December 22, 2009

Senator Charles E. Grassley
Ranking Member
Committee on Finance
United States Senate
Washington, D.C. 20510 Sent by Electronic Transmission

Dear Senator Grassley:

This is in response to your letter of December 7, 2009, requesting information regarding our funding sources and disclosure policies. Mental Health America ("MHA") strongly believes in the principles of transparency and accountability, which are core values guiding our work. Although our goals often overlap with those of our funders, we take pride in acting independently of our funders in programmatic, legislative and litigation activities.

As you requested, I have included with this letter a chart (ATTACHMENT 1) detailing annual amounts of funding from industry sources from 2006 through the present. We have also described the purposes for the grants in a statement of our program and project activities (ATTACHMENT 2).

I have provided below answers to your specific questions regarding policies and disclosure requirements.

1) Please describe the policies for accepting industry funding and whether or not MHA allows companies to place restrictions or provide guidance on how funding will be spent.

The process through which MHA seeks corporate funding involves staff development of proposed activities that are consistent with the mission of the organization. These are subsequently presented to potential sponsors who select those projects that are most attractive to them.

MHA strictly prohibits companies from placing restrictions or providing guidance on how funding will be spent. When we receive funding, it must be unrestricted as stated on page 7 (section i) of our Corporate Support & Sponsorship Guidelines (ATTACHMENT 3). We have sole decision-making authority over what programs and initiatives are created and supported and exercise control, direction and independent judgment over editorial content and decisions. Our Corporate Support & Sponsorship Guidelines (page 4) specifically state that MHA decides what event, program or initiative may be funded and exercises control over all content.

MHA creates and develops programs that carry out our mission to promote mental health, prevent mental illnesses, and ensure adequate care and treatment of persons with mental illness. Funding is sought for and dedicated to a specific program or initiative (page 6, section g of ATTACHMENT 3), but MHA has sole control over the direction of the project and exercises independent judgment with respect to content, decisions and design as set forth in our Corporate Support & Sponsorship Guidelines. MHA imposes accounting restrictions on the expenditure of funds in order to ensure that funds donated for specific projects are expended on those projects.

Our fundraising is guided by the Better Business Bureau Wise Giving Alliance. Relationships must be consistent with IRS Regulations as well as with the Council of Better Business Bureaus Standards for Charitable Solicitations, the Attorney General's Guidelines for Cause Marketing and the National Health Council's disclosure guidelines.

In September, 2006, the MHA board adopted a report from the Task Force on Sources of NMHA Funding that established a goal of balancing MHA funding among its various sources with no more than 33% of funding being received from any given funding source (See ATTACHMENT 4). As can be seen from ATTACHMENT 1, funding from the pharmaceutical industry has decreased each year from 2006. In 2010 we project funding from the pharmaceutical industry to be approximately 33% of MHA's revenue.

2) If MHA allows companies to place restrictions on industry funding, then please explain all restrictions and/or guidance for each transfer of value from industry. For every transfer of value with a restriction, please provide the following information: year of transfer, name of company, and restriction placed on funding.

MHA prohibits restrictions on funding. As stated in answer to Question 1, funding is dedicated to a specific program or initiative that we have created or developed to carry out our mission, but we retain and maintain control over content, decisions and design of all projects, no matter what the source of the funding.

3) Please explain what policies, if any that MHA plans to adopt to ensure transparency of funding in order to provide a greater public trust in the independence of your organization.

Transparency is a fundamental policy, value and principle of Mental Health America. As stated in our Corporate Support & Sponsorship Guidelines, we adhere to the Better Business Bureau's Wise Giving Alliance Standards and the National Health Council's guidelines regarding complete disclosure of sponsorship relationships, fundraising, spending and expenses, reporting and budgeting.

We disclose sources of funding in our annual report, which is posted on our website (ATTACHMENTS 5, 6, and 7). Mental Health America's Board of Directors and its Resources Development Committee continually review and evaluate disclosure and transparency policies and best practices to ensure that we maintain the highest standards and uphold the public trust.

4) Please explain your policies on disclosure of outside income by your top executives and board members.

Article IV, Section 8 of MHAs Bylaws (ATTACHMENT 8) set forth our policies on disclosure of outside income. As stated in subsection g, "every year, members of the Board of Directors shall submit to the Chair of the Board a letter disclosing any direct or indirect benefits received as a result of the Association's agreements with any outside party and any financial interest..." A copy of the Conflict of Interest Disclosure Form is enclosed with this letter (ATTACHMENT 9). Additionally, Conflict of Interest guidelines are incorporated into the vetting process that is employed by the board nominating committee and included in new board member orientation activities.

Section 3.2 of MHA's Employee Handbook requires new employees to disclose any outside employment, consulting contracts, board memberships, or other activities to identify potential conflicts with our work. Each calendar year, employees are required to disclose in writing whether they are on the board of directors of any organization. In addition, the President/CEO is required to disclose all direct and indirect benefits received during

the previous year as a result of MHA's agreement with any outside party. This disclosure includes a listing of all gifts, payments and other forms of compensation received from individuals, organizations, businesses and agencies with which MHA does business.

5) Please provide the disclosures of outside income filed with your organizations by your top executives and board members.

Specific disclosure statements were provided to MHA with the presumption of confidentiality. Accordingly, they are not available for release.

Sincerely,

David L. Shern, Ph.D.
President and CEO
Mental Health America

MENTAL HEALTH AMERICA
INDUSTRY FUNDING JANUARY 2006 - PRESENT

* Descriptions for each restriction is attached

	Program/Project for which Funding was Received	2006	2007	2008	2009
Abbott Laboratories	Employee Giving		90	142	
	Subtotal	**-**	**90**	**142**	**-**
AstraZeneca	Dialogue for Recovery	150,000		125,000	75,000
	Campaign for America's Mental Health			75,000	
	Public Education Department	100,000	165,000		
	Annual Conference	35,000	35,000	85,000	10,000
	Healthcare Reform Department		160,000		
	Policymaker Education Initiative		25,000	75,000	
	Evidence Based Healthcare	50,000		50,000	
	Fall Policy Conference		20,000	25,000	25,000
	Caucus Project			50,000	
	Coalition for Constructive Coverage				30,000
	Worth More Than Weight	52,125			
	Council on Science and Research		25,000	25,000	25,000
	Resource Center			25,000	
	Branding Project	10,000			
	Subtotal	**397,125**	**430,000**	**535,000**	**165,000**
Bristol-Myers Squibb	Campaign for America's Mental Health	275,000	500,000	375,000	420,000
	Dialogue for Recovery	227,500	22,500		
	Annual Conference	35,000	40,000	60,000	10,000
	Centennial Gala				15,000
	Public Policy & Advocacy Department				80,000
	Healthcare Reform Department	275,000	687,500	237,500	
	Council on Science and Research		35,000	35,000	
	Evidence Based Healthcare	250,000			
	Subtotal	**1,062,500**	**1,285,000**	**707,500**	**525,000**
BMS Foundation	Eliminating Behavioral Health Disparties				375,000
	Subtotal	**-**	**-**	**-**	**375,000**
Cephalon, Inc.	Resource Center	20,000			
	Subtotal	**20,000**	**-**	**-**	**-**
Cyberonics	Annual Conference	20,000	2,500		
	Public Education Institute	10,000			
	Dialogue for Recovery	75,000			
	Resource Center	40,000			
	Subtotal	**145,000**	**2,500**	**-**	**-**
Eli Lilly and Co.	Annual Conference	50,000	25,000	35,000	25,000
	Centennial Gala				25,000
	Campaign for America's Mental Health	275,000			
	Healthcare Reform Department	550,000		12,356	195,000
	Medicaid Reform Document		-	33,333	
	Council for Science and Research		25,000	50,000	
	Evidence Based Healthcare	250,000		500,000	
	Public Education Department		300,000	587,644	195,000
	Lilly USA United Way Award				5,000
	Attitudinal Survey	100,000			
	Coalition for Constructive Coverage	75,000	75,000	30,000	25,000
	Subtotal	**1,300,000**	**425,000**	**1,248,333**	**470,000**
Eli Lilly and Co. Fdtn.	Employee Matching Program	8,635	125		800
	Subtotal	**8,635**	**125**	**-**	**800**
Forest Labs	Annual Conference	5,000	5,000	10,000	5,000
	Centennial Gala				5,000
	Healthcare Reform Department	50,000	125,000	50,000	
	Fall Policy Conference			25,000	
	Campaign for America's Mental Health	50,000	165,000		
	Resource Center	25,000			

MENTAL HEALTH AMERICA
INDUSTRY FUNDING JANUARY 2006 - PRESENT

* Descriptions for each restriction is attached

	Program/Project for which Funding was Received	2006	2007	2008	2009
	Employee Matching Program			3,500	500
	Health Writers Symposium - Co-Occurring Disorders	125,000			
	Subtotal	**255,000**	**295,000**	**88,500**	**10,500**
GlaxoSmithKline	Campaign for America's Mental Health	50,000			
	Healthcare Reform Department	50,000			
	Annual Conference	20,000			
	Council on Science and Research	10,000			
	Unrestricted Grant for General Operating	50,000	50,000		
	Branding Project	10,000	15,000		
	Evidence Based Healthcare			77,506	
	Subtotal	**190,000**	**65,000**	**77,506**	**-**
Janssen	Dialogue for Recovery	50,000			25,000
	Annual Conference	20,000	10,000	10,000	10,000
	Centennial Gala			25,000	40,000
	Healthcare Reform Department	200,000	650,000		
	Public Policy & Advocacy Department				150,000
	Campaign for America's Mental Health		150,000		
	Council on Science and Research		25,000	25,000	
	Resource Center		50,000		25,000
	Media Outreach		100,000		
	Coalition for Constructive Coverage				25,000
	Evidence Based Healthcare	150,000			150,000
	Subtotal	**420,000**	**985,000**	**60,000**	**425,000**
McNeil	"Writing A Chapter" Promotion		1,500		
	Subtotal	**-**	**1,500**	**-**	**-**
Neuronetics	Fall Policy Conference	10,000			
	Subtotal	**10,000**	**-**	**-**	**-**
Novartis	Campaign for America's Mental Health	25,000			
	Cause Related Marketing			100,000	
	Evidence Based Healthcare		30,000		
	Subtotal	**25,000**	**30,000**	**100,000**	**-**
Noven	Community Outreach Events			22,500	
	Subtotal	**-**	**-**	**22,500**	**-**
Otsuka	Public Education Institute	10,000	10,000	10,000	
	Subtotal	**10,000**	**10,000**	**10,000**	**-**
Pfizer	Fall Policy Conference			50,000	
	Campaign for America's Mental Health	200,000			
	Dialogue for Recovery	200,000			
	Healthcare Reform Department	222,000	447,000	80,000	
	Evidence Based Healthcare	150,000		145,000	
	NCSL Sponsorship	30,000			
	Public Education Department		250,000	25,000	100,000
	Centennial Gala			50,000	
	Council on Science and Research			25,000	
	Coalition for Constructive Coverage				75,000
	Florida Affiliates Policy Meeting	15,000			
	Subtotal	**817,000**	**697,000**	**375,000**	**175,000**
The Pfizer Fdtn	General Donation	750	1,500		
	Subtotal	**750**	**1,500**	**-**	**-**
PhRMA	Annual Conference			10,000	
	Branding Project	15,000			
	Evidence Based Healthcare	150,000			
	Healthcare Reform Department	11,626	5,000		
	Evidence Based Healthcare Membership	9,000	2,500		
	Subtotal	**185,626**	**7,500**	**10,000**	**-**

MENTAL HEALTH AMERICA
INDUSTRY FUNDING JANUARY 2006 - PRESENT

* Descriptions for each restriction is attached

	Program/Project for which Funding was Received	2006	2007	2008	2009
Schering-Plough	Centennial Gala				15,000
	Matching Gifts			300	
	Subtotal	-	-	**300**	**15,000**
Shire	Workplace Wellness		10,000		
	Subtotal	-	**10,000**	-	-
Solvay/Wyeth Alliance	Annual Conference		10,000		
(HealthSTAR)	President's Council	50,000			
	Subtotal	**50,000**	**10,000**	-	-
Vanda	Unrestricted Grant for General Operating			10,306	
		-	-	**10,306**	-
Wyeth	Campaign for America's Mental Health	100,000			
	Annual Conference	10,000	10,000	15,000	
	Centennial Gala				25,000
	Public Education Department		340,000		
	Healthcare Reform Department	25,000	100,000		
	Fall Policy Conference		25,000	25,000	
	States of Depression Survey		173,135	75,000	
	Council on Science and Research		35,000	35,000	
	Evidence Based Healthcare	150,000			
	Disaster Relief	-	50,000		
	Operations Healthy Reunions	200,000			
	Public Education Institute				5,000
	Schizophrenia Survey		220,000	15,000	
	Coalition Coverage of Mental Health		37,500		
	fundamental health!		435,841		220,000
	Healthwriter's Symposium	50,000			
	Depression Is Real PSA Campaign	100,000		7,500	123,000
	Subtotal	**635,000**	**1,426,476**	**172,500**	**373,000**
	Total	**$ 5,531,636**	**$ 5,681,691**	**$ 3,417,587**	**$ 2,534,300**

Mental Health America

100 years

MENTAL HEALTH AMERICA
Industry Funding Program/Project Descriptions

AFFILIATE SERVICES

Annual Conference: Mental Health America convenes advocates, consumers, educators, researchers, business and community leaders, and health professionals from across the country and our nationwide network of 300 affiliates to explore and examine the new ideas, health care trends, programs and research which are key to advancing the nation's public health agenda and achieving wellness in individuals and communities.

***Eliminating Behavioral Health Disparities*:** Mental Health America and four of its affiliates are deep into the implementation stages of a project aimed at increasing access to culturally competent mental health services for tribal and rural communities. The project focuses primarily on the Four Corners region of New Mexico, which is home to the Navajo and Ute Nations, and spans the borders of Colorado, Utah, New Mexico and Arizona. A dire need for improved services exists within this community as American Indians have dramatically higher rates of suicide, alcohol abuse, violent victimization and PTSD compared to the general U.S. population.

ADVOCACY AND PUBLIC POLICY

***Health Care Reform Department/Public Policy & Advocacy Department*:** MHA staff have developed materials and promoted our messages in meetings with White House, Senate and House of Representatives leaders and staff related to our health reform priorities: (1) Ensuring full and equitable coverage of behavioral health services; (2) Increasing integration of behavioral health and medical care; (3) Prioritizing prevention of mental health and substance use conditions; and (4) Ensuring consumer perspectives are represented in research priority-setting, development, and dissemination. In addition, MHA provided technical assistance to affiliates on a variety of federal and state policy issues, including Medicaid and parity.

Evidence-Based Health: MHA continues to convene and coordinate the National Working Group on Evidence-Based Health (EBH), and we planned and presented our first regional forum (in Boston) to educate a wide-array of state and local advocacy leaders about evidence-based health care and its influence on the overall access and delivery of health care. We continued revising our EBH toolkit so that it is more accessible and usable by various audiences, including lawmakers, advocates, and consumers/patients. We also provided public comments to the Agency for Healthcare Research and Quality National Advisory Council, emphasizing the need to deepen consumer/patient involvement in comparative effective research.

State Legislature Mental Health Caucuses: We are winding up our Legislative Caucus initiative, which currently has six MHA affiliates participating, representing Delaware, Iowa,

Louisiana, Montana, New Mexico, and Ohio. We are writing an issue paper regarding the role of mental health caucuses in promoting state legislative changes and improvements in serving individuals with mental health conditions.

Fall Policy Conference: The Fall Policy Conference convenes our affiliate's policy liasions to focus on specific tools for ensuring mental health is included in healthcare reform efforts, identify financing mechanisms to support integration, and working with consumers, policymakers and other key stakeholders to implement model systems of integration.

Council on Science and Research: Since 2006, MHA's Council on Science and Research has provided a forum for bringing together representatives from different segments of the health care world including leaders in the pharmaceutical industry, key government officials, legislators and their staff, and patient/consumer organizations to have a dialogue on policy implications of certain scientific endeavors.

PUBLIC EDUCATION

Public Education Department: The Public Education Department is the umbrella in which Mental Health America educates the general public about the realities of mental health and mental illness.

Campaign for America's Mental Health: The Campaign is Mental Health America's comprehensive effort to improve Americans' awareness, attitudes and behaviors regarding mental health and mental illness. Mental Health America works closely with 41 Campaign sites to organize and conduct educational, screening and media activities. Sponsorships support these ongoing activities by enabling Mental Health America to provide local outreach grants, free publications and ongoing technical assistance.

Public Education Institute: In the first quarter of each year, Mental Health America hosts the Public Education Institute, a public education training conference for affiliates designed to strengthen efforts around mental health promotion and prevention.

Dialogue for Recovery: MHA is dedicated to promoting the wellness and recovery of all people with mental illness. Dialogue for Recovery (DFR), a key program of MHA, is designed to improve the well-being and quality of life of consumers with serious mental illness (SMI) by addressing factors that promote recovery, including having knowledge about how to navigate the various paths to recovery, including understanding their illness, treatment options, self care and support services; demand better care that's holistic and recovery-oriented; and be a full participant in their care.

fundaMENTAL Health: Mental Health America has undertaken a significant initiative aimed at addressing the impact of mental health conditions on the U.S. workforce. The centerpiece of this initiative is a dynamic, multi-media slide presentation that examines the prevalence and disability of mental health conditions and demonstrates that an investment in behavioral health services and mental health promotion is critical to employee health and productivity, as well as cost containment.

OTHER

Resource Center: Mental Health America's Resource Center is central to the public education and service mission of Mental Health America. The Resource Center touches the lives of hundreds of thousands of people each year by providing accurate, timely and free mental health information and referral assistance. Operated by experienced, professionally trained staff, the Resource Center responds to requests from the public in English and Spanish through Mental Health America's toll-free line, e-mail and online resources.

Centennial Gala: Inspirational Gala to celebrate Mental Health America's 100th Anniversary.

Coalition for Constructive Coverage: Mental Health America organized the Coalition in 2006, convening nine national mental health advocacy and medical organizations to work together to ensure constructive and balanced media coverage and depiction of mental health conditions and issues. The Coalition for Constructive Coverage is the *only* mental health coalition comprised of communication professionals and association leadership. It serves to amplify the mental health community's response to inaccurate or insensitive media coverage of mental health issues.

Depression Is Real: The Depression Is Real Coalition is a group of physician, patient and constituency groups that conducts public education campaigns on depression to help people living with depression, their families, friends and the general public understands this condition. Mental Health America coordinated outreach on a survey assessing the impact of the economic downturn on the mental health of Americans and provided the public with information on how to maintain a balanced lifestyle, manage stress and recognize depression and its symptoms.

Mental Health America
Corporate Support & Sponsorship Guidelines
Adopted: September 2006
Amended: March 2008

A. Purpose

Mental Health America (MHA) seeks financial and in-kind support from organizations and individuals that share our commitment to mental health for all American consumers and their families, support groups, health care providers, the business and government sector, and among our sponsors.

MHA values the support of individuals, government, corporations, and foundations and recognizes the vital role that its contributors provide. Corporate donors particularly have the unique ability to reach a wide audience, encourage other contributors, and enhance involvement of others in the markets in which they operate. The relationship with the business sector must be entered with due diligence and guidelines that are universally applied so as to ensure the reputation and mission of MHA is maintained.

This document formalizes and details a set of guidelines applicable to corporate contributions, third party sponsorships and other partnerships in support of MHA. The goal of these contributions partnerships is to expand the reach of MHA and its affiliate network's programs, products and services consistent with the organization's strategic goals and mission.

B. MHA Philosophy

Mental Health America is the leading national organization in the field of mental health and wellness in this country, reaching millions of people seeking to understand mental health and substance use conditions, prevention, treatment and recovery so as to lead a productive life. MHA is a not for profit 501(c)(3) organization dedicated to promoting mental health, preventing mental disorders and achieving victory over mental illness through advocacy, education, research and services. As a not for profit organization, the MHA relies on the financial support of third parties, including individuals contributions, government grants, private foundation grants, pharmaceutical and other corporate sector contributions, for many of its policy, transformation, educational and awareness programs, campaigns and special initiatives. This support is traditionally given in the form of focused grants to support a particular comprehensive program such as Healthcare Reform, initiatives including emergency response programs, or projects such as the Annual Conference.

MHA strives to remain neutral, fair, balanced and unbiased in all of its programs, services and initiatives. These guidelines support MHA Operating Policy 0-18, and reinforce the Statement of Principles contained within. These guidelines may be amended from time to time by the Resource Development Committee of the Board to meet generally accepted standards as required.

C. Definition of Sponsor and Sponsorship

For purposes of this document, the term "sponsor" means any third-party, including and consumer/retail companies, manufacturers, corporations, corporate and private foundations, pharmaceutical, non-pharmaceutical, and their respective agents which includes PR firms and/or marketing firms hired by or paid by the original third party, whether directly or indirectly.

"Sponsorship" means partnering with a sponsor, or lending or using a sponsor's name, on an MHA program, service or initiative.

Other considerations include:

Corporate Sponsorship — When a company pays an unrestricted rights fee for the opportunity to promote a marketing affiliation with MHA or specific national event(s), program(s) or initiative(s). The following are subsets of sponsorship:

- Fundraising Promotions: an example is a company promoting a cause marketing or donation offer, or hosting its own public fundraising event or promotion that benefits MHA or specific national or local MHA event(s), program(s) or initiative(s). Fundraising offers can include a company promoting the sale of a themed merchandise item or paper icon that benefits MHA or tying the sale of the company's product or service to a themed donation offer, "Buy my product (or use my service) and I'll make a contribution to XYZ."

- Awareness Promotions: When a company promotes MHA or specific national or local MHA event(s), program(s) or initiative(s) through guaranteed media and a themed promotional campaign. Companies who do this are referred to as Promotional Sponsors.

Corporate Giving — When a company makes a grant and/or initiates an employee contributions campaign to benefit MHA in exchange for enhanced employee or community goodwill. There is *no* expectation of a commercial return on behalf of the company.

Strategic Philanthropy — When a company commits philanthropic and marketing resources to benefit MHA or specific national or local MHA event(s), program(s) or initiative(s) in exchange for philanthropic and marketing benefits.

Educational Grant — When a company makes a grant to fund a specific project such as a professional educational program or a patient educational program.

National Team — When a company agrees to promote to its staff participation in an MHA national fundraising event. There is *no* expectation of a commercial return on behalf of the company; rather the company's primary motivation is to boost staff morale. (Note: When a company wants to encourage team participation to the general public, requiring external promotional rights, the relationship becomes a fundraising sponsor).

Exhibits — When a company purchases booth space at an MHA event, such as the annual conference or MHA regional events, for the purpose of generating visibility and/or sampling/display to a targeted audience.

Advertising — When a company purchases ad space in an MHA or specific national program or initiative publication, such as *The Bell* or online publications, for an established rate-card rate.

Licensing — When a company licenses the MHA logo and terminology on products for retail sale. The company agrees to pay a royalty on sales.

Web Portal Sponsorship — When a company pays an unrestricted rights fee for the opportunity to promote the company name (pharmaceutical) and/or product name (non-pharmaceutical) on an approved MHA portal site.

Affinity Sponsor — When a company creates a co-branded product with MHA that is marketed to the organization's supporters. The company agrees to pay a percentage of each transaction as a royalty to the MHA.

Corporate Recognition Program — Companies that support the Association through two or more different kinds of commitments (outlined above) may be recognized by the Association through its Corporate Recognition program.

Outlined below are guidelines for all corporate relationships with an emphasis on alliances that may receive any degree of marketing benefit from the Association.

