,375</td>
</tr>
<tr>
<td>Substance Abuse Prevention:</td>
<td>$883,640</td>
</tr>
<tr>
<td>Substance Abuse Treatment:</td>
<td>$5,121,727</td>
</tr>
<tr>
<td><strong>Subtotal of Discretionary Funding:</strong></td>
<td><strong>$12,851,742</strong></td>
</tr>
<tr>
<td>Total Mental Health Funds:</td>
<td>$8,273,134</td>
</tr>
<tr>
<td>Total Substance Abuse Funds:</td>
<td>$12,600,597</td>
</tr>
<tr>
<td><strong>Total Funds:</strong></td>
<td><strong>$20,875,731</strong></td>
</tr>
</tbody>
</table>

SAMHSA HIV/AIDS Grantees
District of Columbia

A total of $1.8 Million in HIV/AIDS-related funds has been awarded to District of Columbia grantees in FY2007.

- **Community Connections – Iris Project**
  - Target populations: HIV+ women who have severe mental disorders, HIV+ women whose mental health status has not been evaluated, and those individuals who are part of these women’s natural networks.
  - Two primary goals: identify mental health concerns among African American women and providers, and provide a full range of community supports through a newly developed Wellness Intensive Case Management team.
SAMHSA HIV/AIDS Grantees
District of Columbia

• Sasha Bruce Youthwork, Inc.
  – Target population: African American re-entry populations 21 years of age and younger
  – Primary goals: Collaborate with the Sexual Minority Youth “Assistance League to provide comprehensive culturally competent outreach, prevention and referral services to promote positive attitude and behavioral changes regarding substance abuse, HIV and Hepatitis.

• Latin American Youth Center, Inc.
  – Target populations: minority and minority re-entry populations – particularly African American and Latino youth and young adults, ages 13-24 years in DC Wards 1 & 4 and DC youth exiting the juvenile justice system.
  – Primary goals: Deliver integrated prevention services for substance abuse, HIV, Hepatitis and sexually transmitted infections; provide counseling, testing and referral services.
SAMHSA HIV/AIDS Grantees
District of Columbia

• Washington Area Consortium/HIV Infected Youth – Metro TeenAIDS (MTA) and City Year Washington DC (CYDC)
  – Target populations: Youths 13-17 attending DC Public Schools through the DC Students Making Proud Choices! Project.
  – Primary goals: prevent new HIV infections among young people and improve the quality of life for young people already affected by and infected with HIV.

• LaClinica Del Pueblo, Inc. – Puerta Abierta (Open Door)
  – Target populations: Substance-abusing Latino immigrant men who have sex with men in the Washington metro area.
  – Primary goals: Through a partnership with Neighbors’ Consejo, reduce HIV transmission among target population, develop creative, integrated strategies of care, strengthen existing resources for the Latino community and provide a more cohesive standard of care, establish a base of understanding of the overlap in substance abuse and occurrence of HIV in the Latino community in the DC metro area.
CSAT - Minority AIDS Initiative

- Minority AIDS grants are awarded to community-based organizations with two or more years of experience in the delivery of substance abuse treatment and related HIV/AIDS services.
- Programs target African American, Latino/Hispanic and other racial or ethnic communities highly affected by substance abuse and HIV/AIDS.
- HIV Outreach grants served 22,760 clients
- TCE/HIV grants served 18,158 clients
- As a whole, the HIV Portfolio served a combined 40,918 clients

2007 CSAT TCE/HIV Grantees
Minority AIDS Initiative Benefits DC

- APRA used CSAT HIV Outreach grant funds from the Minority AIDS Initiative to purchase one of the nation’s first mobile clinic vans to offer on-site testing for diseases.
- The van, which was purchased in 2000, is still in use.
- It’s equipped with a waiting room, toilet facilities, private consultation room, and seating for 10.

HIV/AIDS Outreach – TCE/HIV Evidences of Success

<table>
<thead>
<tr>
<th>National Outcome Measures (NOMs)</th>
<th>% at Intake</th>
<th>6-Month Follow-up (%)</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients reporting no substance use</td>
<td>31.9%</td>
<td>56.1%</td>
<td><strong>Increased 75.9%</strong></td>
</tr>
<tr>
<td>Clients reporting being employed</td>
<td>25.0%</td>
<td>37.6%</td>
<td><strong>Increased 50.7%</strong></td>
</tr>
<tr>
<td>Clients reporting being housed</td>
<td>33.5%</td>
<td>39.8%</td>
<td><strong>Increased 18.8%</strong></td>
</tr>
<tr>
<td>Clients reporting no arrests</td>
<td>84.9%</td>
<td>87.3%</td>
<td><strong>Increased 2.9%</strong></td>
</tr>
<tr>
<td>Clients reporting being socially connected</td>
<td>68.9%</td>
<td>73.0%</td>
<td><strong>Increased 6.0%</strong></td>
</tr>
</tbody>
</table>
### Risk Behaviors for Women