Corporate Alliances Must Be In Keeping With MHA's Mission And Preserve Constituent Trust

Accepting money from corporations is guided by the Better Business Bureau Wise Giving Alliance. In addition, the Association should refrain from associating with companies that have the potential to damage MHA's image because of the nature of the companies' products, services or reputation. For example:

- The company's products or services must be compatible with and complement Mental Health America's mission and values.
- The company must have a high degree of integrity, a strong corporate reputation and a track record of maintaining a high level of product or service quality.
- The company must demonstrate ethical business practices and a positive image.
- MHA must not directly endorse a corporate sponsor's products or services. Since MHA is not in the business of product testing, no relationship may directly endorse a company's product or service.
- The relationship must be consistent with IRS Regulations as well as with the Council of Better Business Bureaus (CBBB) Standards for Charitable Solicitations, the Attorney General's Guidelines for Cause Marketing and the National Health Council.
- MHA will not enter into sponsorship agreements with tobacco companies, gun manufacturers, alcoholic beverage companies, taser manufacturers and with any other company or product deemed inappropriate by the Resource Development Committee as a sponsor partner or their foundations. MHA may, however, enter into a sponsorship with a subsidiary of such company and/or parent company.

Corporate Alliances Must Substantially Benefit The Association: MHA National, Local Market(S), Event(S), Program(S) And/Or Initiative(S)

All relationships must directly support Mental Health America. MHA will establish a maximum percentage of fees that would go to administrative costs based on accepted philanthropic industry standards. If the Association approves cause marketing/fundraising promotions, all monies raised should go to the Association and/or its national or local event(s), program(s) and/or initiative(s), and an additional administrative fee should be applied to cover any out-of-pocket costs to the Association. In addition, the Association should seek relationships with room for growth, either from a community to a regional/national relationship, or from a national to a regional/area/community relationship.

Corporate Alliances Must Answer To The Association's Priorities

All corporate-supported event(s), program(s) and/or initiative(s), even those co-created with a company, must conform to the Association's priorities.

The Association Must Have Final Approval On All Content And/Or Programming

The Association will decide on which event(s), program(s) and/or initiative(s) a corporation may tie into and/or create and will have final approval over all content.

D. General Requirements

1. MHA prohibits any agreement or action that endorses a specific commercial product, process, service or enterprise.
2. Sponsorships must advance MHA's and/or its networks strategic goals, workplan and mission.
3. Use of the MHA name, logo or other identifying marks by a sponsor will be permitted only with the express prior written consent of the appropriate MHA board, committee or senior level staff executive as appointed by the governing body and subject to these Guidelines.
4. MHA allows exclusive sponsorships only in time-bound, limited activities such as category exclusivity within special events programs and within certain sponsorship programs, subject to prior approval.
5. MHA will maintain strict editorial control over every use of its name and logo in all sponsorships. All statements, illustrations, advertising, promotional or other materials using or referencing the MHA, its logo, marks or message for use in conjunction with a sponsorship program are subject to the advance review and approval of MHA prior to release or use and may not be modified once approved.
6. MHA adheres to the Better Business Bureau's Wise Giving Alliance Standards and the National Health Care Council's guidelines regarding complete disclosure of sponsorship relationships, fund raising, spending and expenses, reporting and budgeting.

E. Specific Requirements

1. Sponsorships may not contain an express endorsement by MHA recommending

purchase of a product or service or suggesting superiority of a specific product or service.

2. MHA programs and initiatives may carry a statement or other appropriate acknowledgment or credit line based on the support or underwriting provided by the sponsor.

3. MHA programs and initiatives may include a sponsor name with or without its corporate logo as part of the sponsor acknowledgment statement. The MHA does not permit the use of branded product names on pharmaceutical sponsorship materials. Branded product names may be permitted on non-pharmaceutical product promotions which will be reviewed on a case by case basis.

4. Rights previously granted to a sponsor that are inconsistent with these Guidelines will be honored and permitted only for the period of time for which they were originally granted.

5. Fund raising cannot be the sole or primary purpose of a sponsorship, except for sponsors of unrestricted fund raising activities.

The Association reserves the right to determine what corporate alliance(s) it will pursue.

The Association will take control of its commercial destiny by determining what is and what is not for sale in advance of creating any alliances. This might preclude offering sponsors select Association benefits, such as sponsorship of Association governance functions.

The Association Must Not Offer Corporate Sponsors Organization-Wide Category Exclusivity

To protect the Association's overall revenue sources, category exclusivity, if given at all, will be limited to a select proprietary platform, event, program, initiative or company's promotional or fundraising campaign. Exclusivity could be limited further by a market or time frame.

The Association Must Approve All Corporate Alliances

The President and CEO of MHA has the authority to sign contracts after they are reviewed by legal counsel.

The Association Must Document All Sponsorships That Include Marketing Benefits In An Agreement

The Association should generate corporate alliance agreements and create a master document with detailed and consistent language that protects the Association's best interests and prevents discrepancies among corporate sponsors. Signed agreements will help manage expectations by specifying all rights, benefits, terms and conditions of each corporate alliance. Legal counsel will review all contracts for signature by the President and CEO. Areas to address in the agreement include:

a. Property Definition
Define the Property with which the corporate sponsor is affiliating, whether it is a specific event, program or initiative; a promotional or fundraising campaign; or a company's fundraising event.

b. Level of Acknowledgment
The Association will specify the level of recognition a corporate sponsor receives, ensuring that recognition of the corporate sponsor is proportionate to fees paid. Higher paying sponsors will receive more recognition (e.g., Web site identification/link, recognition in MHA materials as per National Recognition Strategy (drafted for review)), as well as benefits not available to lower-paying corporate sponsors (e.g., invitations to special functions or identification in Sponsor recognition ads).

c. The Association's Role
The Association will commit its resources to maximize the success of the specific event, program or initiative for both the Association and its corporate sponsors. However, under no circumstances will the Association be obligated to exert any influence to advance a corporate sponsor's other corporate interests as part of the sponsorship, either written or implied.

d. Mark/Logo Use
The Association must retain total control of its marks/logos and corporate sponsor use of those marks/logos. Specify which marks, logos and designations, such as "Official Sponsor" or "Presenting Sponsor," sponsors can use in their packaging, advertising and/or promotions around their sponsored components.

e. Promotional Parameters
The Association must specify the geographic territory (nationwide or within a specific market); scope (internal to employees only or external to general public or both); and time frame (i.e., year-round or three months) for which the sponsor can promote its association.

f. Ownership/Control
The Association must retain ownership and total control of all MHA-themed promotions and materials. The policies, properties and integrity of the Association must remain entirely unaffected by any sponsorship. All materials produced by the Association for a corporate sponsorship program are under the sole ownership of the Association. Any use of these materials by the corporate sponsor outside of the expressed terms of the sponsorship agreement requires written permission from the Association.

g. Resource Commitments
The Association's sponsors' financial commitments should be unrestricted, with the exception of pre-approved, budget-relieving, in-kind products or services (e.g., airline tickets) or added-value products or services (e.g., media commitment). One exception may be educational grants from pharmaceutical companies that support specific initiatives. Payments must be detailed to ensure full value is delivered. Commitments come in the following forms:

- All companies that receive approved marketing benefits must compensate the Association and/or the market for the marketing rights in the form of a rights fee (cash or budget-relieving in-kind) or a minimum cash or promotional guarantee. This applies to Industry Premier Sponsors, Industry Supporters, Strategic Sponsors, National Event/Program Sponsors and fundraising/Promotional Sponsors.

- Companies that conduct pre-approved fundraising promotions should be required to pay the Association funds raised over and above the rights fee/minimum guarantee. In some cases, with MHA's approval, a company may cap its cause marketing fundraising commitment at or above the minimum guarantee.

- Companies that conduct pre-approved fundraising events should be required to pay the Association a minimum of 75 percent of the proceeds raised.

- For those promotional, cause marketing/fundraising sponsorships that require the Association to incur out-of-pocket expenses, the Association should charge an administrative fee to cover those direct expenses.

The Association must determine in advance the method for valuing in-kind products or services (e.g., in-kind airline tickets should be valued at the rate the Association would customarily pay for these tickets). The Association must be allowed to use in-kind products or services for its own purposes or corporate sponsor promotions. For example, the Association would stipulate to its airline sponsor that the in-kind commitment of airline tickets could be used for the Association's administrative purposes, as well as for MHA's or its corporate sponsors' promotional purposes. In addition, include a payment schedule with the bulk of the fee up front, for example, 65 percent on signing; 25 percent four months later; 10 percent at end of year. Accepting revenue for qualified sponsorships from corporations is guided this policy statement, and generally accepted standards of the Better Business Bureau.

h. Expenses
Each corporate sponsor must pay all expenses for implementing its own promotions (e.g., product/literature distribution, direct mail, etc.). The Association will pay to deliver benefits outlined in its sponsorship proposal/agreement to the sponsor (e.g., advertising, signage and hospitality).

i. Use of Funds
Sponsorship fees and monies raised are unrestricted and are to be used at the Association's discretion, not the corporate sponsors'.

j. Category Exclusivity
Specify that there is either no category exclusivity *or* define the extent. If category exclusivity is permitted, narrowly define the corporate sponsor's industry category (e.g., credit card rather than financial services, low-sugar cookie rather than food).

k. Logo Approval Process
The Association and its sponsors have the right to use each other's marks and logos with pre-approval procedures in place. With the Association's approval and within its guidelines, a corporate sponsor may be identified by either its corporate name or brand in the corporate sponsor's promotional literature and use its corresponding corporate or brand logo. Products of the sponsor, however, can not be included in promotional materials. Provide each corporate sponsor an attachment that depicts the designated MHA and/or specific national or local event, program or initiative marks/logo and guidelines for usage in packaging, advertising and promotions, including specifications and PMS colors allowed.

l. Promotional Approvals
The Association shall have complete editorial control over all sponsor-created marketing materials that bear the Association's name. In every case, all materials in print, broadcast or electronic media prepared by the corporate sponsor, including promotional pieces, ad copy and artwork, must be submitted to MHA or the market for pre-approval in writing prior to release. The method of approval will be specified in the agreement, including main MHA staff contact and time frame for approving all sponsor communication vehicles using MHA's identity.

m. Disclosure
The Association and its sponsors shall disclose the nature of their marketing relationship at/in all events/activities, materials and promotions when applicable. Proprietary or confidential information of the corporation is not disclosed. If any solicitation by the corporate sponsor in conjunction with the sale of the corporate sponsor's goods or services states or implies that a portion of the sales price will benefit the Association overall or specific national or local event(s), program(s) or initiative(s), such solicitation shall include:

- The MHA "Fundraising Sponsor" logo (which may be in conjunction with a specific event, program or initiative name, when applicable). If a fundraising promotion extends to the local level, the logo should include the market's geographic identifier as well.
- A statement that states that proceeds to MHA and/or participating markets will be used to support MHA activities and/or activities related to the stated platform, event, program or initiative.
- Duration of the promotion.
- Details on the amount or percentage of funds donated by the corporate sponsor (minimum guarantee) and if there is a donation cap.

n. Assignment/Third-Party Promotions
Corporate sponsors are not allowed to assign rights or conduct third-party promotions without the Association's approval.

o. Licensing/Merchandise Rights
Corporate sponsors must pay additional fees/royalties for the sale of MHA-branded items. These types of arrangements should be documented in a separate licensing agreement. This agreement should also suggest the corporate sponsor consider using the Association's merchandising vendor(s) to purchase any MHA-branded items.

p. Renewal Option
For marketing sponsors who receive category exclusivity, MHA will offer an exclusive negotiating period (e.g., minimum 30 days) with a deadline ending at least three to six months prior to the end of a one-year contract and 16 months prior on multi-year deals.

q. Fulfillment Obligations
The responsibilities and obligations of the Association, including personnel and materials, must be within the organization's capacity to fulfill.

r. Designated Liaisons
Agreements will specify the primary contacts for the Association and the corporate sponsor, as well as the process for approval, reporting and notification. For the corporate sponsor liaison, the highest-ranking official from the sponsoring company who will be the central contact for all sponsorship matters must be identified.

s. Termination
If a sponsor's reputation or integrity is called into question by the Association and/or the public, or through changes in business practices it becomes ineligible, then the Association has the right to terminate the sponsorship. If the business practices of the corporate sponsor in any way reflect negatively upon MHA, then the Association has the option to terminate the relationship. See sample Morality Clause below:

If a sponsoring company is charged with or accused of the commission of any act which is an offense involving moral turpitude under any Federal, State or local law, or any act which casts an unfavorable light upon the other party or such party's association with MHA, or the company performs or commits, or is accused of performing or committing any act which would unreasonably and objectively bring MHA or events, programs, products or services of MHA into disrepute, contempt, scandal or ridicule at any time before, during or after the term of this Agreement, MHA shall be entitled to terminate this Agreement upon ten (10) days written notice to the other specifying the reason, within which period the company may cure such offense, if curable. The determination of whether and to what extent the offense is cured or curable shall be made by MHA at its sole and absolute discretion.

t. Database Building
When relevant, require sponsors to provide the names, addresses and telephone numbers gained as a result of its sponsorship promotions.

u. Reporting
Sponsors must have sound and transparent income reporting and auditing processes in place to assure that the Association receives all benefits outlined in the agreement. Likewise, the Association commits to providing fulfillment reports to sponsors outlining sponsorship benefits promised and delivered.

F. Procedural Requirements

1. Initial screening: An evaluation of the sponsorship will be undertaken by MHA Resource Development staff taking into account MHA goals, priorities, budget and staffing requirements, timetables and deadlines, expected results, and benefits to MHA and its sponsor. The mental health messaging used in the sponsorship must meet MHA's requirements.
2. The budget should include PR/promotion expenditures and respective obligations of MHA and the sponsor, direct and indirect costs, and fees or commissions to ad agencies or promoters or for support services to be paid by the sponsor or MHA, and gross and net proceeds and their distribution and use.
3. Sufficient time must be planned and allowed for MHA review and approval of the sponsorship proposal.
4. Following approval by MHA, a written agreement must be developed with the sponsor specifying the respective obligations of the parties, incorporating the requirements of these Guidelines and identifying the specific time period of the sponsorship and the minimum guaranteed benefits. Program proposals often serve this purpose by detailing required restrictions.
5. The sponsorship must be limited to a specific period of time. The sponsor may not claim any continuing association with MHA after the conclusion of the sponsorship unless otherwise agreed, and no use may be made of the MHA name, logo, or other identifying marks in any advertising or promotion activities of the sponsor after completion of the sponsorship, unless as otherwise agreed.
6. A provision must be made for immediate termination of the sponsorship agreement if either party does not satisfactorily perform its obligations or if other related conditions warrant termination of the sponsorship.

7. MHA reserves the right to continue distribution of sponsorship materials such as patient brochures beyond the conclusion of the sponsorship.
8. MHA products and services advertised in MHA's official publications and the MHA web-site are specifically excluded from these Guidelines.

G. Recognition

Sponsors may be recognized on the Mental Health America website and may include the sponsor logo, link to the sponsor website, and a brief overview of the sponsor's chief business activity. Internet-based sponsorship recognition will generally be limited to a sponsor section of the website but may also include, in certain circumstances, recognition on the site's homepage and in other prominent areas.

The following guidelines will apply:

1. Sponsors may post Mental Health America's logo and a link to www.mentalhealthamerica.net on the sponsor website. The logo use must conform to our Branding Guidelines and any requirement set out in written agreement.
2. Mental Health America does NOT endorse companies, products or services and strictly prohibits the suggestion of endorsement, recommendation, or superiority of one company, product or service over another company, product or service.
3. A Sponsor's logo and link may not reside on Mental Health America program-related pages, with the exception of the Annual Conference, Mental Health Month, or general fundraising activities.
4. When Mental Health America's web site includes links to other sites, the Association does not assume any responsibility or liability for any communications or materials available at the sites to which it links, including responsibility or liability for their accuracy. No link on Mental Health America's website is a referral or endorsement of either the linked-to entity or any product or service.
5. Mental Health America will provide links from its site to others where there is mutual benefit, either formalized in an agreement or by an informal understanding.

TASK FORCE ON SOURCES OF NMHA FUNDING
Report to the Board of Directors
September 9, 2006

Members of the Task Force

Joel Hornberger, Chairperson
Joseph Rogers, Mark Heyrman, David Fassler, Richard Van Horn, Bill Compton, Pender McElroy, Cynthia Wainscott, DJ Ida and Rosa Gil

Staff

Oscar Morgan, Julie Nicholson, Susan Corrigan and Bonnie Smith

Background

The Task Force on Sources of NMHA Funding was created by Sergio Aguilar-Gaxiola M.D., PH.D., Chair of the Board to advise the Board on actions needed to establish guidelines and standards to: 1) avoid dominance or the appearance of dominance of any one funding source and 2) to allow growth for the association and not handicap our financial development of funding from one particular industry or source. The specific charge of the Task Force is as follows:

Review the NMHA Operating Policy O -18, entitled Partnership Values/ Principles, the current funding sources of NMHA and the strategies identified by staff to diversify the source funds. The Task force will recommend, as appropriate, policies to the Board of Directors regarding the derivation of funds supporting NMHA.

The Taskforce conducted a review of the National Health Council (NHC) and the Public Affairs Counsel of the Better Business Bureau (BBB), two national standards setting organizations, as well as non-profit organizations in the field of mental health and health to determine the appropriate positioning for NMHA as the organization seeks to achieve a balanced funding platform.

NMHA meets the standards of the NHC and the BBB as related to reporting of financial information. Both organizations noted that there are no specific guidelines set by non-profits in terms of the percentages for revenue from any one industry source with the exception of Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD).

According to Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD) officials, the establishment of a percentage limit of 30% from the pharmaceutical industry in particular coupled with clearly articulated policies and procedures defined the organization publicly as having protections against influences from one industry. However, as revenue from other sources decreases, the percentage of the overall budget represented by pharmaceutical grants increases automatically and places the organization in a publicly expressed position of exceeding its goal. Currently, the organization cannot accept any additional dollars even when warranted from the pharmaceutical industry thus decreasing the organizations ability to expand

its programs. The percentage limitation serves to heighten concerns regarding fiscal stability and public perception when funds from other sources are not forthcoming.

Recommendations

Following the review of national and specific organizational trends, the Task Force submits the following recommendations to the Board of Directors:

- Establish an internal goal of no more than 33% of funding to be received from pharmaceutical or any other single source funding companies
- Establish a timeline to achieve the funding goal over the next five years within interim annual goals
- Establish a fund diversification strategy which will be monitored at least annually by the Board
- Establish sponsorship guidelines to formalize the conditions under consideration by the Resource Development Committee
- Establish, review and implement a conflict of interest policy to assure full disclosure of Board members in regard to any potential conflicts, thus assuring a culture of transparency in terms of how business is conducted
- Establish a fail-safe system to assure the substantial amount of in-kind contributions received by NMHA are documented and reported

In addition, it was recommended that the fund diversification goals be for internal organizational purposes and not used as a public policy statement now or in the future. The Taskforce also recommended that contributors be recognized through NMHA's web site and Annual Report as outlined in the Donor Recognition Strategy approved by the Resource Development Committee. Thus, the general public has access to the list of supporters to enable them to make informed giving decisions.

Finally, NMHA's Operating Policy O -18, entitled Partnership Values/Principles should be made available to those seeking information about NMHA's protections and process to eliminate external influence.

Mental Health America

Building *the* movement

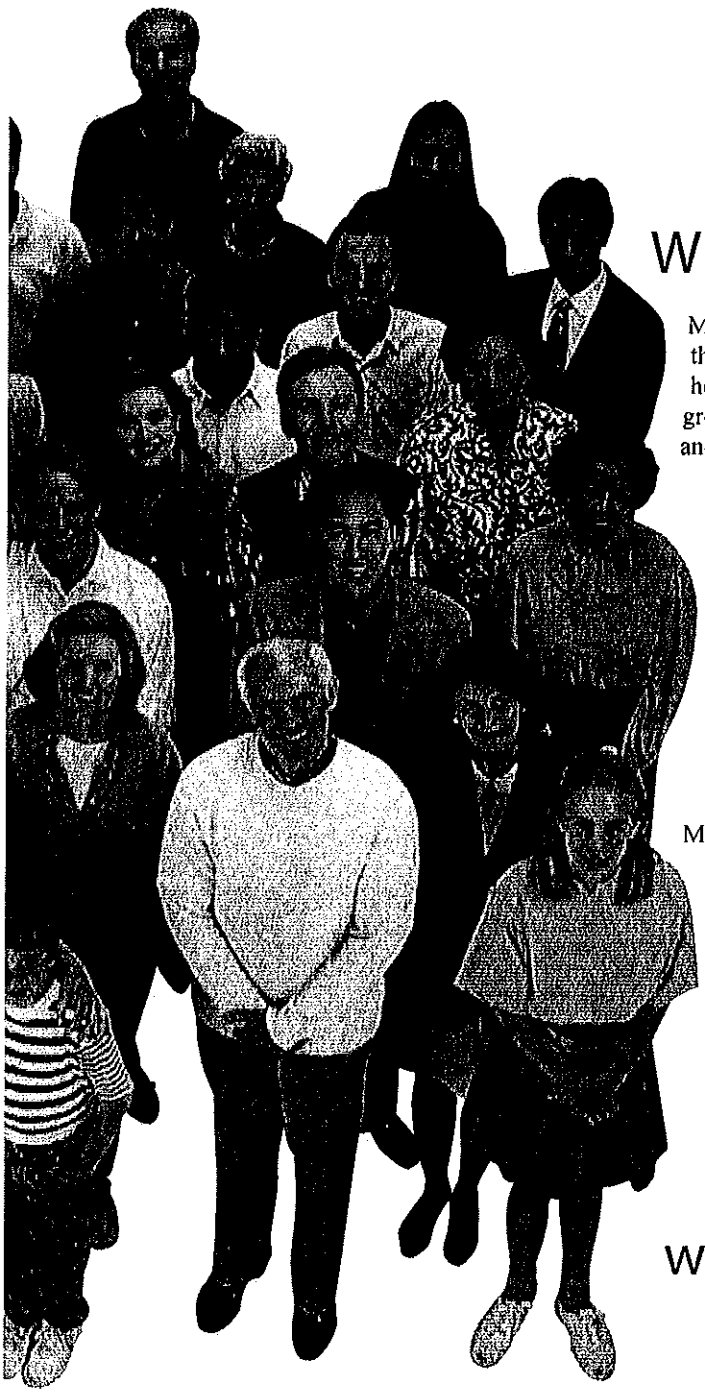
Mental Health America
2006 Annual Report

Building *the* movement

Table of Contents

"...the country's leading nonprofit *dedicated to helping all people* live mentally healthier lives."

WHO IS MENTAL HEALTH AMERICA?



Who Are We?

Mental Health America (formerly the National Mental Health Association) is the country's leading nonprofit dedicated to helping all people live mentally healthier lives. With our more than 320 affiliates nationwide, we represent a growing movement of Americans who promote mental wellness for the health and well-being of the nation—every day and in times of crisis.

Mental Health America Vision

Mental Health America envisions a just, humane and healthy society in which all people are accorded the respect, dignity and the opportunity to achieve their full potential free from stigma and prejudice.

Mental Health America Mission

Mental Health America is dedicated to promoting mental health, preventing mental disorders and achieving victory over mental illnesses through advocacy, education, research and service.

www.mentalhealthamerica.net

Welcome to our 2006 Annual Report

Within these pages, you'll see how nearly a century after Mental Health America's founder Clifford W. Beers launched today's mental health movement, we continue to build on that foundation as a national leader in mental health advocacy, public education, research and services.

We started out 2006 as the National Mental Health Association and closed out the year with our new name—Mental Health America. The new name reflects our leadership in the nation's mental health community and our dedication to ensuring that all people live mentally healthier lives.

Along with our new name, we have a new president and CEO, David Shern, Ph.D., a nationally-recognized scholar and advocate for science-based approaches to improving population mental health status.

In 2006, Mental Health America renewed its fight against injustice in health policy, educated the public about mental health and mental illnesses, and worked toward strengthening a growing movement of Americans who believe that good mental health is fundamental to the health and well-being of every individual—and the nation as a whole.

As you review our achievements in 2006, keep in mind that these successes couldn't have happened without your help and support. Thank you, and we look forward to working with you in 2007 and beyond.

David L. Shern, Ph.D.
President and CEO

Sergio Aguilar-Gaxiola, M.D., Ph.D.
Chair of the Board

Sergio Aguilar-Gaxiola

Advocacy

Mental Health America leads the movement to protect Americans' health and improve the rights of people who have mental health and substance use conditions and their families. Through outreach to policymakers, grassroots activities and partnerships, Mental Health America has helped open access to needed treatments—making a real difference in the lives of millions of Americans.

Online Advocacy

Mental Health America took its online advocacy to new heights in 2006 with our Advocacy Network (http://takeaction.mentalhealthamerica.net). This interactive network delivers timely legislative alerts, allows visitors to contact their members of Congress directly on key issues, and rallies grassroots support across the country for vital issues.

Medicaid

Medicaid enrollees in 2006 were again the target of overzealous budget cutters, who sought to save money by limiting access to needed treatments and services. Mental Health America was on the front lines to block the effects of these changes.

Achievements include:

• Blocking cuts to Medicaid funding for disability rehabilitative services. Working with the staff of some senators and with disability-related organizations, we were able to dissuade Congress from including this provision in its deficit-reduction targets, although the administration is trying again in 2007.

• Easing the requirement to prove American citizenship as a condition for enrollment in Medicaid. Through letters and in-person meetings, we and our advocacy partners convinced the federal Centers for Medicaid and Medicaid Services in the final rule released in 2007 to give Medicaid beneficiaries some flexibility in meeting this requirement.

In addition, we held a regional conference on Medicaid reform with affiliates and other advocates from Georgia, Kentucky, Louisiana, Missouri, Nebraska, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia, which armed advocates with the information they needed to address the issue in their states. We also cosponsored a Webcast outlining how the Federal Deficit Reduction Act could affect the Medicaid program.

Mental Health Insurance Parity

On both the state and federal levels, Mental Health America continued its quest to ensure that health plans that offer mental health coverage set their benefit levels at parity with general health services.

At the federal level, the congressional leadership maintained their decade-long opposition to parity legislation, despite overwhelming bipartisan support for the issue in both the House and the Senate. While actively promoting the legislation, we also worked with our partners and congressional allies to lay the groundwork for many of the parity successes we've enjoyed in 2007.

Meanwhile, governors in New York, Ohio and North Carolina signed parity legislation that we championed with our affiliates in those states. We also made significant progress around parity laws in states such as Alaska, California, Florida, Maryland and Tennessee.

Justice: Early in the year, the Administration had proposed deep cuts to several justice-related programs. Thanks in part to our advocacy, most of these cuts were rejected by Congress. Funding for juvenile justice programs and the Mentally Ill Offender and Treatment Act, which authorizes grants to provide collaboration between the justice and other systems, were both restored to the previous year's levels of $350 million and $5 million, respectively.

Housing: For the second consecutive year, the Administration threatened to impose deep cuts in funding for the Federal Section 811 housing program, which provides supportive housing for people with disabilities. Mental Health America's efforts helped to restore $240 million to the program.

Children and Families

The most vulnerable among us are our nation's children, who too often serve as the primary targets for cuts to the mental health system. We made great strides in 2006 in preserving and protecting programs that support children and families.

Achievements include:

• Successfully urging Congress to restore most of the $18 million in funding to the federal Safe Schools/Healthy Students program that the Administration proposed cutting.

• Meeting with Charlie Curie, then-Administrator of the Substance Abuse and Mental Health Services Administration, to discuss how to minimize the effects of a proposed regulation that would have drastically narrowed the Temporary Assistance for Needy Families program.

• Organizing a regional meeting with our affiliates and other advocates from Indiana, Illinois, Oklahoma, Tennessee, North Dakota, Florida and Texas, to explore innovative approaches to early childhood intervention and prevention services, and to plan how to counter state legislation that would threaten these services.

Building *the* movement

• Collaborating with the American Academy of Child and Adolescent Psychiatry to develop strategies and model state legislation that will help promote better access to care for children who have mental health problems or are at risk for them.

Older Adults

Mental Health America is a long-recognized leader in protecting older adults' access to mental health services. This access was threatened with the creation of Medicare's prescription drug benefit. In 2006, we continued our successful efforts to ensure that the drug benefit program helped rather than harmed older adults.

Successes include:

• Launching a popular online newsletter, "Get Educated, Get Enrolled," which provides updates on deadlines, resources and news for consumers and advocates.

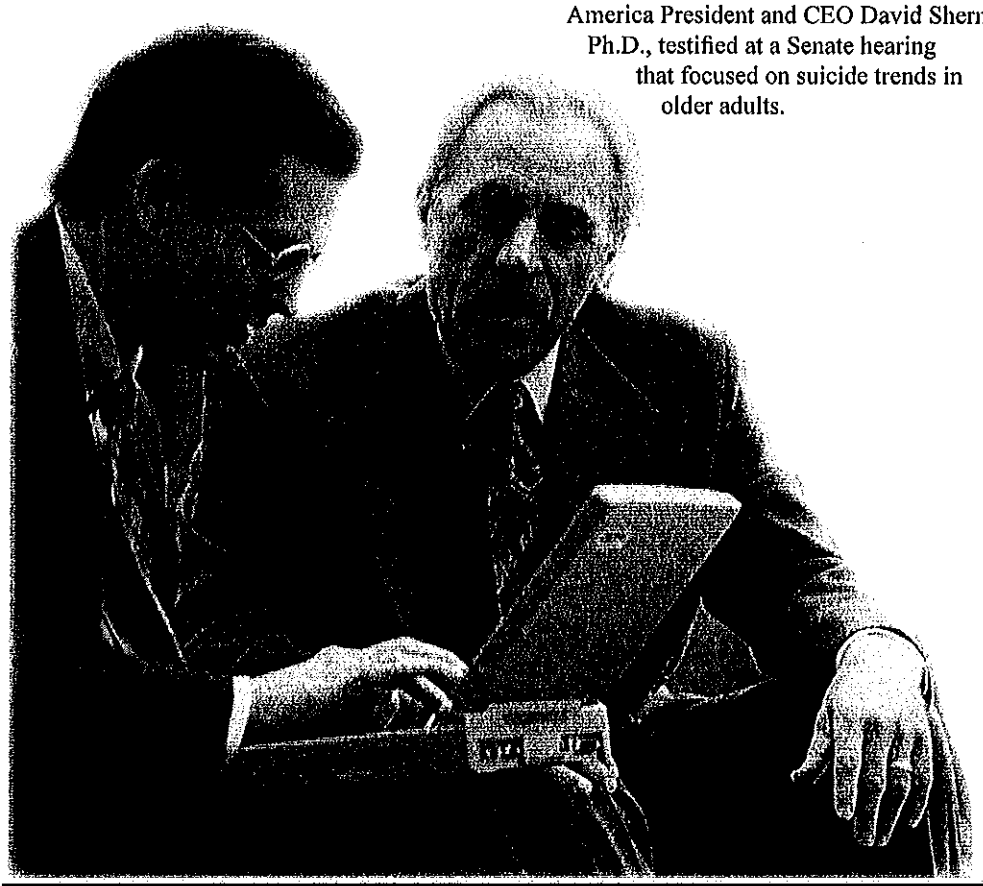
• Submitting comments to the Centers for Medicare and Medicaid Services on the agency's Medicare drug plans for the 2007 plan year and the agency's proposed rule on the use of drug benefit claims data to ensure confidentiality of beneficiaries' medical records. We were also successful in convincing Congress to include key mental health provisions in the Older Americans Act, which include:

• Designating a person in the Federal Administration on Aging to be responsible for implementing the Act's mental health services.

• Awarding competitive grants to states for the development and operations of delivery of mental health services.

• Awarding additional competitive grants to states for public education programs to reduce the stigma of mental illnesses.

In addition, at the invitation of Sen. Gordon Smith, R-Ore., Mental Health America President and CEO David Shern, Ph.D., testified at a Senate hearing that focused on suicide trends in older adults.



Visible Force on Capitol Hill and in State Capitols

State and national policymakers have long relied on Mental Health America and its affiliate field for policy information and analysis, and 2006 was no exception.

Successes include:

• Mental Health America's President and CEO David Shern, Ph.D., joining Rep. Patrick Kennedy, D-R.I., Center for Mental Health Services Director A. Kathryn Power, M.Ed., and others at a congressional briefing about the need to treat psychological trauma as a public health issue.

• Mental Health America's Board Chair Sergio Aguilar-Gaxiola, M.D., Ph.D., chairing a three-hour panel discussion on mental health at the House of Representatives' Hispanic Caucus' Public Policy Conference at the request of Rep. Grace Napolitano, D-Calif.

• Holding joint policy training conferences with our affiliates and others in states throughout the country, including Nebraska, the Pacific Island Territories, Florida, Virginia, Missouri, West Virginia, North Dakota, California and Wisconsin.

• Mental Health America and other organizational members of the Campaign for Mental Health Reform sponsoring a standing-room only briefing, "Mental Health: A Public Heath Crisis," for Senate staff members.

"Mental Health America *leads* the movement to protect Americans' health and improve the rights of people who have mental health and substance use conditions and their families."

Public Education

At the heart of our movement is the message that mental health is fundamental to our overall health, and that mental illnesses are no different from any other medical illnesses. Yet the stigma surrounding mental illnesses still keeps many Americans from seeking the information and care they need. Mental Health America's strong education and media outreach efforts bring attention to these issues, and increase public acceptance of mental health as key to overall health and wellness.

Campaign for America's Mental Health

The Campaign for America's Mental Health is central to Mental Health America's public educational efforts. Through the campaign, launched in 1992, we work with nearly 60 local campaign sites to develop and conduct education events, screenings and activities that reach out to the general public, the media, providers, employers and policymakers.

Highlights in 2006 include:

• Educating 1.4 million people at more than 5,000 events nationwide.

• Screening more than 429,000 people for mental health conditions at locations throughout the country and online.

• Generating more than 1.7 billion media impressions through such media outlets as the *Chicago Tribune, Wall Street Journal, New York Times, Los Angeles Times, New York Post, Washington Post,* CNN.com, *Atlanta Journal-Constitution, Austin American-Statesman, Boston Globe, Forbes* and *Baltimore Sun.*

Resource Center

For nearly 20 years, Mental Health America's Resource Center has provided information and referrals directly to hundreds of thousands of individuals each year through its toll-free line (800-969-6642) and Website (www.mentalhealthamerica.net). In 2006, our online Resource Center's fact sheets and referral information were accessed more than 3.1 million times.

Praise for Our Resource Center

"Thank you so much for taking the time, listening to me and making the call for me to find out where I can go for help".

–From a single mother struggling with suicidal thoughts who requested help so she wouldn't abandon her 11-year-old son.

"You've been phenomenal. You've given me a lot of direction and a lot of help."

–From a woman who wrote with concerns about her friend's possible depression.

"Thank you for the quick reply. I checked out the link and am overwhelmed by the volume of information. This is great. Again, thank you."

–From a provider who called seeking information on funding available for school-based mental health.

Media Outreach

More and more media outlets turn to Mental Health America each year as a trusted source for mental health information. Our media coverage in 2006 outshined previous years with articles focused on antidepressant medication safety issues, mental health in the workplace, stress, children's mental health, older adults' mental health, criminal justice, depression, suicide and military issues.

Achievements include:

• Producing more than 4,000 media hits, a number that surpasses each of the previous five years. This resulted in an average of more than 13 highlights a day—nearly three times higher than the daily average for 2005.

• Garnering placements in Yahoo! News, *The Washington Post,* MTV.com, *Los Angeles Times, Chicago Tribune,* CNN.com, United Press International, Black Enterprise, National Public Radio, *Forbes, The American Journal of Psychiatry,* CBS News and more.

Major Media Activities

Antidepressant Warning: Mental Health America helped to lead a coalition of organizations in 2006 to promote the accurate media coverage of a Food and Drug Administration hearing on the safety of antidepressant medications. When the FDA debated the same issue in 2004, media coverage ignored the significant risk of untreated depression. Fortunately, our coalition's work produced balanced coverage around the 2006 hearings:

• The coalition's messages appeared in nearly every major media outlet for a total of 87 million media impressions.

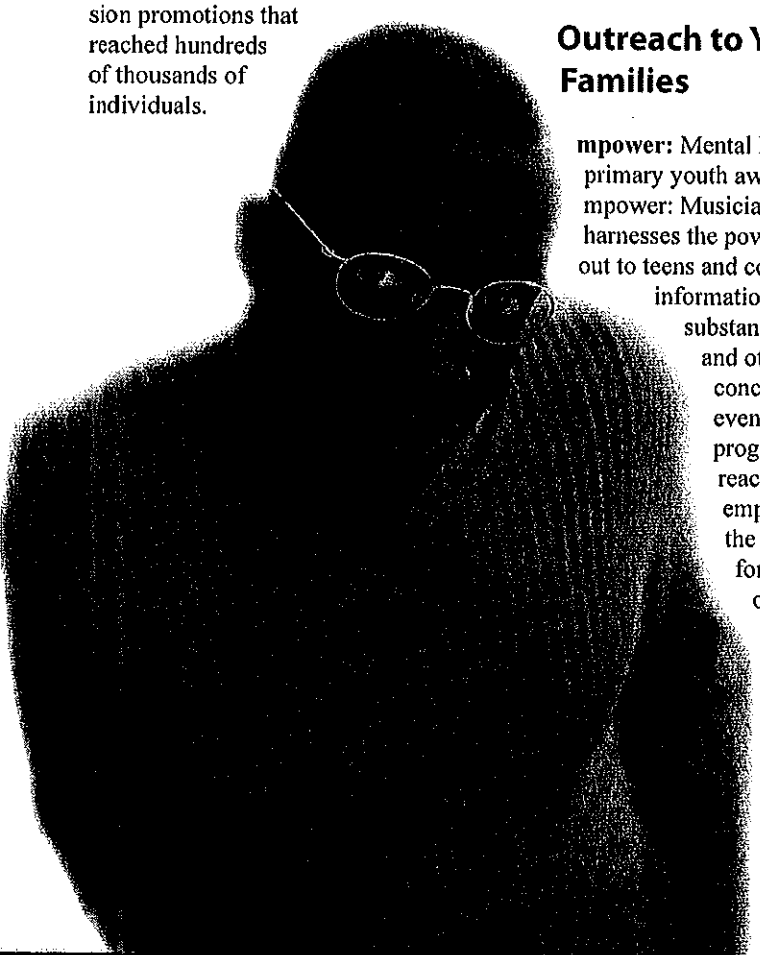
• Coalition messages influenced the FDA committee, which ultimately voted not to add the warning label to antidepressant prescriptions for adults.

• The FDA committee—for the first time—recognized untreated depression as a major risk for suicide.

Building the movement

Desk-Side Briefings: Mental Health America held "desk-side briefings" with the editors of major national magazines to discuss coverage of depression in children and adults, and to offer background information, tips and resources for recognizing and treating the disorder. The private briefings were held with the editors of *Parents, Good Housekeeping, All You, Prevention, BabyTalk, Parenting, SELF, MORE, Ladies Home Journal* and *Redbook.*

History Channel Partnership: Mental Health America partnered with The History Channel for the world premiere of "Lincoln," a documentary that honored the former president's remarkable accomplishments despite his life-long struggle with depression. Our nationwide campaign to spread the word about the television show included positive messages about mental health through brochures displayed in physician offices, bookstore counter cards, donation containers, and television promotions that reached hundreds of thousands of individuals.



Media Awards: Our annual Mental Health Media Awards competition highlights excellence in press coverage of mental health issues and showcases Mental Health America's value as a "go-to" resource for reporters. Winners in 2006 hailed from such news organizations as *Newsweek, The Los Angeles Times* and National Public Radio.

Outreach to Consumers

Dialogue for Recovery: Our Dialogue for Recovery program helps to enhance the recovery and quality-of-life for people with severe mental illnesses by working to improve communication between mental health consumers, their healthcare providers and family members with the goal of supporting consumer involvement in treatment decisions. In 2006, the program educated more than 1.3 million people at 2,700 events held throughout the country.

Outreach to Youth and Families

mpower: Mental Health America's primary youth awareness campaign, mpower: Musicians for Mental Health, harnesses the power of music to reach out to teens and college-age youth with information about depression, substance abuse, suicide and other issues. Through concert tie-ins, special events, forums, classroom programs and Web outreach, the campaign has empowered youth across the country to take action for the good of their own mental health and get involved in the movement.

Highlights in 2006 include:

• More than 41,000 young people were educated at over 22 events.

• Mental Health America's www.mpoweryouth.org Website received more than 372,000 hits.

• Musician Lindsay Rush performed two back-to-back mpower concerts for 1,000 middle- and high-school students in New Hope, Penn. featuring Mental Health America-led presentations on depression, stress, eating disorders and bullying.

• Angela Rossi, a musician based in Chicago, hosted "Rock Your Mind for a Good Cause," a benefit concert supporting mpower.

Children's Mental Health Awareness Day: Mental Health America joined up with the National Association of Social Workers, the National Federation of Families for Children's Mental Health and the National Alliance on Mental Illness in 2006 to recognize National Children's Mental Health Awareness Day. To mark the occasion, the organizations hosted a briefing on Capitol Hill where the Substance Abuse and Mental Health Services Administration released key findings from its national evaluation of community-based services for children and families.

Outreach to Veterans

Operation Healthy Reunions: Mental Health America launched this groundbreaking initiative to address the mental health needs of our nation's troops and their families during the mobilization, deployment and post-deployment periods. The program in 2006 focused on educating service members returning from Iraq and Afghanistan and their families about the potential mental health consequences of trauma exposure, and the need for early diagnosis and treatment. Through this program, we released to 700 stations nationwide radio public service announcements that address the issues returning combat veterans and their families face.

Research and Services

Mental Health America aggressively supports new research efforts, the dissemination of those findings, and the delivery of innovative services that help ensure communities have access to effective approaches to care.

Evidence-based Health Care

Individualized care is at the heart of effective, high-quality mental health treatment. One of Mental Health America's goals in 2006 was to assess the impact of the current health care trend toward evidence-based medicine. This new trend can make it a challenge to ensure that treatment decisions balance cost concerns with scientific evidence, physician judgment, and consumer experiences and preference. To address these issues, in 2006 we launched the National Working Group on Evidence-based Health Care, a collaboration of more than 40 consumer and provider organizations (www.evidencebasedhealthcare.org).

The Working Group seeks to ensure greater focus on and involvement for consumers in national and state-focused quality-of-care initiatives. A core activity of these initiatives is the review, interpretation, and dissemination of information about scientific research that consumers, providers and policymakers use to make decisions about health care delivery and coverage.

In 2006, we worked closely with organizations such as the Oregon Center for Evidence-based Policy, the Center for Medicaid and Medicare Services, the Agency for Health Care Research and Quality, the Institute of Medicine and Consumers Union to engage in a broad dialogue about these initiatives and improve the translation of evidence into practice and policy.

Highlights include:

• Working with the Pharmacy Quality Alliance and other organizations involved in developing quality standards derived from evidence-based care to include individuals with disabilities and other conditions in their policymaking bodies.

• Expressing our desire in a letter published in the journal *Health Affairs* that the Oregon Center for Evidence-based Policy's Drug Effectiveness Review Project make its process of reviewing and translating research into practice be more transparent to the public.

National Consumer Supporter Technical Assistance Center

In its eighth year since being established through a Center for Mental Health Services grant, Mental Health America's National Consumer Supporter Technical Assistance Center (NCSTAC) is going strong. The Center helps build the mental health movement by directly supporting organizations that focus on empowering consumers and helping them through their recovery.

Grantee Training

NCSTAC accomplishes its mission in part by supporting five local organizations across the country with funding and intensive technical assistance. In 2006, NCSTAC ran a week-long grant-writing seminar for grantee sites and statewide consumer organizations to increase their self-sufficiency. After the seminar, many participants applied for and received foundation grants.

Publications

NCSTAC offers a variety of materials that help consumer groups meet the needs of their communities. In 2006, the Center overhauled its library of publications that focus on various components of organizational development and capacity building and has distributed thousands to organizations. The titles include:

- *Assessing Communities for Systems Transformation*
- *How to Establish a 501(c)(3) Organization*
- *Fundraising Basics*
- *How to Establish and Maintain a Consumer Advisory Board*
- *Guide to Proposal Writing*
- *Working with Volunteers*
- *Working with the Media*

Technical Assistance

NCSTAC provided extensive technical assistance to its grantee sites and other consumer supporter organizations. From helping the Albuquerque Drop-In Center in New Mexico complete its community-needs assessment to assisting the West Virginia Mental Health Consumers' Association create educational materials about system transformation in its state, NCSTAC offered vital support to groups nationwide.

"Mental Health America aggressively supports *new research* efforts..."

ALABAMA
Mental Health America of Etowah County
Mental Health Association in Morgan County
Mental Health America in Montgomery
Mental Health America of Southwest Alabama
Mental Health Association in Tuscaloosa County

ARKANSAS
Mental Health America of Northwest Arkansas

ARIZONA
Mental Health America of Arizona

CALIFORNIA
Mental Health Association in California
Mental Health America of the Central Valley
Mental Health Association of Alameda County
Mental Health America of Los Angeles
Mental Health Association in Sacramento
Mental Health America of San Diego County
Mental Health Association of Santa Barbara County
Mental Health Association of San Francisco
National Mental Health Association in Ventura County
Mental Health America of Yuba/Sutter

COLORADO
Mental Health America of Pikes Peak Region
Mental Health America of Colorado
Mental Health Association of Pueblo

CONNECTICUT
Mental Health Association of Connecticut

DELAWARE
Mental Health Association in Delaware

DISTRICT OF COLUMBIA
Mental Health Association of the District of Columbia

FLORIDA
Mental Health Association of Volusia and Flagler Counties
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Mental Health America of Bay County
Mental Health Association of Broward County
Mental Health Association of Central Florida, Inc.
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Mental Health America of Greater Tampa Bay, Inc.
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Mental Health Association of Northeast Florida, Inc.
Mental Health Association of Okaloosa & Walton Counties
Mental Health Association of Palm Beach County, Inc.