- According to CDC data, 80% of HIV/AIDS is transmitted to women through unprotected sex.
- CSAT data shows consistent decreases in unprotected sexual risk behaviors among women 6 months after intake.
Risk Behaviors for Men

- Male clients reporting having unprotected sex decreased consistently across all risk behaviors from intake to 6 month follow-up.

![Bar Chart]

Source: SAIS data FY 2004 through 4/11/08

Rapid HIV Testing Initiative (RHTI)

- The RHTI was designed to reduce HIV incidence rates among minority populations who may be at an even greater risk for acquiring or transmitting HIV associated with substance abuse and/or a mental health disorder than other populations.

- RHTI Partners
  - Substance Abuse and Mental Health Services Administration (SAMHSA)
  - Centers for Disease Control and Prevention (CDC)
  - Health Resources and Services Administration (HRSA)
  - National Association of State Alcohol and Drug Abuse Directors (NASADAD)
  - National Alliance of State and Territorial AIDS Directors (NASTAD)
  - National Association of State Mental Health Program Directors (NASMHPD)
  - Department of Justice (DOJ), Serious and Violent Offenders Reentry Initiative
  - National Institute on Drug Abuse (NIDA)
Rapid HIV Testing Initiative (RHTI)

- SAMHSA secured a federal contract with OraSure Technologies to supply rapid HIV test kits at no cost to eligible service providers.
- SAMHSA, along with CDC and HRSA, provided the District of Columbia with Rapid HIV Testing Kits.
- From FY 2005 through FY 2007, 416,895 rapid testing kits were distributed to CSAT and CSAP grantees.
- **24,000 Test Kits and 372 Control kits were delivered to the District of Columbia Department of Health, Addiction Prevention and Recovery Administration (APRA) from April, 2005 to March 2006.** DC staff from APRA also received training from SAMHSA on administrating the test and providing counseling.

Rapid HIV Testing Initiative Goals

- Incorporate the new rapid HIV testing methodology into SAMHSA's qualified program sites as a strategic intervention:
  - To facilitate early diagnosis of HIV among at-risk minority populations involved in substance abuse (SA) and/or living with a mental health (MH) disorder, and
  - To increase referrals to sustained quality counseling, treatment, and other supportive care services for such persons diagnosed with HIV;
- Provide effective counseling to persons who previously tested negative to decrease their risk of acquiring HIV;
- Identify an increased number of evidence-based prevention and treatment programs and practices in the area of HIV/AIDS associated with SA and/or MH.
Rapid HIV Testing Requirements in FY 2008 TCE/HIV RFA

- CSAT has an HIV testing requirement in the FY 2008 TCE/HIV RFA:
  - All grantees must provide on-site HIV testing in accordance with State and local requirements or provide referral to an HIV testing site certified by the local health department if the client requests off-site HIV testing.
  - **CSAT expects that all FY 2008 TCE/HIV grantees test a minimum of 80% of all clients.**
    - Grantees must justify an HIV testing rate below 80%.
    - CSAT will consider any failure to provide an adequate justification when making annual determinations to continue a grant and the amount of any continuation award.
  - HIV testing may also be made available to the injection and/or sexual partners of the clients

SAPT Block Grant Set-Aside

- The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reorganization Act of 1992 amended Title XIX, Part B, Subpart II of the Public Health Service Act
- Requires States with an AIDS case rate of 10 or more per 100,000 individuals (“Designated States”) to set-aside a certain percentage of the SAPT Block Grant to establish 1 or more projects for early intervention services for HIV.
- Currently, all Designated States are required to set aside 5% of their SAPT Block Grant allocations for early intervention HIV services.
FY 2008 SAPT Block Grant
Set-Aside

• In FY 2008, 21 States, Puerto Rico, and U.S. Virgin Islands were HIV “Designated States.”
• Total SAPT HIV Set-Aside funding: $56.77 Million
  – HIV early intervention projects include counseling, HIV testing, and referral services.
  – States are being encouraged to use part of their HIV set-aside to purchase Rapid HIV Test Kits

Block Grant HIV Set-aside States

= HIV Set-aside State (Reported 10 HIV cases per 100,000 to CDC)
Access to Recovery (ATR)

- ATR is a Presidential Initiative designed to promote client choice through
  - the expansion of treatment capacity,
  - the implementation of a voucher system, which allows most grantees to choose their target populations and geographic area(s) of coverage, and
  - the inclusion of non-traditional substance abuse treatment providers such as faith- and community based organizations.
- The program is expected to address the treatment gap in other available substance use treatment programs.