GEORGIA
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National Mental Health Association of Augusta
Mental Health Association of Clayton County
Mental Health America of Etowah Valley
Mental Health America of Georgia
Mental Health America of South Coastal Georgia

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Mental Health America of Hawai'i
Mental Health Association in Maui County
Mental Health Association in Hawaii County

IOWA
Mental Health America of Dubuque County
Hamilton County Mental Health Association
Mental Health Association of Siouxland

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Mental Health America of Clinton County
Mental Health Association in Daviess County
Mental Health America of DeKalb County
Mental Health America of Delaware County, Inc.
Mental Health America of Dubois County
Mental Health America of Michiana
Mental Health America of Floyd County
Mental Health America of Fulton County
Mental Health Association in Gibson County
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Mental Health Association in Hendricks County
Mental Health America of Henry County, Inc.
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Mental Health America of Jackson County, Ind.
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Mental Health America of Jefferson County
Mental Health America of Knox County
Mental Health Association in Kosciusko County
Mental Health America of Lake County
Mental Health Association in Marshall County
Mental Health America of Monroe County, Inc.
Mental Health America of Morgan County

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Mental Health Association in Perry County
Mental Health America of Porter County
Mental Health America of Putnam County
Mental Health America of Randolph County
Mental Health America of Rush County
Mental Health Association in Spencer County
Mental Health Association in Steuben County
Mental Health America of Tippecanoe
Mental Health America of Vanderburgh County
Mental Health America of Vigo County
Mental Health Association in Wayne County
Mental Health Association in Wells County
Mental Health Association in White County

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Mental Health America of Reno County
Mental Health Association of South Central Kansas

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Mental Health America of Kentucky
Mental Health America of Northern Kentucky

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Mental Health Association in Caldwell Parish
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Mental Health Association of Montgomery County
Mental Health Association of Prince George's County
Mental Health Association of Southern Maryland
Mental Health Association in Talbot County
Mental Health Association of Washington County

MICHIGAN
Mental Health Association in Michigan

MISSOURI
Mental Health Association of Greater St. Louis

MISSISSIPPI
Mental Health America of Mississippi

MONTANA
Montana Mental Health Association
Mental Health Association of Daniels County
Mental Health Association of Great Falls
Mental Health Association of Sheridan County
Mental Health Association of Sweet Grass & Stillwater Counties

NEBRASKA
Mental Health Association of Nebraska

NEW JERSEY
Mental Health Association in New Jersey
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Mental Health Association of Essex County
Mental Health Association in Hudson County
Mental Health Association of Monmouth County
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Mental Health Association of Ocean County
Mental Health Association in Passaic County
Mental Health Association in Southwestern New Jersey

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Mental Health Association of New Mexico

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Mental Health Association in Cattaraugus County
Mental Health Association in Chautauqua County
Mental Health Association of Clinton County
Mental Health Association of Columbia-Greene Counties, Inc.
Mental Health Association of Courtland County, Inc.
Mental Health Association of Dutchess County
Mental Health Association of Erie County, Inc.
Mental Health Association in Essex County, Inc.
Mental Health Association in Franklin County
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Mental Health Association in Jefferson County
Mental Health Association of Nassau County
Mental Health Association in Niagara County
Mental Health Association of Rochester/Monroe Counties, Inc.
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Mental Health Association in Orange County, Inc.
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Mental Health Association of Oswego County, Inc.
Mental Health Association in Putnam County
Mental Health Association of Rochester/Monroe Counties, Inc.
Mental Health Association of Rockland County, Inc.
Schuyler County Mental Health Association
Mental Health Association of the Southern Tier, Inc.
Mental Health Association in Suffolk County
Mental Health Association in Tompkins County
Mental Health Association in Ulster County, Inc.
Warren-Washington Association for Mental Health
Mental Health Association of Westchester County, Inc.

NORTH CAROLINA
Mental Health Association of Central Carolinas, Inc.
Mental Health Association in North Carolina
Mental Health Association in Greensboro, Inc.

Mental Health America Affiliates
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Mental Health America of North Dakota

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Mental Health America of Knox County
Mental Health America of Licking County
Mental Health Association of Miami County
Mental Health Association of Southwest Ohio
Mental Health America of Summit County
Mental Health America of Union County

OKLAHOMA
Mental Health Association in Tulsa

OREGON
Mental Health America of Oregon

PENNSYLVANIA
Mental Health Association in Pennsylvania
The Advocacy Alliance-A Mental Health Association
Mental Health America of Allegheny County
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Mental Health Association of Franklin/Fulton Counties
Mental Health America of Lancaster County
Mental Health Association of Mercer County, Inc.
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Mental Health America of York and Adams Counties

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Mental Health Association of Rhode Island

SOUTH CAROLINA
Mental Health Association in Anderson County
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Mental Health America of Aiken County
Mental Health Association in Barnwell County
Mental Health America of Bamberg County
Mental Health Association in Beaufort/Jasper Counties
Mental Health America of Calhoun County
Mental Health Association in Cherokee County
Mental Health Association in Chester County
Mental Health Association in Clarendon County
Mental Health Association in Darlington County
Mental Health Association In Georgetown County
Mental Health America of Greenville County
Mental Health America of Greenwood County
Mental Health America of Horry County
Mental Health America of Kershaw County
Mental Health Association in Lancaster County
Mental Health America of Laurens County
Mental Health Association in Lee County
Mental Health Association in Marion County
Mental Health America of McCormick County
Mental Health America Oconee County
Mental Health America of Orangeburg County
Mental Health America of the Piedmont, Inc.
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Mental Health America of Sumter County
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Mental Health Association of East Tennessee, Inc.
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Mental Health Association of Fort Bend
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Mental Health America of Greater Houston
Mental Health America of Southeast Texas County
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UTAH
Mental Health Association in Utah

VIRGINIA
Mental Health America of Virginia
Mental Health America of Augusta
Mental Health America of Central Virginia
Mental Health America of Charlottesville-Albemarle
Mental Health America of Fauquier County
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Mental Health Association of Martinsville & Henry Counties
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Mental Health Association of Rockbridge County
Mental Health America of Halifax
Mental Health America of the New River Valley
Mental Health Association in South Hampton Roads
Mental Health Association of Warren County

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Vermont Association for Mental Health

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Mental Health Association in Calumet County
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Our heartfelt thanks goes to those individuals who have made a significant commitment to the future of mental health by including Mental Health America in their estate plans or who have established a charitable gift annuity.

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William Bishop
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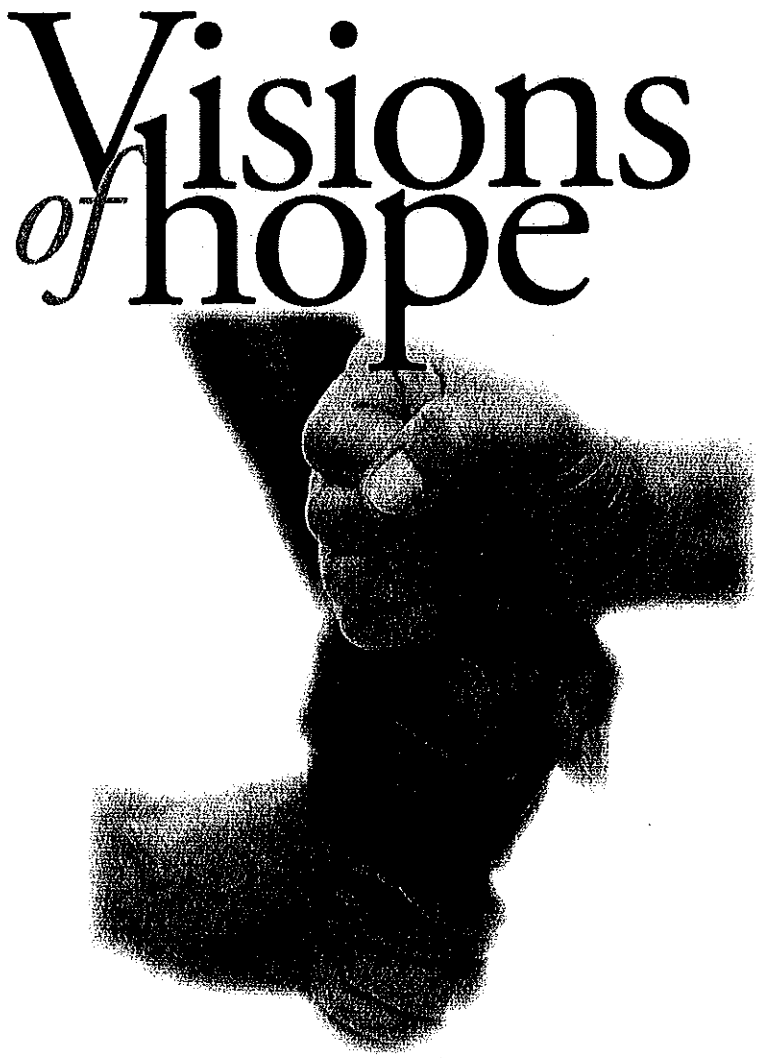

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Active Minds
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Advancements Association for Personality Disorder
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Alliance for Aging Research
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Alliance for Mental Health Consumers Rights
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American Academy of Family Physicians
American Academy of Neurology
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Academy of Physician Assistants
American Association for Geriatric Psychiatry
American Association for Marriage and Family Therapy
American Association for Psychosocial Rehabilitation
American Association of Children's Residential Centers
American Association of Community Psychiatrists
American Association of Pastoral Counselors
American Association of People with Disabilities
American Association of Practicing Psychiatrists
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Association of Jewish Aging Services of North America
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Center for the Advancement of Children's Mental Health
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Center of Substance Abuse Prevention
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Food and Drug Administration, Office of Special Health Issues
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National Alliance to End Homelessness
National Asian American Pacific Islander Mental Health Association
National Asian Women's Health Organization
National Assembly of Health and Human Service Organizations
National Association for Children's Behavioral Health
National Association for Continence
National Association for Health and Fitness
National Association for Rural Mental Health
National Association for the Advancement of Colored People (NAACP)
National Association for the Advancement of Orthotics & Prosthetics
National Association for the Dually Diagnosed
National Association of Anorexia Nervosa and Associated Disorders—ANAD
National Association of Case Management
National Association of Children's Hospitals
National Association of Community Health Centers
National Association of Counties
National Association of County and City Health Officials
National Association of County Behavioral Health Directors
National Association of Developmental Disabilities Councils
National Association of Elementary School Principals
National Association of Mental Health Planning & Advisory Councils
National Association of Pediatric Nurse Practitioners
National Association of Protection and Advocacy Systems
National Association of Psychiatric Health Systems
National Association of Psychiatric Treatment Centers for Children
National Association of School Nurses
National Association of School Psychologists
National Association of Social Workers
National Association of State Directors of Special Education
National Association of State Mental Health Program Directors
National Black Nurses Association
National Boys and Girls Clubs of America
National Center for Policy Research for Women & Families
National Center on Institutions and Alternatives
National Coalition against Domestic Violence
National Coalition for the Homeless
National Coalition of Mental Health Consumers and Professionals
National Committee to Preserve Social Security and Medicare
National Council for Community Behavioral Healthcare
National Council of Jewish Women
National Council of La Raza
National Council of Negro Women
National Council on Alcoholism and Drug Dependence
National Council on Family Relations
National Council on Problem Gambling
National Council on Suicide Prevention
National Council on the Aging
National Down Syndrome Congress
National Down Syndrome Society
National Eating Disorders Association
National Education Association Health Information Network
National Educational Alliance for Borderline Personality Disorder
National Exchange Club Foundation
National Foundation for Depressive Illness
National Health Council
National Health Law Program
National Hispanic Medical Association
National Hopeline Network
National Housing Conference
National Institute of Mental Health
National Interfaith Coalition for Spiritual Healthcare
National Latino Behavioral Health Association
National Law Center on Homelessness & Poverty
National Leadership on African American Behavioral Health
National League of Cities
National Medical Association
National Mental Health Awareness Campaign
National Mental Health Consumers' Self-Help Clearinghouse
National Multiple Sclerosis Society
National Network for Youth
National Organization for Rare Disorders
National Organization of People of Color Against Suicide
National Osteoporosis Foundation
National Panhellenic Conference
National Parent Teachers Association
National Partnership for Women and Families
National Recreation and Park Association
National Rural Health Association
National Schizophrenia Foundation
National Senior Citizens Law Center
National Sleep Foundation
National Therapeutic Recreation Society
National Treatment and Research
Native American Counseling, Inc.
NETWORK, a Catholic Social Justice Lobby
New York University Child Study Center
NISH (National Industries for the Severely Handicapped)
Obsessive Compulsive Foundation
Office & Professional Employees
Older Adult Consumer Mental Health Alliance
Organization of Student Social Workers
OWL—The Voice of Mid-Life and Older Women
Parkinson's Pipeline Project
Partnership for Recovery
Presbyterian Church (USA), Washington Office
Prevent Child Abuse America
Rebecca Project for Human Rights
Renfrew Center Foundation
Samaritans Suicide Prevention Center
School Social Work Association of America
Screening for Mental Health, Inc.
Service Employees International Union
Shaken Baby Alliance
Sjogren's Syndrome Foundation
Society for Adolescent Medicine
Society for Prevention Research
Suicide Prevention Action Network USA
The AIDS Institute
The Arc of the United States
The Carter Center
The Jonathan O. Cole Mental Health Consumer Resource Center
Washington Business Group on Health
Washington State University
Y-ME National Breast Cancer Organization

Mental Health America

Financial Statements

For the Year Ended December 31, 2006
(With Summarized Financial Information for the Year Ended December 31, 2005)

and
Report Thereon

RAFFA

CONSULTING
ACCOUNTING
TECHNOLOGY

Certified Public Accountants

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Mental Health America

We have audited the accompanying statement of financial position of Mental Health America, (MHA) as of December 31, 2006, and the related statements of activities, functional expenses and cash flows for the year then ended. These financial statements are the responsibility of MHA's management. Our responsibility is to express an opinion on these financial statements based on our audit. The prior year summarized comparative information has been derived from MHA's 2005 financial statements and, in our report dated March 31, 2006; we expressed an unqualified opinion on those statements.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of MHA as of December 31, 2006, and the changes in its net assets and its cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

RAFFA, P.C.

Washington, DC
May 15, 2007

MENTAL HEALTH AMERICA

STATEMENT OF FINANCIAL POSITION
December 31, 2006
(With Summarized Financial Information as of December 31, 2005)

	2006	2005
ASSETS		
Cash and cash equivalents	$ 1,196,812	$ 1,359,369
Accounts receivable, net of allowance for doubtful accounts of $1,000 in 2006	300,679	235,494
Grants and contracts receivable	822,520	867,463
Bequests receivable	594,537	586,016
Prepaid expenses	51,808	76,141
Inventory	96,392	195,019
Investments	2,910,420	2,641,986
Property and equipment, net	691,021	281,180
TOTAL ASSETS	$ 6,664,189	$ 6,242,668
LIABILITIES AND NET ASSETS		
Accounts payable and accrued expenses	$ 264,522	$ 536,695
Charitable gift annuities	45,077	54,145
Capital lease obligations	290,948	220,863
Deferred lease incentives	283,508	-
Deferred revenue	109,206	32,331
TOTAL LIABILITIES	993,261	844,034
Net Assets		
Unrestricted		
Undesignated	228,879	973,073
Reserve fund	674,885	25,728
Building reserve fund	2,460,982	2,358,074
Net property and equipment fund	116,564	60,317
Jo Blaylock Memorial fund	58,562	58,533
Total Unrestricted	3,539,872	3,475,725
Temporarily restricted	1,842,085	1,633,938
Permanently restricted	288,971	288,971
TOTAL NET ASSETS	5,670,928	5,398,634
TOTAL LIABILITIES AND NET ASSETS	$ 6,664,189	$ 6,242,668

The accompanying notes are an integral part of these financial statements.

MENTAL HEALTH AMERICA

STATEMENT OF ACTIVITIES
For the Year Ended December 31, 2006
(With Summarized Financial Information for the Year Ended December 31, 2005)

	Unrestricted	Temporarily Restricted	Permanently Restricted	2006 Total	2005 Total
REVENUE AND SUPPORT					
Grants, contracts and contributions	$ 1,105,268	$ 5,564,410	$ -	$ 6,669,678	$ 6,587,001
Affiliate support	554,443	-	-	554,443	664,625
Bequests	303,464	-	-	303,464	95,875
Investment income	239,898	13,884	-	253,782	31,294
In-kind contributions	173,106	-	-	173,106	45,208
Special events	95,000	-	-	95,000	101,000
Sales	58,223	-	-	58,223	32,157
Combined federal campaign	55,445	-	-	55,445	60,585
Rental income	19,229	-	-	19,229	134,053
Net assets released from restrictions:					
Satisfaction of program restrictions	5,370,147	(5,370,147)	-	-	-
TOTAL REVENUE AND SUPPORT	7,974,223	208,147	-	8,182,370	7,751,798
EXPENSES					
Program Services					
Constituency services	2,526,786	-	-	2,526,786	2,232,911
Education	2,003,706	-	-	2,003,706	1,753,697
Advocacy	1,008,212	-	-	1,008,212	1,249,190
Research	1,117,019	-	-	1,117,019	954,073
Total Program Services	6,655,723	-	-	6,655,723	6,189,871
Management and general	820,219	-	-	820,219	716,102
Fundraising	434,134	-	-	434,134	347,518
TOTAL EXPENSES	7,910,076	-	-	7,910,076	7,253,491
Change in Net Assets	64,147	208,147	-	272,294	498,307
NET ASSETS, BEGINNING OF YEAR	3,475,725	1,633,938	288,971	5,398,634	4,900,327
NET ASSETS, END OF YEAR	$ 3,539,872	$ 1,842,085	$ 288,971	$ 5,670,928	$ 5,398,634

The accompanying notes are an integral part of these financial statements.

MENTAL HEALTH AMERICA

STATEMENT OF FUNCTIONAL EXPENSES
For the Year Ended December 31, 2006
(With Summarized Financial Information for the Year Ended December 31, 2005)

	Program Services					Supporting Services			
	Constituency Services	Education	Advocacy	Research	Total Program Services	Management and General	Fundraising	2006 Total	2005 Total
Salaries and benefits	$ 1,243,203	$ 1,086,445	$ 708,690	$ 716,760	$ 3,755,098	$ 375,310	$ 258,737	$ 4,389,145	$ 4,603,497
Professional fees and contract service payments	227,603	238,012	58,912	126,229	650,756	249,966	41,400	942,122	447,311
Conference and meetings	298,482	176,995	58,270	97,833	631,580	-	21,932	653,512	365,036
Occupancy	119,516	95,613	62,149	47,807	325,085	105,174	47,807	478,066	674,935
Grants	407,355	-	-	-	407,355	-	-	407,355	336,400
Outside printing and art work	7,308	214,400	7,303	6,969	235,980	-	-	235,980	78,541
Travel	57,095	17,568	15,606	28,880	119,149	10,303	18,318	147,770	149,933
Telephone	22,542	49,552	26,057	15,318	113,469	10,462	-	123,931	110,286
Equipment and donations to affiliates	30,431	24,294	15,839	12,215	82,779	26,652	12,114	121,545	-
Miscellaneous	20,692	49,225	24,400	14,099	108,416	-	2,911	111,327	122,190
Depreciation and amortization	28,050	22,440	14,584	11,220	76,294	24,684	11,220	112,198	141,224
Postage and shipping	25,716	13,928	11,913	37,034	88,591	-	12,487	101,078	86,479
Supplies	35,855	12,883	2,961	1,480	53,179	15,083	6,033	74,295	119,378
Loss on disposal of equipment under capital lease	2,938	2,351	1,528	1,175	7,992	2,585	1,175	11,752	18,281
TOTAL	$ 2,526,786	$ 2,003,706	$ 1,008,212	$ 1,117,019	$ 6,655,723	$ 820,219	$ 434,134	$ 7,910,076	$ 7,253,491

The accompanying notes are an integral part of these financial statements.

MENTAL HEALTH AMERICA

STATEMENT OF CASH FLOWS
For the Year Ended December 31, 2006
(With Summarized Financial Information for the Year Ended December 31, 2005)
Increase (Decrease) in Cash and Cash Equivalents

	2006	2005
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	$ 272,294	$ 498,307
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	112,198	141,224
Allowance for doubtful accounts receivable	-	1,000
Loss on disposition of equipment	11,752	18,281
Unrealized loss (gain) on investments	(71,078)	21,087
Realized (gain) loss on investments	(1,280)	59,444
Donated investments	(1,893)	(16,196)
Changes in assets and liabilities:		
Accounts receivable	(65,185)	116,024
Grants and contracts receivable	44,943	508,374
Bequests receivable	(8,521)	(25,839)
Prepaid expenses	24,333	88,869
Inventory	98,627	20,366
Accounts payable and accrued expenses	(272,173)	341,270
Deferred lease incentives	283,508	-
Deferred revenue	76,875	(15,239)
NET CASH PROVIDED BY OPERATING ACTIVITIES	504,400	1,756,972
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of property and equipment	(389,871)	(30,345)
Proceeds from sales of investments	5,142,061	3,776,092
Purchases of investments	(5,336,244)	(3,519,931)
NET CASH PROVIDED BY (USED IN) INVESTING ACTIVITIES	(584,054)	225,816
CASH FLOWS FROM FINANCING ACTIVITIES		
Line of credit	-	(841,965)
Payments under charitable gift annuities	(9,068)	(11,160)
Principal payments on capital lease obligations	(73,835)	(112,657)
NET CASH (USED IN) PROVIDED BY FINANCING ACTIVITIES	(82,903)	(965,782)
NET INCREASE IN CASH AND CASH EQUIVALENTS	(162,557)	1,017,006
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR	1,359,369	342,363
CASH AND CASH EQUIVALENTS, END OF YEAR	$ 1,196,812	$ 1,359,369
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for interest	$ 6,082	$ 26,860
SUPPLEMENTAL SCHEDULE OF NONCASH INVESTING AND FINANCING ACTIVITIES		
Equipment acquired under a capital lease	$ 143,920	$ 169,400
Obligation for equipment acquired under capital lease	(143,920)	(169,400)
Equipment disposed of upon capital lease termination	-	(105,038)
Cancellation of debt upon termination of capital lease	-	105,038
	$ -	$ -

The accompanying notes are an integral part of these financial statements.

MENTAL HEALTH AMERICA

NOTES TO FINANCIAL STATEMENTS
For the Year Ended December 31, 2006

1. Organization and Summary of Significant Accounting Policies

Organization

The National Mental Health Association, organized in 1950, doing business as Mental Health America (MHA), is a private voluntary health and human services advocacy organization which promotes a wide range of mental health issues through advocacy leadership, public and professional education, community and consumer services, and ongoing research. MHA's primary sources of revenue are grants and contributions from foundations, government agencies and corporations and membership dues received from affiliated organizations nationwide.

Affiliates

Each of the mental health associations affiliated with MHA elects its own board of directors, conducts service programs independent of MHA, and maintains its own financial accounts. Accordingly, the financial statements of MHA do not include the accounts and activities of these affiliated organizations.

Cash and Cash Equivalents

MHA considers money market funds and certificates of deposit purchased with an original maturity of three months or less to be cash and cash equivalents. Money market funds held in certain investment portfolios are not considered cash and cash equivalents as these amounts are not available for the general operating purposes of MHA.

Inventory

Inventory is stated at cost on a first-in, first-out (FIFO) basis and consists of publications on hand at the end of the year.

Investments

Investments are comprised of federal home loan bonds, bond and equity mutual funds, equities and money market funds and are recorded in the financial statements at fair value. Investments include the board designated reserve fund, building reserve fund, the net property and equipment fund, the Jo Blaylock Memorial Fund, and funds that have been permanently restricted by the donor.

1. Organization and Summary of Significant Accounting Policies (continued)

Property and Equipment and Related Depreciation and Amortization

Fixed assets are recorded at cost. Furniture and equipment are depreciated using the straight-line method over the estimated useful lives of 3 to 7 years, with no salvage value. Equipment purchased under capital lease agreements is amortized on the straight-line basis over the life of the lease. Leasehold improvements are amortized over the shorter of the remaining term of the lease or the useful life of the improvements. Expenditures for major repairs and improvements are capitalized; expenditures for minor repairs and maintenance costs are expensed when incurred. Upon the retirement or disposal of assets, the cost and accumulated depreciation are eliminated from the respective accounts and the resulting gain or loss is included in revenue or expenses in the accompanying statement of activities.

Classification of Net Assets

The net assets of MHA are reported in three self-balancing groups as follows:

- Unrestricted net assets represent the portion of expendable funds that are available for support of MHA's operations. It also includes the net assets of the reserve fund, the building reserve fund, the net property and equipment fund and the Jo Blaylock Memorial fund, all of which have been designated by the Board of Directors. (See Note 8)
- Temporarily restricted net assets represent amounts that are specifically restricted by donors for various programs or use in future periods.
- Permanently restricted net assets represent amounts that include donor-imposed restrictions that stipulate that the resources be maintained in perpetuity and that only the earnings on such amounts be used in the manner specified by the donor.

Revenue Recognition

MHA reports gifts of cash and other assets as restricted support if they are received with donor stipulations that limit the use of the donated assets. When a donor-imposed restriction expires, that is, when a stipulated time restriction ends or purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the accompanying statement of activities as net assets released from restrictions.

Unrestricted contributions and grants are reported as revenue in the year in which payments are received and/or the promises are made. Revenue recognized on grants that have been committed to MHA, but have not been received, is reflected as grants and contracts receivable in the accompanying statement of financial position.

continued

MENTAL HEALTH AMERICA

NOTES TO FINANCIAL STATEMENTS
For the Year Ended December 31, 2006

1. Organization and Summary of Significant Accounting Policies (continued)

Revenue Recognition (continued)

Affiliate support is recognized in the period received or a written promise has been made.

MHA recognizes bequests in the year the promise to give becomes unconditional, which is at the time the probate court declares the will valid and the proceeds are measurable in amount.

In-Kind Contributions

Donated materials, services and facilities are recorded as in-kind contributions at the estimated fair market value as of the date of the donation.

Functional Allocation of Expenses

The costs of providing the various programs and other activities have been summarized on a functional basis in the accompanying statement of functional expenses. Accordingly, certain costs have been allocated among the programs and supporting services benefited based on direct costs.

Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

2. Grants and Contracts Receivable

Grants and contracts receivable include $385,000 of unconditional promises to give from foundations and corporations. Also included in grants and contracts receivable is $437,520 of grants and contracts receivable from U.S. government agencies which represents billings that have been presented to grantors but remain unpaid at year end or amounts available to be drawn down as needed by MHA. All amounts are considered fully collectible. $637,520 is due within one year and $185,000 is due within one to five years.

3. Bequests Receivable

Bequests receivable totaled $594,537 at December 31, 2006 and consists of trust agreements which are irrevocable and are administered by a trustee or fiscal agent. Distributions are to be made to MHA (lead trusts) or to the donor's designee (remainder trusts) during the terms of the agreements. At the end of the terms, a portion of the remaining trust assets, as defined in the trust agreements, are to be distributed to MHA. All amounts are considered fully collectible and due in one to five years.

4. Investments

Investments as of December 31, 2006 consisted of the following:

	Fair Value
Equity mutual funds	$1,701,788
Bond mutual funds	1,021,975
Federal home loan bonds	134,811
Money market funds	50,697
Equities	1,149
Total	$2,910,420

As of December 31, 2006, investment income consisted of the following:

Interest and dividends	$ 181,424
Unrealized gains	71,078
Realized gain	1,280
Total	$ 253,782

5. Property and Equipment and Accumulated Depreciation and Amortization

Property and equipment are comprised of the following as of December 31, 2006:

Office furniture and equipment	$ 704,724
Leasehold improvements	303,759
Equipment under capital lease	386,400
Total	1,394,883
Less: accumulated depreciation and amortization	(703,862)
Net property and equipment	$ 691,021

continued

6. Commitments

Operating Leases

MHA leases its office space under a non-cancelable operating lease that expires April 30, 2016. The lease provides for fixed annual rental increases. Under accounting principles generally accepted in the United State of America (GAAP) lease incentives are amortized over the life of the lease on a straight-line basis as an offset to rent expense. The difference between the GAAP rent expense and the required lease payments is reflected as deferred lease incentives in the accompanying statement of financial position. Under GAAP all rental payments, including fixed rent increases are recognized on a straight-line basis over the term of the lease. Rent expense has not been recorded on a straight-line basis in the accompanying financial statements as the difference is not material to the financial statements.

MHA also sub-leases a portion of the office space. Revenue from these sub-leases totaled $19,229 for the year ended December 30, 2006 and is included in rental income in the accompanying statement of activities. Total rent expense attributable to MHA's office space for the year ended December 31, 2006 was $446,767 and is included in occupancy expense in the accompanying statement of functional expenses.

The future minimum rental payments required under these operating leases, net of sub-lease income, as of December 31, 2006 are as follows:

For the Years Ending December 31,	Total	Sublease	Net
2007	$ 397,008	$ 16,200	$ 380,808
2008	406,933	-	406,933
2009	417,106	-	417,106
2010	427,534	-	427,534
2011	438,222	-	438,222
Thereafter	2,028,770	-	2,028,770
Total	$ 4,115,573	$ 16,200	$ 4,099,373

7. Capital Leases

MHA leases office equipment under three capital leases which expire at various times through 2010. The leased equipment is included in property and equipment at a cost of $386,400 with accumulated amortization of $89,204 as of December 31, 2006.

continued

7. Capital Leases (continued)

The future minimum lease payments required for these capital leases at December 31, 2006 are as follows:

For the Year Ending December 31,	
2007	$ 100,824
2008	100,824
2009	66,680
2010	33,772
Total future minimum lease payments	302,100
Less: amount representing interest	(11,152)
Present value of net minimum lease payments	290,948
Less: current portion	(95,251)
Long-term portion	$ 195,697

8. Net Assets

Board Designated Unrestricted Net Assets

The Board of Directors of MHA has designated certain unrestricted net assets for the purpose of establishing a reserve fund. The Board has approved a policy whereby the board approves annual contributions to the fund are made in an amount that equals 20% of the change in unrestricted net assets before depreciation. The Board of Directors may approve annual contributions in excess of the amount prescribed by the funding policy. The objective of the reserve fund is to stabilize the financial position by providing cash availability and asset growth and to provide a method of funding programs not supported by other funding sources. During the year ended December 31, 2006 an additional contribution of $313,000 was approved by the Board of Directors to be contributed to the fund.

MHA's Board has also designated the gain from the sale of its building in 2002 to be invested and used to purchase a new building in the future.

Also included in unrestricted net assets is a fund designated by the Board for property and equipment. This amount is calculated by subtracting the amount owed on property and equipment (i.e., the capital lease obligations) from the net book value of total property and equipment.

continued

MENTAL HEALTH AMERICA

NOTES TO FINANCIAL STATEMENTS
For the Year Ended December 31, 2006

8. Net Assets (continued)

Board Designated Unrestricted Net Assets (continued)

The Board of MHA has also designated unrestricted net assets to create the Jo Blaylock Memorial Fund. The fund was created to recognize Mr. and Mrs. Blaylock's contribution to mental health. The $50,000 initially designated plus any investment earnings thereon are to be used for educational purposes.

Temporarily Restricted Net Assets

Certain temporarily restricted net assets are available for use among the programs of MHA based on specific donor restrictions. Other amounts with donor restrictions that can be interpreted to cover more than one program were allocated to such programs based on prior years' experience. The amounts available as of December 31, 2006 are as follows:

Education	$ 352,026
Constituency services	457,161
Advocacy	851,870
Research	181,028
Total	$ 1,842,085

Permanently Restricted Net Assets

Permanently restricted net assets include the following:

- The Quayle Bequest which requires that the principal be invested in perpetuity and that only the income be expended to support the training and use of volunteers and/or to pay hospital attendants servicing those who are mentally ill.
- The Anna Belle Edwards Bequest which requires that the principal be invested in perpetuity and that only the income be expended to support research as to the cause and cure of mental illness giving attention to the therapeutic use of mega-vitamins for such illness.

Because the interest income earned on the above bequests is restricted for stated purposes, it is recorded as temporarily restricted revenue in the accompanying statement of activities and is released from restriction as the program restrictions are met. Interest income earned on permanently restricted net assets totaled $13,884 for 2006.

9. Line of Credit

MHA has a $1,000,000 secured revolving line of credit with Chevy Chase bank. The interest rate is calculated based on a 90 day London Interbank offered rate (LIBOR) plus 1.75% which, as of December 31, 2006, was 7.12%. The line of credit expires on September 30, 2007. As of December 31, 2006, there was no balance outstanding on this line of credit. MHA is required to meet various covenants in accordance with the terms of the agreement.

10. Pension Plan

MHA has a noncontributory, defined contribution retirement plan which is available to all employees who have completed one year of service and attained 21 years of age. Employer contributions are made to the plan according to the employee's years of service based on percentages as defined in the plan document. Employees are vested in the employer contributions according to the employee's years of service with MHA as defined in the plan document. Pension expense for the year ended December 31, 2006 totaled $48,355 and is included in salary and benefits on the accompanying statement of functional expenses.

11. Hotel Contracts Contingency

MHA has entered into agreements with several hotels for the provision of conference facilities and room accommodations for its meetings through June 2008. The agreements contain various clauses whereby MHA is liable for liquidated damages in the event of cancellation or lower than anticipated attendance. As of December 31, 2006, management of MHA has estimated that the maximum possible amount of liquidated damages is approximately $102,000. However, management of MHA does not believe that any losses will be incurred under these contracts.

12. Income Taxes

Under Section 501(c)(3) of the Internal Revenue Code, MHA is exempt from the payment of taxes on income other than unrelated business income. For the year ended December 31, 2006 no provision for income taxes was made as MHA did not have any net unrelated business income.

continued

MENTAL HEALTH AMERICA

NOTES TO FINANCIAL STATEMENTS
For the Year Ended December 31, 2006

13. Prior Year Summarized Financial Information

The accompanying financial statements include certain prior year summarized comparative information in total but not by net asset class. Such information does not include sufficient detail to constitute a presentation in conformity with accounting principles generally accepted in the United States of America. Accordingly, such information should be read in conjunction with the MHA's financial statements for the year ended December 31, 2005, from which the summarized information was prepared.

14. Reclassifications

Certain 2005 amounts have been reclassified to conform with the 2006 presentation.

Mental Health America
Consolidated Financial Report of Income & Expense Balance Sheet

This report is compiled by consolidating Mental Health America's and its affiliate's IRS Form 990s. This is an unaudited report.

SUPPORT & REVENUE	
Direct Public Support:	19,686,211
Contributions	5,148,550
Special Gifts	6,815
Grants(non-government)	18,000
Bequests	220
Membership Dues	28,038
Indirect Public Support	8,956,602
United Way	305,095
CFC	521
Chapter Support Received by State MHA	0
Government Grants	101,538,810
Federal Government Grants	86,140
State, Local Government Grants	853,356
Program Service Revenue	64,075,206
Membership Dues/Assessments	1,439,572
Interest (Savings/Temp. Cash Invest.)	653,654
Dividends/Interest (Securities)	931,503
Net Rental Income	426,652
Other Investment Income	16,132
Net on Sale of Assets	298,044
Net Income/Special Events	1,924,624
Net Sales Income	72,876
Other Revenue	2,131,626
TOTAL REVENUE	**208,598,246**
EXPENSES	
Program Services	179,823,470
Management & General	22,551,378
Fundraising	3,260,371
Payments to Affiliates	452,650
TOTAL EXPENSES	**206,087,869**
NET ASSETS	
Excess or (Deficit) for Year	2,510,378
Net Assets/Fund Bal. beg. Year	102,061,672
Other Changes Net Assets/Fund Balance	922,619
Net Assets/Fun Bal. end of Year	105,494,669

MENTAL HEALTH AMERICA
2006-07 LEADERSHIP

Board Officers

Sergio Aguilar-Gaxiola, M.D., Ph.D.
Board Chair
Sacramento, Calif.
Professor of Clinical Internal Medicine & Director
Center for Reducing Health Disparities/
University of California, Davis

Crystal Cook
Vice Chair, Public Affairs
Steamboat Springs, Colo.
Proprietor, Sol Day Spa

Joseph De Raismes, III, J.D.
Vice Chair, Public Policy
Boulder, Colo.
Attorney/Mental Health Advocate

Larry Fricks
Executive Committee Member-at-Large
Cleveland, Ga.
Director, Appalachian Consulting Group

Joel Hornberger
Vice Chair, Strategic Planning
Talbott, Tenn.
Chief Operating Officer
Cherokee Health Systems

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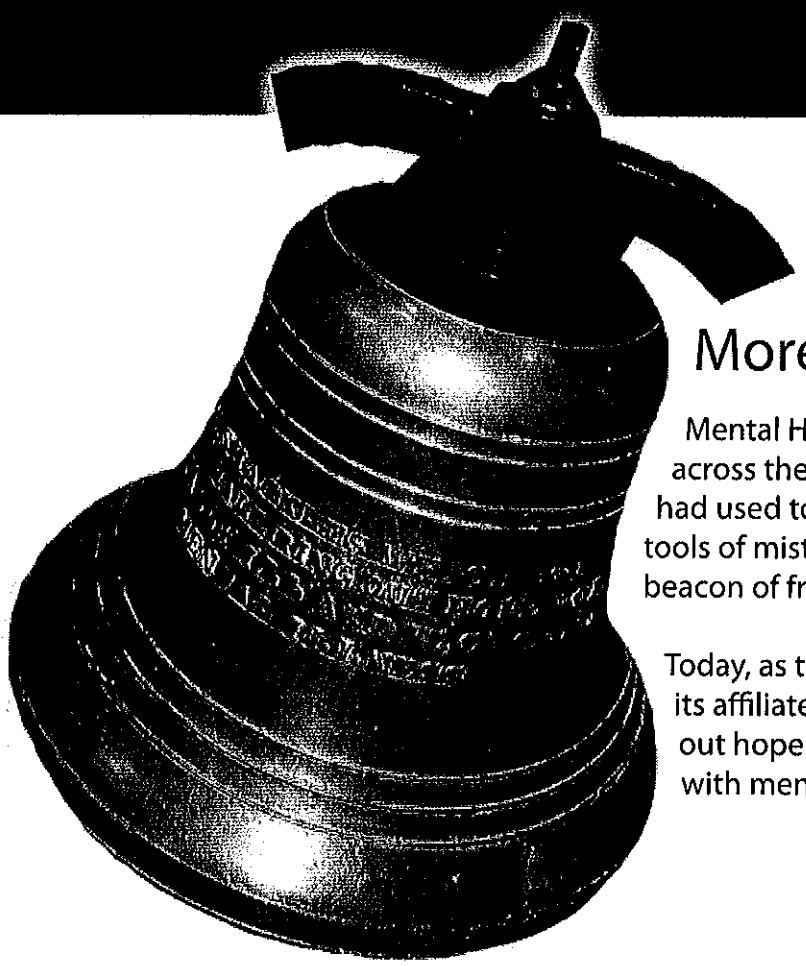
President and CEO
Crider Center for Mental Health

2006 Mental Health America
Annual Report



More than 50 years ago,

Mental Health America issued a call to asylums across the country for the chains and shackles they had used to restrain patients. We then took these tools of mistreatment and forged them into a powerful beacon of freedom: the 300-pound Mental Health Bell.

Today, as the symbol of Mental Health America and its affiliates, the Mental Health Bell continues to ring out hope for the millions of people who are living with mental illnesses.

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Mental Health America

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changing minds.
changing lives.

mental health america

annual report 2007

Mental Health America

Table of Contents

Who Are We?

Mental Health America (formerly the National Mental Health Association) is the country's leading nonprofit dedicated to helping all people live mentally healthier lives. With our more than 320 affiliates nationwide, we represent a growing movement of Americans who promote mental wellness for the health and well-being of the nation—every day and in times of crisis.

Mental Health America Vision

Mental Health America envisions a just, humane and healthy society in which all people are accorded the respect, dignity and the opportunity to achieve their full potential free from stigma and prejudice.

Mental Health America Mission

Mental Health America is dedicated to promoting mental health, preventing mental disorders and achieving victory over mental illnesses through advocacy, education, research and service.

www.mentalhealthamerica.net

Welcome to our 2007 Annual Report

The strength of Mental Health America is evidenced in so many ways throughout our 300-plus affiliate network. Each and every year, our affiliates provide critical and ongoing support to millions of mental health consumers and their families. Recognizing shifting and changing attitudes, Mental Health America is charting a vital course and we are determined that by educating communities and affecting significant life improvements, we can and we are ***"Changing Minds. Changing Lives."***

To understand the scope of our affiliates' contributions and dedication, in both large and small communities throughout the United States, in this 2007 Annual Report we are highlighting three affiliate signature programs as well as profiles of mental health consumers whose lives have been vastly improved by the participation in these affiliate programs. These individual profiles help emphasize our sense of urgency to reach out to a greater number of persons with mental health and substance use conditions.

2007 witnessed exceptional progress on the legislative front. Mental Health America worked with Congressmen Patrick Kennedy and Jim Ramstad, who sponsored mental health parity legislation in the U.S. House of Representatives, and with affiliates across the country to mount a series of field hearings to document the need and support for a federal insurance parity bill. Thanks to the efforts of our Mental Health America affiliates, these hearings galvanized support and gave the Paul Wellstone Mental Health and Addiction Equity Act, H.R. 1424, a powerful launch that paved the way for a historic first vote in the House on a comprehensive mental health/addiction parity bill. In early 2008, this landmark legislation passed the House of Representatives by a vote of 268 to 148. Mental Health America also helped to shape and win support for S. 558, the Senate parity bill, which chamber passed unanimously in September 2007.

In late 2007, Mental Health America called for significant policy changes with the release of its new report, "Ranking America's Mental Health: An Analysis of Depression Across the States," which for the first time linked each state's mental health status and suicide rates to the ability of its residents to access care.

Through our national office staff's concerted and strategic efforts as well as our affiliates' innovative grass-roots programs " – from healthcare policy, to access to individualized care and appropriate treatment – we will continue on our unwavering path to ***"Changing Minds. Changing Lives."***

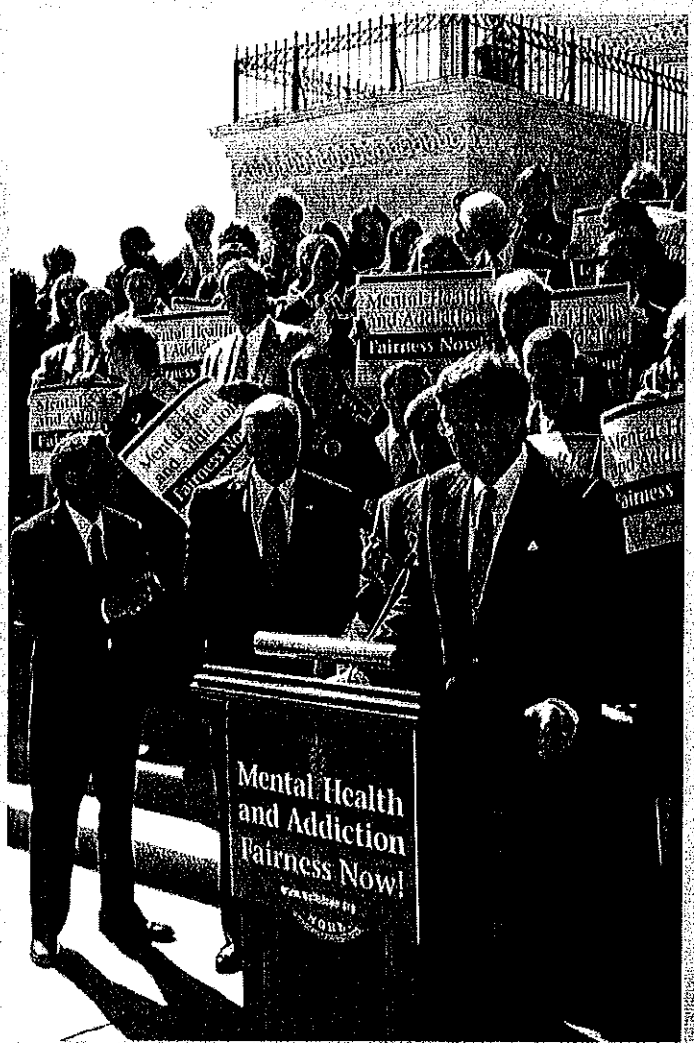
David L. Shern, PhD
President and CEO

Sergio Aguilar-Gaxiola, MD, PhD
Chair of the Board

Advocacy

Public Policy and Advocacy

Mental Health America works at the federal and state levels to advocate for access to effective care and to end discrimination against people with mental and addictive disorders. We do this through community systems change and direct advocacy. Nationally, Mental Health America utilizes direct advocacy and coalition partnerships and broad public grassroots campaigns to shape the tone and content of federal policies affecting mental health issues, and redirect the national debate to embrace mental health as one of the top public health issues. Mental Health America's Healthcare Reform Advocacy Training works with state and local affiliates to provide issue education, fosters cross-germination of strategies and model policies, and builds coalitions that are broad-based and supported through the planning and execution of targeted action plans around specific issues.

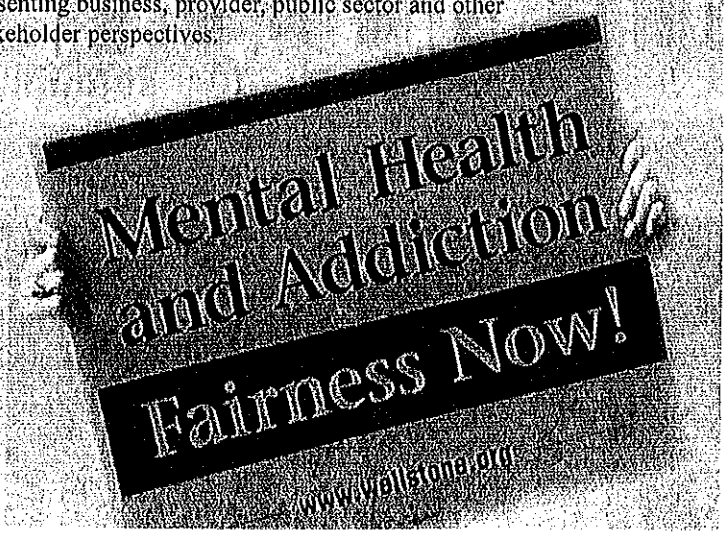


Mental Health Parity

Congressional Field Hearings

Reflecting the strength and depth of our affiliate field, Mental Health America worked with Congressmen Patrick Kennedy and Jim Ramstad, who sponsored mental health parity legislation in the House of Representatives, and with affiliates across the country to mount a series of field hearings to document the need and support for such legislation. The hearings – which took place early in 2007 – set the stage for Congressional committees to consider parity legislation with an eye to its passage in the 110th Congress.

The hearings took place over three months in virtually all regions of the country, with particular emphasis on key media markets and important legislative districts. Mental Health America affiliates – working with Mental Health America, local congressional offices, and community partners – participated in all phases of planning, from identifying witnesses and developing testimony to securing venues and publicizing the event. Each hearing was unique in highlighting poignant consumer accounts, profiling local needs, documenting the cost of not providing parity, and presenting business, provider, public sector and other stakeholder perspectives.



In addition, the hearings gave visibility to the leadership and coalition-building roles of the local Mental Health America affiliates, and further cemented ties between Mental Health America, local congressional offices, media and others.

Thanks to the efforts of our Mental Health America network, these hearings gave the Paul Wellstone Mental Health and Addiction Equity Act, H.R. 1424, a powerful launch and paved the way for a historic first vote in the House of Representatives on a comprehensive mental health/addiction parity bill. This landmark legislation passed the U.S. House of Representatives on March 5, 2008, by a vote of 268 to 148.

Mental Health America also played an active part in helping shape and winning support for S. 558, the Senate parity bill, which chamber passed unanimously in September 2007.

Parity–State Children's Health Insurance Program (SCHIP)

Mental Health America led the charge to include a mental health parity requirement in SCHIP plans, highlighting the fact that many states impose discriminatory benefit limits on mental health services in their State Children's Health Insurance Program (SCHIP) plans – including limits on inpatient care and outpatient visits. This advocacy effort, which was mounted in the context of a broader effort to reauthorize SCHIP, was very successful. Final SCHIP reauthorizing legislation that passed the House and Senate in 2007 incorporated this new ban on discriminatory limits on mental health care for children.

Unfortunately, President George W. Bush vetoed the reauthorization bill, and Congress was unsuccessful in overriding that veto. However, as a result of Congress including this provision in the bill it passed, we are very well positioned to see mental health parity again included when Congress resumes consideration of SCHIP.