ATR Program Goals

- Ensure genuine, free, and independent client choice for clinical treatment and recovery support services at the appropriate level of care.

- Ensure that assessment, clinical treatment, and recovery support services funded by ATR are provided pursuant to a voucher or vouchers given to and presented by a client.
Examples of Services That Can be Paid for Using ATR Vouchers

- Employment coaching
- 12-step groups
- Recovery coaching
- Spiritual support
- Child Care
- Housing Support
- Literacy Training
- Traditional Healing Practices, e.g.:
  - Sweat lodge
  - Sundance ceremony
  - Burning sage
  - Beading
  - Other

District of Columbia Access to Recovery

- DC was awarded approximately $10.6 million over three years.
- Year one total funding: $3,522,968
- 9.4% of year one funding is slotted for methamphetamine treatment programs ($329,456).
- Year one client target (including methamphetamine clients) – 1,494
- Target Area – The 8 wards of the District of Columbia.
District of Columbia Access to Recovery

- ATR program plans to provide culturally sensitive substance abuse treatment and recovery support services over the three-year federal grant period.
- The key target population includes the estimated 20,000 substance abusers who annually exit jail or prison and return to the District's streets.
- Three additional special populations will be targeted over the life of the grant: single women, women with dependent children, and methamphetamine users.

District of Columbia Access to Recovery

<table>
<thead>
<tr>
<th>Clinical Services</th>
<th>Recovery Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Treatment</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>Intensive Outpatient Treatment</td>
<td>Transportation</td>
</tr>
<tr>
<td>Residential Adolescent</td>
<td>Education</td>
</tr>
<tr>
<td>Residential Adult – Women</td>
<td>Spiritual Counseling</td>
</tr>
<tr>
<td>Residential Women with Children</td>
<td>Relapse Prevention</td>
</tr>
</tbody>
</table>
The Mental Health HIV Services Collaborative (MHHSC) Program

• The Center for Mental Health Services’ (CMHS) MHHSC grant program is designed to support the provision of culturally competent HIV/AIDS-related mental health treatment and case management services to persons in minority communities.

• MHHSC serves to strengthen & expand the capacity of community-based entities to address the treatment needs of under-served individuals.

The MHHSC Program – Cohort I (2001-2005)

20 MHHSC grant sites:

• provided approximately 8,000 individuals with HIV-related mental health services,

• engaged in collaboration with other HIV & behavioral health services providers in their locations, enhancing a network of care.

• received training on providing culturally-competent care

• formed or expanded Consumer Advisory Boards that played a meaningful role in project activities.
The MHHSC Program – Cohort II (2006-2010)

There are currently 16 MHHSC grant sites in Cohort II

- Allocated for Grant Awards: $8.4 Million annually (approximately $525 K per grantee per year)
- NOMs data from grant sites is being collected by CMHS’ new TRAC system, which went live in 2007.
- Data is expected to be available later in FY 2008.

The Mental Health Care Provider Education in HIV/AIDS Program (MHCPE) III

- CMHS’ annual allocation of $450,000 is in the form of 3 contracts for professional training on HIV & mental health:
  - American Psychological Association ($150,000 annually)
  - American Psychiatric Association ($150,000 annually)
  - National Association of Social Workers ($150,000 annually)
- This program has supported training for over 200,000 mental health care providers.
**mental health AIDS**

- *mental health AIDS* is a free, online, quarterly biopsychosocial research update designed to summarize, organize, and facilitate the practical application of the immense and ever-increasing body of peer-reviewed literature on HIV & mental health for front line clinicians.
- The format reflects a systems-oriented approach to the understanding of health and disease.
  - HIV mental health treatment planning considers not only the psychiatric & psychological aspects of infection, but the biological, social & spiritual aspects as well, so that treatment may be offered from a "biopsychosocial" perspective.
  - A "systemic" model of this type reinforces the use of the provider-client relationship in delivering health and mental health care.

---

**Minority Education Institution Initiative (MEI)**

The Center for Substance Abuse Prevention’s (CSAP) MEI Initiative focuses on several priority racial and ethnic groups and subpopulations, including African American/Black, Hispanic/Latino, & 19 Native American/American Indian students on minority campuses.