Medicare

Mental Health America has also been a leader in calling for legislation to repeal Medicare's 50-percent coinsurance rate for outpatient mental health services. The higher out-of-pocket cost constitutes a substantial barrier for many Medicare beneficiaries in need of mental health services. Research by Substance Abuse and Mental Health Services Administration indicates that as a result of this obstacle to accessing outpatient services, Medicare beneficiaries are more likely to utilize costly inpatient care. We advanced our goal last year when the House passed Medicare legislation that reduced the 50-percent coinsurance rate to the 20-percent rate that generally applies to outpatient services. Here too, advocacy has moved the ball further than ever, providing a greater foundation for overturning this inequitable provision in future Medicare bills.

In 2007, the passage and/or implementation of strong parity legislation in New York, Ohio, Colorado, and North Carolina significantly expanded access to mental health insurance coverage. This is a growing awareness and acceptance that all people in America should have a right to health care benefits, including needed behavioral health services.

FY 2008 Mental Health Funding

Among the advocacy challenges we faced in 2007 was maintaining adequate federal funding for mental health programs in the face of an Administration budget that proposed severe cuts in 2008. As a leader in the broader public health (Coalition for Health Funding Board Member) and disability communities (Consortium for Citizens with Disabilities Board Member), Mental Health America helped spearhead efforts that opposed those deep cuts and pressed Congress to increase funding for mental health supports and services, and other public health discretionary spending. These efforts included mounting congressional briefings, drafting "Dear Colleague" letters on behalf of congressional champions, generating coalition letters signed by a large swath of the broader public health and disability communities, and engaging our affiliates to weigh in with their elected officials. For example, Mental Health America helped draft a letter that was ultimately endorsed by over one thousand groups in support of the congressional funding levels. Although the House and Senate passed Labor, Health and Human Services Appropriations bills, which funds the bulk of mental health services and supports, by overwhelming margins (66 percent of the House and 75 percent of the Senate supported their bills), the President vetoed this bill and the House failed to override the veto by one vote.

In the end, the final FY 2008 funding package averted the steep cuts we had fought. Although the initial advocacy gains in human services were derailed by a veto that came within one vote of being overridden, they nevertheless have helped build a base of support for important programs among members of the House and Senate for future budget and appropriations.

Improving Veterans' Access to Mental Health Services

For years, Mental Health America and its affiliates have been at the forefront of advocacy for meeting the mental health needs of returning service-members. In April 2007, Mental Health America

testified on this issue at a hearing before the Senate Committee on Veterans' Affairs. Our testimony offered a series of specific recommendations that were ultimately reflected in the Mental Health Improvements Act of 2007 (S. 2162) adopted by the Committee in November 2007.

Mental Health America also moderated a Senate Mental Health Caucus-sponsored briefing and, building on the recommendations reflected in our Senate testimony, worked with Senator Pete Domenici to develop legislation to improve veterans' access to mental health services. That legislation, the Veterans' Mental Health Outreach and Access Act, S. 38, calls for the Department of Veterans Affairs (VA) to establish a national program for training returning veterans to provide outreach and peer-support services to other returning veterans, and to contract with community mental health centers in areas where returning veterans cannot reasonably access VA mental health care. Working with leaders of the House Committee on Veterans' Affairs, Mental Health America won adoption of these provisions, which were included in House-passed Veterans' Health Care Improvement Act, H.R. 2874.

Mental Health America's call for the VA to foster the use of peer-outreach services and partnerships with community providers was supported by a number of major national veterans' organizations, and was reflected in congressional appropriations' report language.

Across the country Mental Health America affiliates are working with state legislatures who want to be there for returning veterans and their families who need help. Most bills addressed funding for prevention outreach and service activities to fill the gap for veterans who are geographically isolated from VA services. A special area of interest is with returning members of the National Guard. Affiliates like the Mental Health America of North Carolina were active in gaining support for the Citizen-Soldier Support Program, a community-based initiative aimed at mobilizing community organizations and services to support and strengthen local citizen soldiers, their families and loved ones.

Protecting Access to Mental Health in Medicaid

In 2007, a growing number of new federal and state policies sought to reduce health care costs and extend limited coverage to the uninsured. The trend led to the increased use of Medicaid waivers, and new options under the Deficit Reduction Act reduced access to vital mental health services. There was a clear need to provide Mental Health America affiliates and other mental health advocates with the tools to influence reform discussions before mental health and addiction treatment services were scaled back.

In response, Mental Health America's Healthcare Reform Department facilitated multiple state-level strategy meetings and technical assistance to help advocates across the country successfully educate and engage policy leaders on how to protect access to mental health services. Mental Health America worked with advocates in Louisiana, Indiana, West Virginia, California and elsewhere to develop and support sensible reforms of the Medicaid benefit.

In fact, West Virginia stakeholders were so empowered to communicate Medicaid reform concerns to the public and policy leaders that their efforts led to an inclusion of mental health services in new benefit packages.

By assisting states in advocating for mental health, Mental Health America has contributed to the growing capacity of the field to address increasingly complex reforms and to build and sustain relationships that will enable us to bring mental health to the forefront of the healthcare debate.

In Washington DC, Mental Health America and other advocates – facing the prospect of severe Medicaid cutbacks – succeeded in pushing Congress to delay implementation of dramatic Administration-initiated regulatory changes to Medicaid reimbursement policy for rehabilitative and school-based administrative services. The proposed regulations on rehabilitative services would have limited access to community-based care for children and adults with mental health conditions. In addition, school personnel could no longer help low-income children with mental health needs sign up for Medicaid or help coordinate their care across multiple agencies. An intensive education and advocacy effort resulted in Congress halting implementation of these regulations for six months. That important action was included in legislation that also averted cuts to Medicare physician payments, and provided advocates needed time to prevent lasting damage to this important program.

Building our Grassroots Movement

In 2007, Mental Health America undertook a major initiative to develop an online community to promote awareness of mental health issues and increase constituent participation in federal and state advocacy campaigns. The end result, the Advocacy Network, provides a venue for individuals who want to know more about mental health and wellness, who understand the issues confronting our nation and communities and who want to take action to help everyone's mental health and wellness.

In 2007, Mental Health America engaged a growing movement of advocates to take action on federal and state advocacy campaigns. More than 4,300 Americans signed the ***Vision for Change*** petition calling on Congress to make mental health a priority, over 321,000 emails and faxes were sent to Congress and state legislatures, and Mental Health America grew its constituency by 66 percent.

In addition to organizing national advocacy, Mental Health America is establishing State Advocacy Networks that allow affiliates to grow the number of individuals taking action on state level policy issues. Mental Health America is providing affiliates with state of the art tools, intensive technical assistance and resources to guide the development of state sites through strategic content consultation, technical design, and project planning. Working together with our affiliate field, Mental Health America continues to grow and engage the grassroots community in support of mental health and wellness for the entire country.

Evidence-Based Healthcare

Mental Health America is leading efforts to ensure more powerful consumer involvement in national and state initiatives designed to improve quality of care. A core activity of many of these initiatives is the review, interpretation, and dissemination of information about scientific research that consumers, clinicians and policymakers use to make decisions about health care delivery and coverage. Comprised of more than 40 consumer, caregiver, practitioner and researcher organizations, **the National Working Group on Evidence-Based Healthcare** (the Working Group) is committed to promoting accurate and appropriate evidence-based policies and practices that improve the quality of healthcare services in the United States.

THE NATIONAL WORKING GROUP ON
EVIDENCE-BASED HEALTH CARE

In 2007, Mental Health America successfully promoted wider recognition of the patient/consumer perspective and the importance of consumer and clinician inclusion in all dialogues about evidence-based healthcare including:

• A patient/consumer-focused forum, "Nothing About Us Without Us: Patient / Consumer Participation in Evidence-Based Health Care," to highlight international and U.S. models for including patient/consumer perspectives in the development, review and dissemination of evidence about effectiveness, safety and benefits and risks of health care interventions.

• A white paper titled "Rebalancing Evidence-Based Healthcare: The Central Role of Patients and Consumers."

• Congressional testimony and comment on patient/consumer concerns in comparative effectiveness research.

• Media messages and Power Point presentations to enable participating organizations to communicate with their constituencies about this complex topic.

Mental Health America and the Working Group's efforts have yielded important results, including wider recognition of the patient perspective and the importance of inclusion and ensuring that patient perspectives are represented in research, academic and policy dialogues about evidence-based healthcare.

Strategic Technical Assistance

During 2007, Mental Health America continued to inform and coalesce mental health stakeholders across the country to articulate alternative policies, identify financing mechanisms and implement community-led strategies that promote a quality-focused system of health care for children, youth, adults, older adults and families. Mental Health America's strategic technical assistance offers a "war room" of rapid support to grassroots coalitions fighting advocacy battles across the country. Examples of direct technical assistance include analysis of legislation, fact sheets, assistance developing talking points or testimony, research and model legislation. Strategic response technical assistance continues to demonstrate positive outcome successes.

As the pressure and ability to innovate at the state and local policy levels increases, mental health advocates continue to confront challenges in sustaining a steady program of education, outreach and engagement tools that keep policymakers focused on mental health as a priority issue. The Healthcare Reform Program will continue to meet the challenge with a concerted initiative focused on policymaker education and engagement.

Public Education

Driven by a passion to improve the mental well-being of all Americans, Mental Health America works tirelessly to effect positive nationwide change in knowledge, attitudes and behaviors of mental health issues. Our communications and educational campaigns focus on directing individuals to appropriate mental health services, informing all Americans of the need for quality mental health care and constantly battling the stigma of mental health issues that hinder millions of Americans from seeking needed treatment.

Through our educational efforts, Mental Health America integrates the message of "mental wellness for a lifetime" into all its public educational activities. We strive to create an enlightened environment in which people feel comfortable seeking help, providers are able to deliver quality services and policymakers will have the knowledge and will to support pro-mental health measures. Mental Health America is committed to achieving mental health for everyone, every day and in times of crisis. Every step of the way, we are ***"Changing Minds. Changing Lives."***

2007 Mental Health Month

For more than 50 years, our country has celebrated Mental Health Month in May to raise awareness about the importance of mental wellness for all and to educate the public about mental illnesses.

The theme for the 2007 observance was MIND Your Health with a focus on three objectives: (1) Raise awareness about the potential health implications of severe mental illness among consumers (as well as families and providers) and the importance of adopting a recovery and wellness lifestyle; (2) Build broad public recognition around the role of mental health to overall health and the factors that promote mental wellness; and (3) Highlight the importance of developing community-based approaches to addressing children's health and wellness.

A number of activities were held by the national office to recognize the Mental Health Month observance, including aggressive national media outreach and participation in a Children's Mental Health Awareness Day event on May 8 on Capitol Hill. Mental Health America developed a variety of public education, media and advocacy materials for affiliate organizations and the general public. Select publications include a poster highlighting the detrimental effects of stress on the body, new fact sheets, including Staying Well When You Have a Mental Illness and Managing Life's Challenges, and print and radio Public Service Announcements.

Mental Health America also developed A Guide to Effective Public Education Programming, which features a program planning framework, planning and evaluation tools, outreach ideas, media outreach tips and other resources to help organizations plan Mental Health Month and year-round activities.

What Does Gay Mean?

In 2002, Mental Health America embarked on an effort to address the significant mental health impact of anti-gay prejudice. "What Does Gay Mean?" was an initiative developed to raise awareness about the damaging mental health effects of bullying and help parents teach their children tolerance and respect for all people.

As part of this initiative, Mental Health America developed the booklet, "What Does Gay Mean?", a resource for parents looking for guidance on how to talk to their children about diversity in a sensitive, age-appropriate manner.

In 2007, in an effort to reach culturally-diverse audiences, the program focused specifically on outreach to Latino communities. Mental Health America developed a Spanish adaptation of the booklet, "What Does Gay Mean?" The new publication, "Qué Significa Ser Gay?" was distributed to Mental Health America's affiliates, partner organizations and to the general public through Mental Health America's Resource Center.

As part of this effort, Mental Health America issued grants to three Mental Health America affiliates actively working with the Latino community in their areas to support community events, such as parent education workshops and skills building sessions, in addition to media outreach. Grantees included:

• **Mental Health Association in North Carolina** held workshops for Latino women on the topic of bullying, particularly around issues of sexual orientation. They also held a workshop on bullying at their Annual Latino Women's Conference, with attendance of over 150 participants.

• **Mental Health Association of Montgomery County, MD** conducted educational workshops for Latino parents and youth to address the damaging mental health effects of bullying, to foster the mental wellness of youth who are victims of bulling, to improve understanding and respect for youth who are gay/lesbian/bisexual/transgender, and to help parents discuss issues of sexual orientation in an appropriate way.

• **Mental Health Association of New York City** held workshops for Latino parents to address issues related to bullying of gay youth and offered workshops for Latino parents of lesbian, gay, bisexual and transgender youth to focus on how parents can help their children who have been bullied because of sexual orientation and protections offered to their children under New York City and State Law.

Mental Health America also conducted a national public opinion survey of over 500 Latino parents to better understand their attitudes and communication with their children about bullying, sexual orientation and prejudice. Mental Health America conducted media outreach and held a media telephone briefing to highlight the findings from the survey. The teleconference featured Mental Health America Board Chair Dr. Sergio Aguilar-Gaxiola and Jesus Sanchez, project manager at Youth in Focus in California, who spoke during the conference about his personal experiences growing up a gay Chicano youth.

Post-Traumatic Stress Disorder (PTSD) Fact Sheet

Mental Health America developed a new online resource on Post-Traumatic Stress Disorder. This publication includes information on the signs and symptoms of PTSD, treatment, helping a family member who has PTSD, personal stories and an "Ask the Expert" column featuring David Riggs, PhD, an expert on trauma and PTSD and Executive Director of the Center for Deployment Psychology at the Uniformed Services University of the Health Sciences.

Campaign for America's Mental Health

The Campaign for America's Mental Health (Campaign) is Mental Health America's comprehensive effort to improve Americans' awareness, attitudes and behaviors regarding mental health and mental health conditions. In 2007, Mental Health America worked closely with nearly 60 affiliate Campaign sites to organize and conduct local educational, screening and media activities, which resulted in more than 90 million local media impressions and more than 2 million people educated at 3,926 events.

In addition to local outreach, Mental Health America embarked on a comprehensive research effort to inform the development of a new focus for the Campaign, to roll out in 2008. Mental Health America based its research strategy on key principles of social marketing and sought to determine:

- How wellness is understood
- How individuals perceive wellness in relation to mental health and overall health
- What words, phrases and ideas have meaning when communicating about mental health in a wellness framework
- What people do (or plan/try to do) on a daily/regular basis to stay/feel well

Phase one research activities include an environmental scan; literature review of medical, public health, and social sciences journals; 28 in-depth interviews with Mental Health America and affiliate staff, Board Members, consumers and external experts; two focus groups; and an online survey. From this research, Mental Health America identified the Campaign's target audience as people who are experiencing extreme life stress, are concerned about their mental health and may be seeking solutions to improve it. Phase two of the research was designed to test message concepts and appeals and involved four additional focus groups; two phone discussions with affiliates; and two online surveys. This research revealed the need for a Campaign with an empowering, positive focus on resiliency and wellness to overcome individuals' reluctance to address mental health concerns. Campaign development will continue in 2008.

2007 Public Education Institute

In January 2007, Mental Health America held its annual Public Education Institute, Building a Culture of Mental Wellness, a training conference for affiliates designed to strengthen efforts

around mental health promotion and prevention. The conference – attended by nearly 100 participants – featured renowned experts and advocates from around the country, including representatives from the Centers for Disease Control and Prevention, the Lance Armstrong Foundation and the University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School. Highlights of topics covered include social marketing, message development and consumer wellness and recovery.

Dialogue for Recovery

Through the Dialogue for Recovery (DFR) educational initiative, Mental Health America seeks to enhance recovery, health and quality-of-life for individuals with severe mental health conditions. The program works to improve communication between mental health consumers, their healthcare providers, family members and others to support an individual's empowerment and recovery. Through DFR, Mental Health America and its affiliates in 2007 generated over 85 million local media impressions and educated more than 1.5 million people at over 3,800 local educational events.

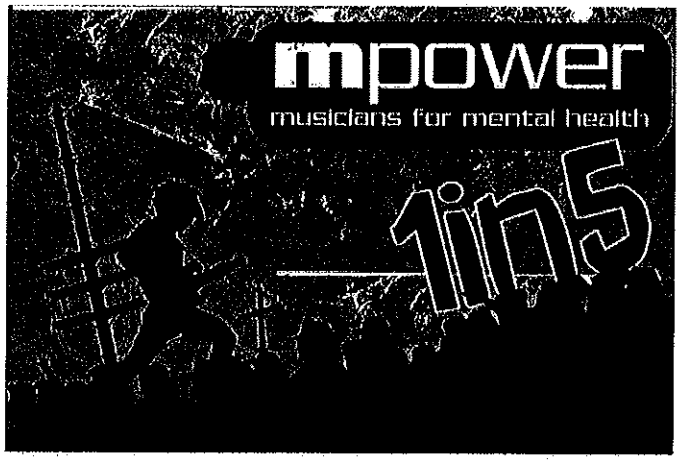
Dialogue for Recovery Video

In 2007, Mental Health America worked with Horizons TV, Inc. through a grant from the Shelby Cullom Davis Foundation to produce a 20-minute documentary DVD featuring the real stories and experiences of four consumers in recovery. Mental Health America staff recruited local consumers with severe mental illnesses and asked them to share their experiences with recovery through one-on-one on-camera interviews. The resulting 20-minute video is designed to promote the message that recovery is possible and is intended for use in recovery-focused workshops and trainings, presentations and at conferences. The b-roll footage may also be used in public service announcements and in other media outreach.

Smoking Cessation

In 2007, Mental Health America, through a grant from the Smoking Cessation Leadership Center, surveyed its affiliate field to determine the readiness of Mental Health America and its affiliates to adopt smoking cessation as a programming priority. The online survey was designed to assess affiliates' awareness and attitudes about the issues of smoking and smoking cessation among people with severe mental health conditions.

The online survey revealed that Mental Health America's affiliates are interested and supportive of smoking cessation and prevention, and are open to adopting these areas given the right information and resources. In addition to the survey, Mental Health America developed a myths and facts fact sheet for its affiliates to shed light on the magnitude of the issue of smoking among consumers. The final survey report and fact sheet will be released in 2008.



Mpower Awards

Mpower is a youth outreach initiative of Mental Health America that uses the power and influence of music to talk about mental health in a language that truly resonates with youth. Through an edutainment format, Mpower aims to raise awareness and change youth attitudes about mental health, fight stigma, and empower youth to get informed, get help and get involved.

As part of Mpower, Mental Health America gives out Mpower Awards each June during its Annual Meeting. The awards recognize and encourage the important work of young mental health advocates around the country. At its Annual Meeting in June 2007, Mental Health America presented six outstanding youth with Mpower Awards for their exceptional efforts to raise mental health awareness and reduce stigma among their peers. Award recipients include musician, Lindsay Rush, 21, New Hope, PA; Serena Iacono, 23, Minneapolis, MN; Stacy Hollingsworth, 23, Old Bridge, NJ; Liz Kollaja, 18, Jenks, OK; Andy Werlein, 21, Waukesha, WI; and Alexis Chappell, 23, Washington, DC.

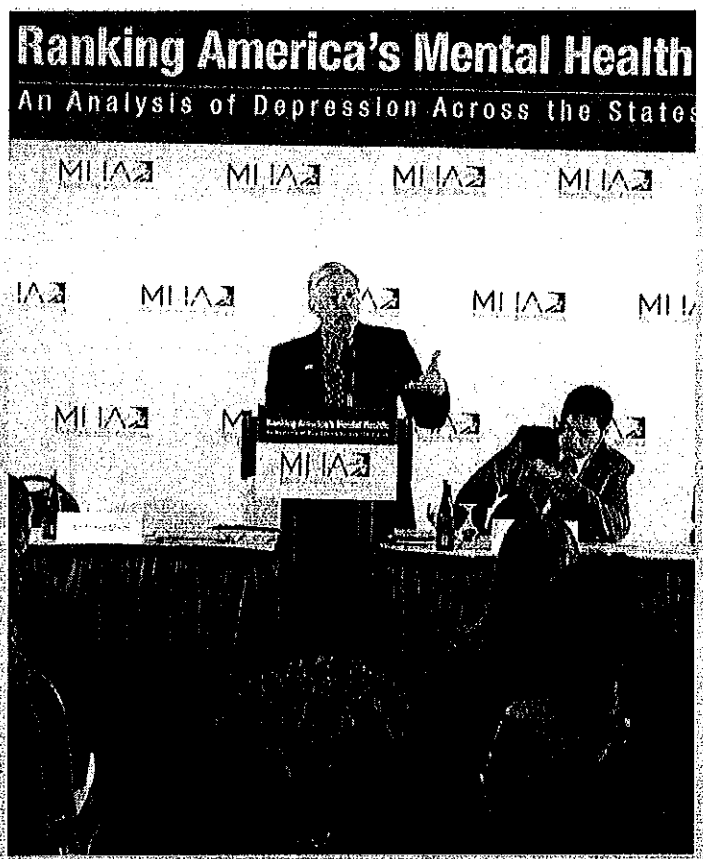
Mental Health America Promotes Accurate Media Coverage of FDA Warning on Antidepressants

In 2007, Mental Health America worked to educate the media and the general public about the danger of untreated depression and the implications of an expanded FDA "black box" warning on SSRI antidepressants. Mental Health America spearheaded the Coalition for Constructive Coverage – a coalition of mental health advocacy and public education organizations – which was

formed in late 2006 to promote balanced coverage of the FDA hearings. In 2007, the Coalition developed media strategies and common messages, identified mental health consumers and other representatives for media opportunities and promoted the views of national mental health experts to ensure fair and balanced coverage of the FDA's decision and other mental health issues. Coalition member organizations appeared in numerous media outlets including the *New York Times, USA Today* and many others.

As a result of the Coalition's activities and Mental Health America's leadership, the FDA acknowledged that untreated depression is the biggest risk for suicide and decided not to extend the "black box" warning to all ages.

Mental Health America also played a leading role in publicizing new CDC data showing a dramatic increase in suicide deaths among youths, which researchers believe may be related to a 2004 FDA decision to place "black box" warnings on antidepressants for youth. Researchers are currently investigating the association between the suicide increase – the largest in the years 1990 to 2004 – and falling antidepressant prescription rates surrounding the FDA's decision.



Mental Health America Responds to Virginia Tech Shootings

In the days following the tragic shootings at Virginia Tech on April 16, Mental Health America and its affiliates sprang to action, educating the public and aiding people through their grief and shock.

Affiliates across the country quickly disseminated resources to help students, parents and educators respond to and cope with the tragedy. Mental Health America, the only national mental health organization to speak out about the tragedy, moved quickly to put our crisis communications into effect. Through interviews with major media outlets such as CBS, "ABC World News with Charles Gibson," the *New York Times,* the "Diane Rehm Show" and the Fox News Channel, we helped to ensure that the public dialogue stayed on a constructive – not destructive – path. Our messages worked to counter the myth associating mental illnesses with violence, and included a warning to the public to avoid diagnosing or profiling others on the basis of the gunman's mental health.

Mental Health America Report Links States' Depression Status to Access to Care

In November 2007, Mental Health America called for significant policy change with the release of its new report, *Ranking America's Mental Health: An Analysis of Depression Across the States,* which for the first time linked each state's mental health status and suicide rates to the ability of its residents to access care.

In general, the Ranking of America's Mental Health Report found that states that offer more access to mental health services have lower rates of depression and suicide than states with more limited access to care. The study ranked all 50 states and the District of Columbia based on rates of depression and suicide using national data.

"The take-home message from this study is that access to care makes a difference," said Dr. David Shern, PhD, president and CEO of Mental Health America, at a Nov. 28 press briefing at the National Press Club in Washington, DC. "One of our goals with this report is to close the gap between science and availability of services."

While a number of factors including biology and environment impact an individual's mental health, this study shows that states can significantly improve their populations' mental health status by adopting policies that expand access to mental health treatments.

In "Ranking America's Mental Health," Mental Health America found statistically significant associations between the following factors and better depression status and lower suicide rates:

• **Mental health resources:** On average, the higher the number of psychiatrists, psychologists and social workers per capita in a state, the lower the suicide rate.

• **Barriers to treatment:** The lower the percentage of the population reporting that they could not obtain health care because of costs, the lower the suicide rate and the better the state's depression status. In addition, the lower the percentage of the population that reported unmet mental health care needs, the better the state's depression status.

• **Mental health treatment utilization:** Holding the baseline level of depression in the state constant, the higher the number of antidepressant prescriptions per capita in the state, the lower the suicide rate.

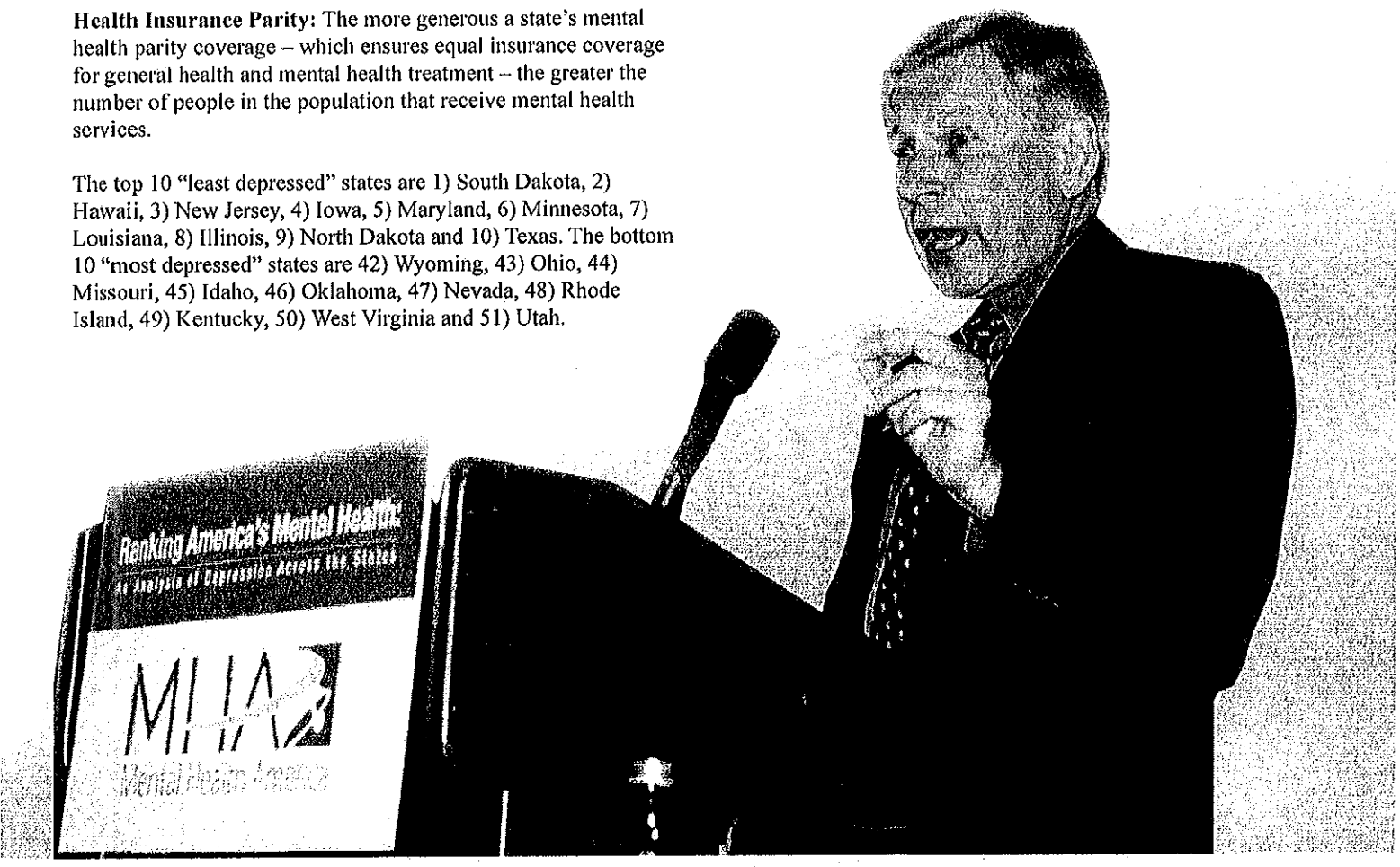
• **Socioeconomic Characteristics:** The more educated the population and the greater the percentage with health insurance, the lower the suicide rate. The more educated the population, the better the state's depression status.

Health Insurance Parity: The more generous a state's mental health parity coverage – which ensures equal insurance coverage for general health and mental health treatment – the greater the number of people in the population that receive mental health services.

The top 10 "least depressed" states are 1) South Dakota, 2) Hawaii, 3) New Jersey, 4) Iowa, 5) Maryland, 6) Minnesota, 7) Louisiana, 8) Illinois, 9) North Dakota and 10) Texas. The bottom 10 "most depressed" states are 42) Wyoming, 43) Ohio, 44) Missouri, 45) Idaho, 46) Oklahoma, 47) Nevada, 48) Rhode Island, 49) Kentucky, 50) West Virginia and 51) Utah.

The media response was overwhelmingly positive, resulting in an exclusive print story in *USA Today* and an exclusive broadcast story on *CNN: American Morning.* Wire story coverage took on lives of their own, re-running in dozens of publications and on cable and network news. **Overall, the coverage resulted in approximately 70 million media impressions across 87 markets in 40 states.** There were 37 print and wire stories, including five editorials, and 199 television segments/reads on 123 stations, with 181 mentioning Mental Health America. *CNN* and *CNN: Headline News* mentioned the story 11 times in a three-day period. Dr. Shern also participated in a Radio Media Tour with 12 radio stations.

Overall, Mental Health America doubled its annual media coverage from approximately 1 billion media impressions to more than 2 billion in 2008. Three key events/activities were contributors to this increased media coverage: the Coalition for Constructive Coverage (led by Mental Health America) strategic media relations efforts around the black box warnings, the tragic shootings at Virginia Tech, and the States of Depression Project.



Affiliate Services

Mental Health America works in partnership with its more than 320 state and local affiliate organizations to promote mental wellness for the health and well-being of the nation through advocacy, education, research and service. Through the many efforts and outreach programs of the National Office, individual affiliates are connected to the entire Mental Health America network and the mental health movement. State and local affiliates bring together mental health consumers, family members and supporters of consumers, service providers and other advocates for collaboration and action. By communicating regularly with the National Office and each other, MHA affiliates can share ideas, challenges and best practices to help meet the needs of their communities.

In 2007, Affiliate Services and Relations launched two new programs in response to an overwhelming need by the field to both prepare new leaders and new affiliates for success, and to increase shared and effective learning opportunities among the affiliate membership.

Class of 2007 – Bell 101

In January 2007, Mental Health America's Affiliate Services Department created the BELL 101: Class of 2007 program. BELL 101 is a year long education and networking program targeting potential and renewing affiliates. The goals of the BELL 101 program are:

One: To provide affiliates with the best possible platform and grounding to become successful, stable and effective agents of health and wellness in their communities.

Two: To provide a stronger presence throughout the country capable of meeting and supporting our national mission, vision, values and purpose.

In the past, we had received many calls and letters of interest in starting or becoming an affiliate from a variety of sources, varying in size, location, member composition, focus of interest and outreach. This program is a way to get these fledgling organizations involved in our movement and assist them in their organizational development. The program is also a way to rejuvenate older affiliates who may have a new executive director who needs extra technical assistance and support to grow in his/her position.

Accomplishments

The 15 members of the Class of 2007 completed 22 hours of classes, covering all 8 categories from our Standards of Affiliation. Faculty for these classes consisted of National staff members and affiliate field staff. The curricula consisted of many of the materials developed for the Mental Health America Mission Kit, along with supplemental materials supplied by different departments within the organization.

The participants in this program were from 12 states and represented 8 renewing affiliates and 6 potential affiliates. Of the potential affiliates, three became chartered member affiliates in January 2008, Central California, Southern Nevada, and San Diego (Calif.). A fourth organization also joined in November 2007, Mental Health Association of Fauquier County.

National Staff Institute

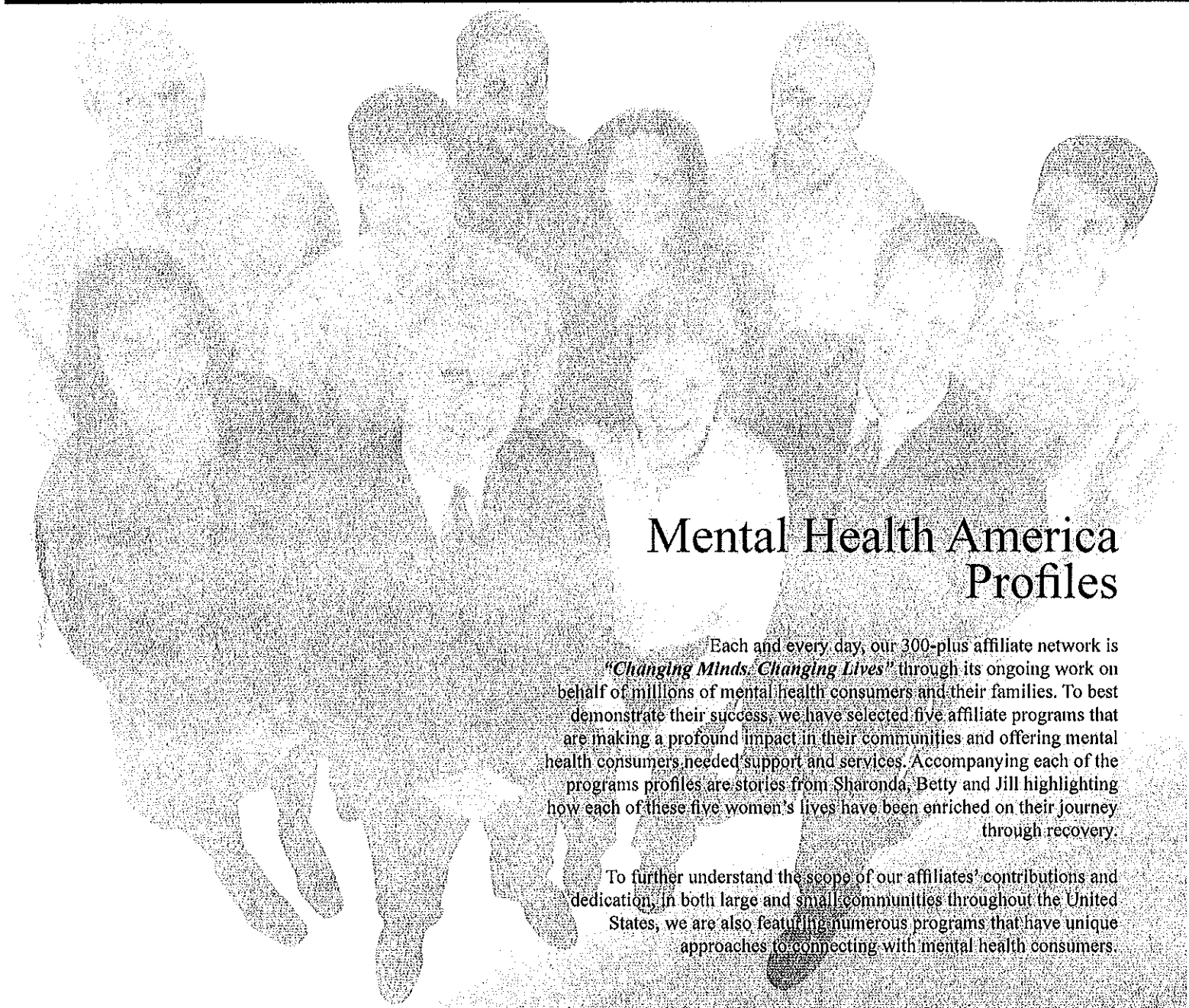
History

In June 2006, a small group of executive directors gathered at the annual conference to discuss reforming what had once been called the National Staff Council, an informal gathering each year of affiliate leaders based on friendship, shared learning, and developing strong affiliate management. The NSC had been voluntarily dissolved a decade before, and was replaced with a regional meeting hosted by the national Mental Health America in an affiliate community.

The latter was done in conjunction with a national board meeting. Many affiliates who had experience the NSC regretted its demise, and therefore committed in June 2006 to rebuild an affiliate connection and leadership development activity. It would be called the National Staff Institute, and would focus on regional meetings and depend upon host affiliate sites and other leadership for the curriculum, training, and camaraderie.

Accomplishments

NSI committee members met throughout 2007, focusing on issues around management as well as critical concerns of unmet needs throughout the affiliate field. The first NSI in over a decade was held October 24-26, 2007, in Salt Lake City, Utah, and 20 affiliate members were hosted by Mack Gift and his staff and many of his board members. Three themes emerged over the work that attendees completed collectively, all of which were put into play immediately after folks flew home. Critical were concerns around: eliminating disparities in mental health among rural and frontier communities and regions; developing actual regional meetings among affiliates "across state lines" that have similar challenges and populations; developing a permanency for the NSI focus on top level management and development, focusing not just for today but with an eye to the future and where we need to be in five to ten years in our field and network.



Mental Health America Profiles

Each and every day, our 300-plus affiliate network is ***"Changing Minds. Changing Lives"*** through its ongoing work on behalf of millions of mental health consumers and their families. To best demonstrate their success, we have selected five affiliate programs that are making a profound impact in their communities and offering mental health consumers needed support and services. Accompanying each of the programs profiles are stories from Sharonda, Betty and Jill highlighting how each of these five women's lives have been enriched on their journey through recovery.

To further understand the scope of our affiliates' contributions and dedication, in both large and small communities throughout the United States, we are also featuring numerous programs that have unique approaches to connecting with mental health consumers.

Senior Companion Program of Wichita, Kansas

Mental Health Association of South Central Kansas

With 33.8 percent of the senior population living alone in the Wichita tri-county area, issues of isolation and premature institutionalization can become a reality for many seniors who wish to remain at home. Senior Companions, sponsored by the Mental Health Association of South Central Kansas and funded by the Corporation for National & Community Services, provides a link to the outside world where there is freedom from isolation, neglect, abuse and depression. Companions can become advocates for clients in need of proper care, but more importantly, Senior Companions are friends to their clients.

Qualified Senior Companions (residents who are at least 60 years of age and 125 percent below the poverty line) provide friendship and assistance with daily tasks to frail senior citizens who wish to remain living independently in their own homes. Senior Companions offer adults contact with the world outside of the home and make the lives of the homebound less lonely. They help clients with household chores, alert caregivers to potential health problems, remind clients to take medications, provide them with transportation to doctors' appointments, and encourage them to do what it takes to remain healthy at no cost.

One Such Companion

One such Companion is Betty Gulley, 80 years old. Betty volunteers at a public housing facility where she visits four clients weekly. One of her clients had fallen and dislocated her shoulder. Betty began performing light housekeeping duties like shopping and running errands.

Betty Gulley (on right)

Betty went the extra mile when she took this seriously ill client directly to the hospital from her doctor's office. Betty called the client every day at the hospital even when she was ill herself. Her client and the client's children are extremely grateful for Betty's ongoing support and assistance.

"By having the Senior Companion, I have been able to work and know that my mother is okay," said a family member. "Betty has been a great help to my mother and to me. I am very thankful to God for the Senior Companion Program."

Betty's services and the services of other Companions do not go unnoticed. These volunteers are known most for their positive attitudes, not to mention the cost savings to the clients and their caregivers.

"My Senior Companion takes me shopping. I have bad eyesight and she helps me get around more easily. She keeps me informed about services. I really appreciate her. I don't suffer from depression, thanks to her friendship," said a Senior Companions client. Senior Companion services are free to both the client and caregiver.

Workforce Development Pipeline

Mental Health America of Los Angeles

Mental Health America of Los Angeles' Human Services Academies were started in 1998 in collaboration with the Los Angeles Unified School District. The academies aid low-income minority students, with the ultimate goal of increasing the number of bilingual and multicultural youth who become human service workers. Currently, MHALA works with a total of 800 Academy students, 90 percent of whom are from underrepresented minority groups.

Although the HSAs successfully aided students in graduating from high school and matriculating to various post-secondary education institutions, the majority of students were not enrolling in mental health classes. MHALA realized that there was less cohesion and support for the students than there had been in high school. In addition, there were no obvious educational options that encouraged students to work in community mental health.

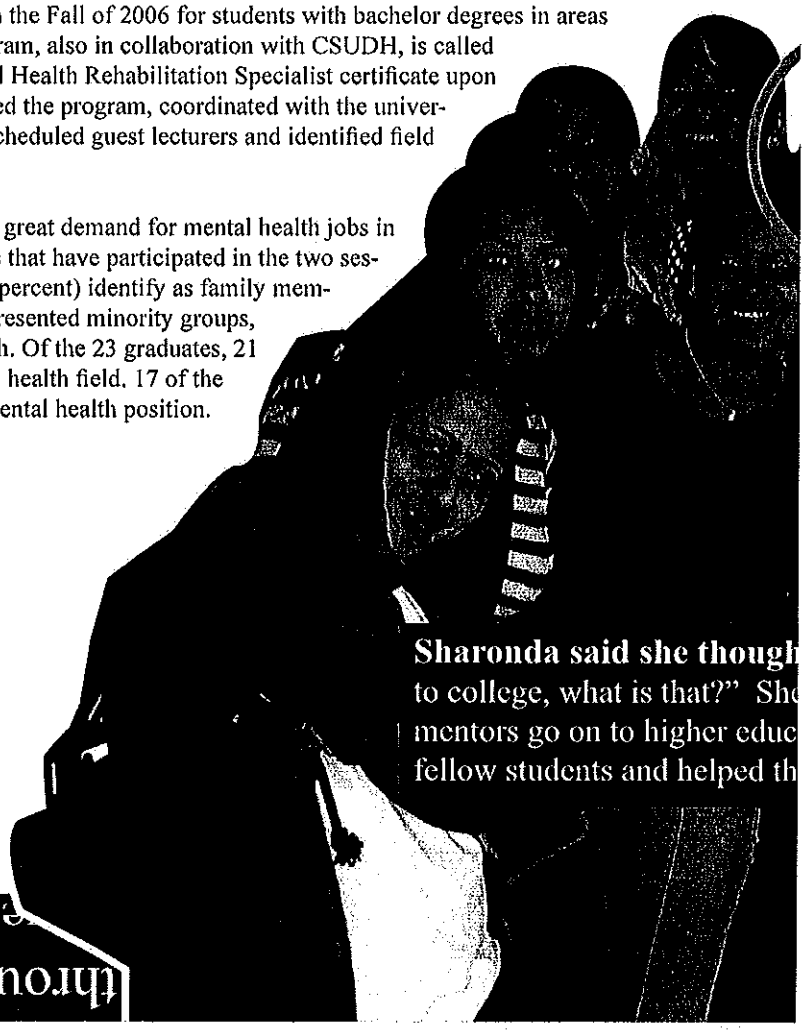
To create more of a pipeline for students to enter the mental health field, MHALA and its education partners developed three recovery-focused post-secondary programs for students, mental health clients and entry-level professionals.

In the fall of 2006, MHALA partnered with Cerritos Community College to create an 18-unit, six-course (five classes and a field placement) program to be used towards an AA degree in psychology, transfer studies or as an independent certificate called the Mental Health Worker Certificate.

When students graduate from Cerritos College, they can move towards employment or go on to get their bachelors degree while working. In the fall of 2007, MHALA partnered with California State University, Dominguez Hills (CSUDH) to create a bachelor's level Mental Health Rehabilitation Specialization. The four-course specialization, consisting of three classes and a field placement, was designed and approved.

The third post secondary program was implemented in the Fall of 2006 for students with bachelor degrees in areas other than human services or mental health. This program, also in collaboration with CSUDH, is called the Jump Start Fellowship. Graduates receive a Mental Health Rehabilitation Specialist certificate upon completion of the eight week course. MHALA designed the program, coordinated with the university, recruited and assisted students with enrollment, scheduled guest lecturers and identified field placement sites.

Jump Start has attracted and trained people who are in great demand for mental health jobs in Los Angeles County. Of the 49 Jump Start participants that have participated in the two sessions, 28 (57 percent) identify as consumers, 14 (28.5 percent) identify as family members, 31 (63 percent) identify as people from underrepresented minority groups, and 16 (33 percent) speak languages other than English. Of the 23 graduates, 21 (91 percent) are actively pursing a career in the mental health field. 17 of the 23 graduates (74 percent) are already employed in a mental health position.



Sharonda said she though
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twork is "Changing Minds. Changing Lives"

Motivated Student

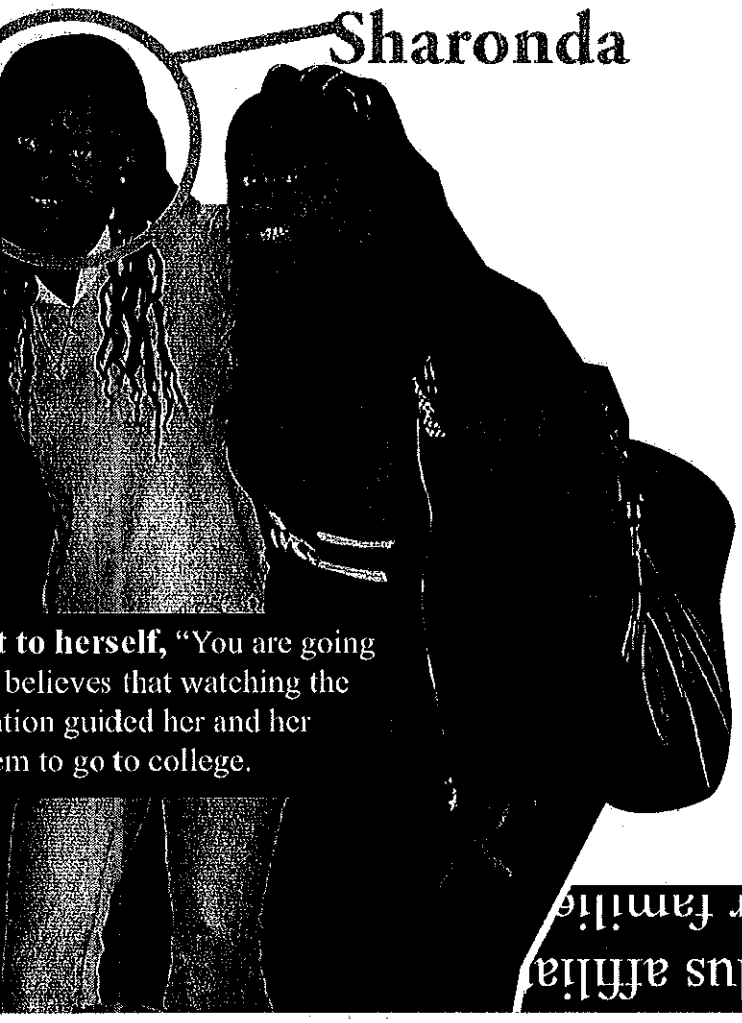
As a young child, Sharonda Miller watched her single mother constantly struggle to overcome the barriers of the public welfare system. In 2001, after joining a friend at an after school-class on teamwork activities, the then-10th grader decided that she wanted to do whatever she had to in order to be in the class. Upon going to her school counselor, Sharonda found out that the only way to be in the after-school class was to join Narbonne High School's Human Services Academy (HSA).