- The goals are to
  - Increase substance abuse prevention education, awareness and HIV/AIDS/Hepatitis health promotion services to reduce health disparities for racial and ethnic minority college communities.
  - Increase HIV testing activities on campuses.
  - Improve internal and external collaboration with partners to maximize the impact of MAI funding to minority education institutions.
Minority Education Institution Initiative (MEI)

- Minority Education Initiative Program Coordinating Center (MEI-PCC) administers a total of 18 subcontracts:
  - 11 Historically Black Colleges and Universities (HBCUs)
  - 4 Hispanic Serving Institutions (HSIs),
  - 3 Tribal Colleges and Universities (TCUs).
- Activities provided by MEI institutions in FY 2006 & FY 2007 included:
  - 474 Peer Educator Training sessions conducted
  - 866 HIV Awareness Educational Workshops held on campus and at satellite locations
  - 7,685 HIV Rapid Testing & Standard Testing were conducted

Of the 25,000 students engaged in FY 2006 & FY 2007 MEI activities:
- 77% were between the ages of 18 and 21 years of age
- 75% were African-American
- 61% were female
- 9% were Hispanic/Latino
- 6% were Native American
FY 2008
Treatment for Homeless

Award Information:
• **Application Deadline: May 29**
• Funding Mechanism: Grant
• Anticipated Total Available Funding: Up to $10 million
• Anticipated Number of Awards:
  – Treatment for Homeless-General - Up to 13
  – Treatment for Homeless-Services in Supportive Housing - Up to 12
• Anticipated Award Amount: Up to $400,000
• Length of Project Period: Up to 5 years
• For more information & application: [http://www.grants.gov/](http://www.grants.gov/)

**Program Purpose:** Expand and strengthen treatment services for persons who are homeless (including those who are chronically homeless), who also have substance use disorders, mental disorders, or co-occurring substance use and mental disorders. The statutory authority for this program prohibits grants to for-profit agencies and to States. Also, grantees from the FY 2004, 2005 and 2006 cohorts for the Treatment for Homeless program are not eligible to apply for this program.

FY 2008
Targeted Capacity Expansion Grants – TCE

Award Information:
• **Application Deadline: April 18**
• Funding Mechanism: Grant
• Anticipated Total Available Funding: Up to $7.0 Million
• Anticipated Number of Awards: Cat. 1: Up to 14 grants, Cat 2: Up to 8 grants
• Anticipated Award Amount: Cat 1: Up to $250,000, Cat 2: Up to $400,000
• Length of Project Period: Up to 3 years
• For more information & application: [http://www.grants.gov/](http://www.grants.gov/)

Category 1: American Indian/Alaska Native & Asian America/Pacific Islander Populations:
Focused on the treatment needs of smaller native communities by expanding and/or enhancing treatment services

Category 2: Local Recovery-Oriented Systems of Care:
Focused on providing support to local organizations that can link services critical to the target population and demonstrate the principles of Recover-Oriented Systems of Care (ROSC).
Recovery Month – September 2008

Goals:

• Support the administration’s goal of reducing demand and promoting the message that recovery is possible
• Generate momentum for hosting state and local community-based events
  – Enhance knowledge. Improve understanding. Promote support for addiction treatment
• Publicize messages that:
  – Reduce the stigma & discrimination associated with addiction
  – Encourage those in need to get treatment
  – Support those who are already in recovery

Get involved in Recovery Month

Help bring hope and healing to others

• Visit the Recovery Month Web site at www.recoverymonth.gov
• Use the tools to spread the Recovery Month message:
  – Toolkits, presentations, giveaways, public service announcements, and more
• Join thousands of individuals and organizations by hosting a Recovery Month event in your community
• Educate others about the effectiveness of treatment and the hope of recovery
• For more information call 1-800-662-Help
SAMHSA Information

• SAMHSA web site: www.samhsa.gov
• Treatment locator web site: www.samhsa.gov/treatment
• Access to Recovery web site: http://atr.samhsa.gov
• For information regarding grants & application: http://www.grants.gov/
• Mental Health AIDS newsletter: http://mentalhealthaids.samhsa.gov/index.asp
• Mental Health Care Provider Education: http://mentalhealth.samhsa.gov/publications/allpubs/NMH02-0141/default.asp
• SHIN 1-800-729-6686 for publication ordering or information on funding opportunities
  – 1-800-487-4889 – TDD line
• 1-800-662-HELP – SAMHSA’s National Helpline (average # of tx calls per mo.- 24,000)