Once an HSA student, Sharonda's educational experience improved. She took a class by "one of the few teachers at the school who challenged us and made us do college-like work." She also met with two MHA mentors, one who was African American/ Filipino and the other who was Mexican. These two mentors were the only minorities that Sharonda saw going to college.

Sharonda said she thought to herself, "You are going to college, what is that?" She believes that watching the mentors go on to higher education guided her and her fellow students and helped them to go to college.

During the 11th grade student worker program, Sharonda was placed at an elderly care center and got the "greatest piece of advice from Mrs. Betty," a blind resident at the center. Mrs. Betty never had the opportunity to go to college, but Sharonda said "she looked straight at me, as if looking in my eyes, and said 'go to college' and it was convincing so I knew I had to go." Sharonda explains that she always had the desire to help people but she did not know that it could be her profession. Visiting the MHALA Village helped her see the ways in which people can work in the helping profession and really make a difference in the lives of people with mental illness.

Before graduating from the HSA, Sharonda ran the after-school program that had convinced her to enroll in HSA in the first place. She went to California State University Long Beach with a full scholarship and decided to study Sociology. At that time, she dealt with being a low-income student, having to move out on her own at the age of twenty, maintaining three jobs, working seven days a week to pay rent, attending school full-time and keeping her grade point average above a 3.0, and having to take care of her 16-year-old sister.



Sharonda

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em to go to college.

In her final year at college, Sharonda was working for Educational Talent Search, a program through the California State University system that helps get low-income, under-privileged children into college. As part of her job, she was reconnected with MHALA staff and asked to give an inspirational speech to the current HSA students. After hearing her speak, MHALA staff asked her to join the HSA team as a coordinator.

She explains that, "many of the students I work with live in poverty and are the first in their families to attend college, so a major part of my job requires that I encourage them and ease their fears about furthering their education. I often tell the students about my own experience with college and they usually become more motivated once they know that I can relate."

Sharonda is currently as busy as ever; she is pursuing her Masters of Social Work at the University of Southern California, interning with the Department of Children and Family Services and continuing to work as a coordinator for Narbonne High School's HSA.

Mental Health Walk-In Center

Mental Health Association in Indian River County

Supported by the Indian River County Mental Health Collaborative, the Mental Health Association in Indian River County's Mental Health Walk-In Center provides immediate and accessible mental healthcare for adults who are facing emotional problems and/or emotional crisis. The program is for individuals who do not require hospitalization but need to talk with a therapist and/or access community resources.

The program provides services to residents who are uninsured and/or underinsured. The Walk-In Center provides crisis intervention, mental health assessments, counseling, referrals to community resources, and family support and education. 100 percent of Walk-In Center clients receive an initial screening within 15 minutes of arrival. Clients in need of psychiatric medication to assist with treatment will have access to such medication providing they meet the criteria established by the Walk-In Center. Walk-In Center clients with ongoing needs are linked and integrated with appropriate community providers once their initial crisis is resolved.

An Abuse Victim is Saved

Jill was frightened and alone. She was the victim of domestic violence for more than 20 years and the violence continued to escalate. After connecting with the counselors at the Mental Health Association in Indian River County, she is thriving and now able to help other abused women with her experience and insight.*

"I was married for years and the abuse started more like verbal abuse," Jill explained. "He was great at manipulating me and making me doubt myself, which crippled me. Gradually he became violent and physically abusive. I've had my head slammed into cement and even been thrown across the room. I had been a victim for so long I started to think that everyday normal life was to be emotionally and physically abused."

Jill and her husband moved from another state to Florida and had no family support system she could rely on when the violence against her became too much to bear. Fortunately, she found some literature about the Mental Health Association in Indian River and decided to seek help from the organization.

"I came to the MHA in a crisis moment," she said. "I needed to connect with someone and feel safe. That's exactly what happened at the MHA office – from the moment I spoke to the receptionist and then was seen by the staff. I couldn't say enough good things about the staff. They were warm, caring and comforting. They really saved me. When I walked in they didn't ask me to fill out a bunch of forms and say they needed money up front. They showed they cared about me and my problems. They could tell I was an emotional wreck."

It was the beginning of a long-standing relationship between Jill and the Walk-In Center.

"My counselor was great at relating to me," explained Jill. "We really connected one-on-one and she helped me learn to take care of myself and to look at my situation clearly. Even though I am not in counseling anymore, she still wants updates on my life now and then."

Jill had stayed in her abusive relationship for a variety of reasons: fear, shame, inadequate financial resources and child responsibilities. Overcoming her fears proved to be her ticket out of a dangerous married life.

"People used to laugh at me because I was terrified of the smallest things like spiders. I would literally scream and run if I saw one," she explained. "Or the fear of flying in an airplane was another thing that made me a nervous wreck. Although as a child I flew internationally without any anxiety and had even considered a career as a flight attendant before I was married. Through my counseling sessions, I realized that I had transferred my domestic violence fears into other situations. Once I faced the real fear and problems in my life I wasn't afraid of the little things anymore. By facing my real fear, I was able to move forward in my life. Counseling was the best thing that could have happened for me."

**Jill wishes to remain anonymous.*

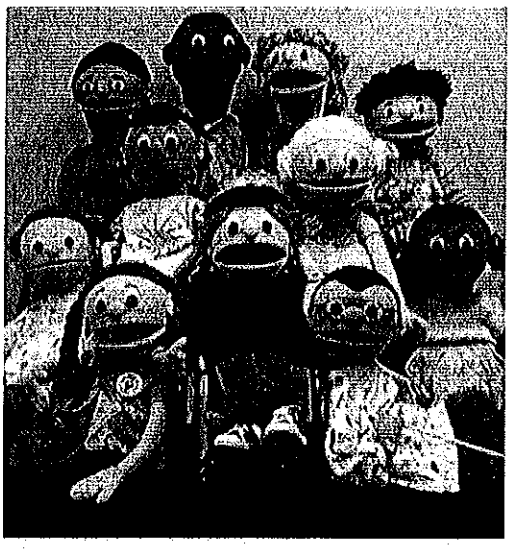
Affiliate Profiles

(left to right) Laverne Williams and Terrie Williams

Mental Health America of Montgomery organizes *Operation Santa Claus.* Funds are raised to provide holiday gifts and stocking stuffers to designated individuals living independently, in group homes, in a mental treatment center, or with family members. The program also sponsors a Christmas party where mental health consumers participate by reading poems and singing songs. Each year, more than 600 mental health consumers receive holiday gifts.

MHA of San Diego has recently instituted *Breaking Down Barriers,* a program to reach out to underserved communities and provide information about what services are available throughout the county. The program has substantially increased the number of Spanish-speaking clients who are receiving mental health care.

Promoting Alternative Thinking Strategies (PATHS), a comprehensive violence prevention program, teaches children emotional and social competency skills, improving classroom performance and strengthening interpersonal relationships. This **Mental Health America of Michiana** program is offered once per week for 12 weeks in a classroom setting. More than 1,000 children benefited from *PATHS* in 2007.


Kids on the Block puppet troupe

Kids on the Block is a puppet troupe that performs for more than 10,000 children annually and utilizes multicultural, life-sized puppets that perform skits on mental health topics to promote mental wellness and stigma reduction for children, their families, and caregivers. This **Mental Health America of Georgia** program has served as a vehicle for children to understand and address issues related to mental health, especially misconceptions. As a result of watching *Kids on the Block* programs, many children have come forward with issues requiring attention from the school counselor and other professionals.

Mental Health America of Vigo County's *Supportive Housing Program* provides housing and supportive services to individuals with a mental illness who are chronically homeless. The programs three main objectives are to increase skills and income, foster residential stability and develop self-determination. 80 percent of participants entering the program will maintain affordable safe housing when exiting the program. Seventy-five percent of participants will increase medication compliance as documented by program staff and 85 percent of participants will receive healthcare services and or enroll in a social service agency program.

Stigma of Mental Illness Lifetime Education (SMILE), offered by **Mental Health Association of Nebraska** is a consumer-designed, directed and presented anti-stigma/anti-discrimination workshop for providers and other professionals. In 2007, more than 200 professionals attended the SMILE workshops and earned CEU credits.

Mental Health Association in New Jersey is also busy with its *Promoting Emotional Wellness and Spirituality (PEWS)* program. *PEWS* provides outreach and education to the African-American church community with the goal of opening up dialogue surrounding mental health issues within the church, addressing stigma and expanding access to mental health services. *PEWS* also works to recruit church lay members for the purpose of creating a Mental Health Ministry to educate and care for church members, and liaison with mental health providers.

CHOICES is a consumer-driven program to educate mental health consumers on the hazards of smoking, and engages them to quit their habit. **The Mental Health Association in Southwestern New Jersey** program has reached more than 3,000 consumers with data illustrating that more than 90 percent expressed a desire to quit smoking. Training is provided in mental health and residential service settings and includes access to anti-smoking treatment.

Students give voice to Check Your Head through the art of Hip Hop

Mental Health America of Colorado's school program, *Check Your Head,* uses hip hop elements in school settings to inform students about mental health, and coordinates free mental health services for low-income and homeless populations who have limited or no access to mental health resources.

Each year, **Mental Health Association in New York State** *Policy Program* creates a priority list based in part on input from town hall meetings held around the state. The organization is currently working with other agencies to improve conditions in adult homes, to improve pay and benefits for mental health workers, and to include PTSD as a covered mental health disorder. After five years of hard work, Timothy's Law was signed and enacted by former New York Governor George Pataki. The statewide parity bill is named for 12-year-old Timothy O'Clair, who completed suicide after being denied access to mental health services by his parents' insurance. There have also been increases in much-needed services such as Medicaid waivers and a cost-of-living increase for mental health workers, which has been extended for another three years.

Rochester Monroe County provides support, education, information, and respite services for families with children who have emotional and behavioral challenges through its *Better Days Ahead* program. Support groups for parents and teen age youth are offered as well as parenting classes. *Better Days Ahead* is staffed by individuals who are themselves parents of children with emotional and behavioral problems. *Better Days Ahead* helps families become advocates for themselves and their children and works to assist families in avoiding residential placements.

In 2007, the *Ombudsman* services of **Mental Health America of Franklin County (Ohio)** assisted more than 1,000 mental health consumers and their families. The *Ombudsman* acts as an advocate for clients by listening to concerns or complaints and helping to find a solution, supplying information and referrals to community resources, helping clients "get through the system," especially when they are receiving services from more than one agency, and coaching clients on how to best work with service providers.

Red Flags is a depression awareness curriculum designed for middle schools. This **Mental Health America of Summit County (Ohio)** curriculum equips children, parents and school personnel with knowledge to identify when a child may be struggling with depression. The program helps schools establish protocols for dealing with children who may be depressed. Contact is then made with a counseling center in order to facilitate referrals when appropriate.

The Mental Health Association of the Cincinnati Area, Inc. and the DBA Mental Health Association of Southwest Ohio offers a *40-hour Law Enforcement Training* course for police officers and first responders to situations involving people with mental illness. This award-winning program, which has received recognition from the U.S. Department of Justice, also involves police recruits, dispatchers, and 911 operators. The two affiliates also co-sponsor a citizens' police academy for mental health professionals and staff a monthly meeting of law enforcement and mental health professionals.

Mental Health America of Lancaster County hosts *The Realities of Living with a Mental Illness* program. Family advocates, peer educators and mental health consumers meet with approximately 2,500 students annually to discuss living with mental illness where a consumer shares her/his story.

Mental Health America of Aiken County offers *Nurture Home,* an emergency shelter and transitional living program for homeless young mothers and their children. *Nurture Home* focuses on educating consumers on effective/caring parenting, breaking the cycle of abuse, breaking the cycle of poverty, and self-sufficiency. Many of the *Nurture Home* residents return to school or continue their education and most subsequently graduate from high school or GED programs.

The P.A.C.E Center of Mental Health America hosts a *Veterans Assistance* program to help veterans and their families access Veterans' Administration medical benefits, employment assistance and education on mental health issues. A concentrated effort is made in educating the general public on the stigma surrounding mental health issues of returning veterans, such as post-traumatic stress disorder.

Mental Health 101 is an educational program of **MHA of East Tennessee** that sponsors a school-based outreach program. Students learn the signs and symptoms of mental illness and are taught personal help-seeking strategies. Suicides in the two counties where the program has had the longest tenure have fallen by 85 percent since 2002. In 2007, *Mental Health 101* was taught in 53 schools across 21 counties, reaching 9,941 students.

Walk for Mental Health is held the first weekend in May to kick off May is Mental Health Month. It is the largest and most important annual fundraising and awareness event for **Mental Health America of Central Virginia.** Income from this event has allowed the affiliate to increase its staff and outreach services in the community.

Affiliate Network

ALABAMA
Mental Health America of Etowah County
Mental Health Association in Morgan County
Mental Health America in Montgomery
Mental Health America of Southwest Alabama
Mental Health Association in Tuscaloosa County

ARKANSAS
Mental Health America of Northwest Arkansas

ARIZONA
Mental Health America of Arizona

CALIFORNIA
Mental Health Association in California
Mental Health America of the Central Valley
Mental Health Association of Alameda County
Mental Health America of Los Angeles
Mental Health Association in Sacramento
Mental Health America of San Diego County
Mental Health Association of Santa Barbara County
Mental Health Association of San Francisco
National Mental Health Association in Ventura County
Mental Health America of Yuba/Sutter

COLORADO
Mental Health America of Pikes Peak Region
Mental Health America of Colorado
Mental Health Association of Pueblo

CONNECTICUT
Mental Health Association of Connecticut

DELAWARE
Mental Health Association in Delaware

DISTRICT OF COLUMBIA
Mental Health Association of the District of Columbia

FLORIDA
Mental Health Association of Volusia and Flagler Counties
Mental Health Association of West Florida, Inc.
Mental Health America of Bay County
Mental Health Association of Broward County
Mental Health Association of Central Florida, Inc.
Mental Health Association of Southwest Florida
Mental Health America of Greater Tampa Bay, Inc.
Mental Health Association of Indian River County
Mental Health Association of Northeast Florida, Inc.
Mental Health Association of Okaloosa & Walton Counties
Mental Health Association of Palm Beach County, Inc.

GEORGIA
Mental Health Association of Northeast Georgia
National Mental Health Association of Augusta
Mental Health Association of Clayton County
Mental Health America of Etowah Valley
Mental Health America of Georgia
Mental Health America of South Coastal Georgia

HAWAII
Mental Health America of Hawai'i
Mental Health Association in Maui County
Mental Health Association in Hawaii County

IOWA
Mental Health America of Dubuque County
Hamilton County Mental Health Association
Mental Health Association of Siouxland

ILLINOIS
Mental Health America of Illinois
Mental Health America of Mclean County
Mental Health Association of the North Shore
Mental Health Association of Illinois Valley, Inc.
Mental Health Association of the Rock River Valley

INDIANA
Mental Health America of Indiana, Inc.
Mental Health America of Blackford County
Mental Health America of Boone County
Mental Health America of Cass County
Mental Health Association in Clark County
Mental Health America of Clinton County
Mental Health Association in Daviess County
Mental Health America of DeKalb County
Mental Health America of Delaware County, Inc.
Mental Health America of Dubois County
Mental Health America of Michiana
Mental Health America of Floyd County
Mental Health America of Fulton County
Mental Health Association in Gibson County
Mental Health America of Greater Indianapolis
Mental Health Association in Greene County
Mental Health America of Hamilton County
Mental Health America of Hancock County
Mental Health Association in Hendricks County
Mental Health America of Henry County, Inc.
Mental Health America of Howard County
Mental Health America of Jackson County, Ind.
Mental Health Association in Jay County
Mental Health America of Jefferson County
Mental Health America of Knox County
Mental Health Association in Kosciusko County
Mental Health America of Lake County
Mental Health Association in Marshall County
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Mental Health America of Morgan County

Affiliate Network *continued*

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Mental Health America of Porter County
Mental Health America of Putnam County
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Mental Health America of Rush County
Mental Health Association in Spencer County
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Mental health needs to be as important as physical health. This mindset needs to be adopted by government, physicians, and insurance companies along with individuals!

–Donor since 2001

Visions of Hope Legacy Society

Our heartfelt thanks goes to these individuals who have made a significant commitment to the future of mental health by including Mental Health America in their estate plans or who have established a charitable gift annuity.

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William Bishop
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Visions of Hope

"This organization seemed like it could do the most good. That's why I have begun to support it. It's my way of paying back the community for what it has given to my family."

–Donor since 2002

A Family's Journey

by David Theobald

My family has been contributing to Mental Health America for nearly a decade. Mental Health America is the single most important charity to me because of its outstanding advocacy work for individuals with mental illness. My mother developed late-onset schizophrenia when I was in college. For the next 22 years until her death last year, she led her family on a journey of extremes that seemed unreal but is likely familiar to those struggling with severe mental illness.

Prior to her illness, Mom raised four children with great energy and little help. She also diligently supported my dad attending many business functions and traveling extensively. People always remarked on Mom's graciousness – the sincere interest she showed in other people, always asking the right questions and listening intently.

Mom had always been moody but in her '40s experienced increasingly severe paranoia and delusions. She divorced my father and shortly afterward began lashing out at all of her family and friends – eventually cutting off contact from the world outside her home. We suspected mental illness but it was still hard to accept her hurtful words and actions.

We could not do much for Mom for several years due to the legal system. My dad would call the neighbors and township for updates. To put it mildly, our attempts to visit were rebuffed. The court finally agreed to her removal from the house and a psychaintric evaluation when her utilities were about to be shut off for non-payment. I remember the doctors saying they had never seen as advanced a case of psychosis.

"Through my years of caring for Mom – and more recently coping with her loss – *I've found Mental Health America* to **be an invaluable** source of both information and inspiration."

Within six months of beginning treatment, Mom had regained her senses and wanted to see her children again. I remember driving out to see her with great trepidation after a break of four years. As soon as I opened my car door, I heard her calling my name and she walked up and hugged me and apologized for all the trouble had caused. And with great poignancy, I recall her disappointment at my not being able to stay the night at the care facility with her.

There were many ups and downs caring for Mom and trying to reintegrate her into our family. The medications did not work for certain periods and when they did usually caused side-effects of lethargy and weight gain. Most of the time she was able to share in our lives and actually have some fun. One of my last memories was the thrill she got being raced around in her wheelchair by her grandchildren.

Through my years of caring for Mom – and more recently coping with her loss – I've found Mental Health America to be an invaluable source of both information and inspiration. I pray that others can avoid the painful experience of mental illness through the heightened public awareness and improved access to treatment that Mental Health America fights for.

"Mental Health America ***is the single most*** **important charity** to me because of its outstanding advocacy work for individuals with mental illness."

Mental Health America's 2007 Financials

In 2007, Mental Health America increased total revenue by $957,000, due in part to a $376,000 increase in grants and contributions, and a $776,000 increase in bequests. Additionally, Mental Health America decreased total expenses by $747,000.

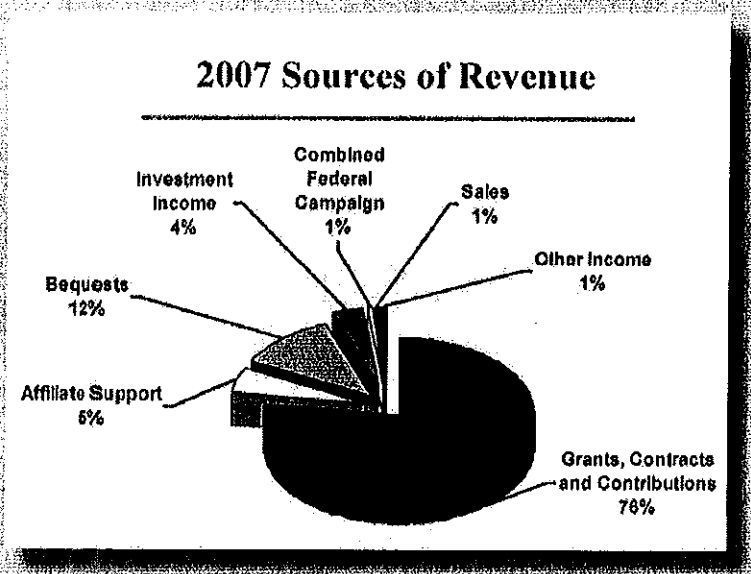
The charts below detail distribution of revenue and expenses:

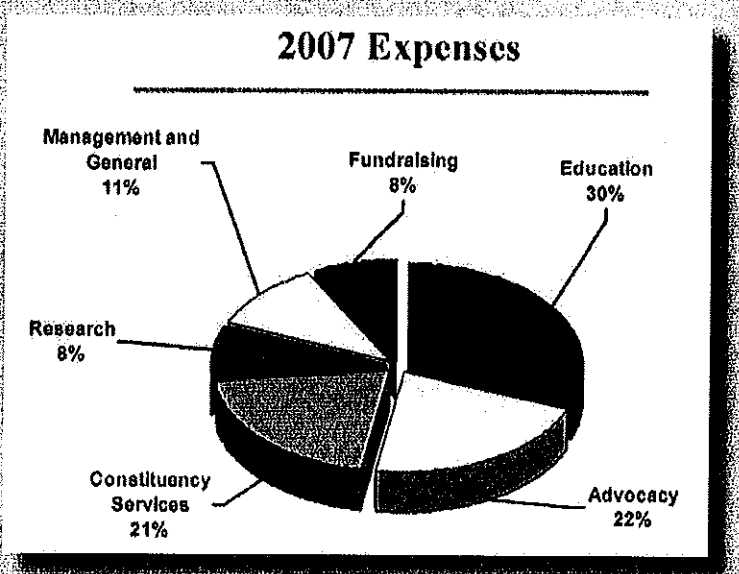
Revenue and Support

	2007		2006	
Grants, Contracts and Contributions	$7,046,071	76%	$6,669,678	80%
Bequests	$1,078,950	12%	$303,464	4%
Affiliate Support	$497,417	5%	$554,443	7%
Investments	$330,790	4%	$253,782	3%
Sales	$74,063	1%	$58,223	1%
Combined Federal Campaign	$49,427	1%	$55,445	1%
Other Income	$61,800	1%	$287,335	4%
Total Revenue and Support	**$9,138,618**		**$8,182,370**	

Expenses

	2007		2006	
Education	$2,200,065	30%	$2,003,706	25%
Advocacy	$1,562,068	22%	$1,260,890	16%
Constituency Services	$1,499,891	21%	$2,274,108	29%
Research	$565,943	8%	$1,117,019	14%
Management and General	$768,241	11%	$820,219	10%
Fundraising	$566,308	8%	$434,134	5%
Total Expenses	**$7,162,526**		**$7,910,076**	





For a full Mental Health America 2007 Financial Report, please go to:
www.mentalhealthamerica.net/go/financial

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Leader of the
"Consumer
Empowermrment"
Movement
Bill Compton

Bill Compton, *a member of Mental Health America's Board of Directors, passed away at age 61. He led Project Return "The Next Step" a network of peer support groups run by the National Mental Health Association of Greater Los Angeles to empower mental health consumers and help them gain the skills they need to live independently.*

MHA
Mental Health America

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Alexandria, VA 22311
Ph: 703-684-7722
Fax: 703-684-5968
Url: www.mentalhealthamerica.net

Mental Health America

Who Are We?

Mental Health America (formerly the National Mental Health Association) is the country's leading nonprofit dedicated to helping all people live mentally healthier lives. With more than 300 affiliates nationwide, we represent a growing movement of Americans who promote mental wellness for the health and well-being of the nation—every day and in times of crisis.

Mental Health America Vision

Mental Health America envisions a just, humane and healthy society in which all people are accorded the respect, dignity and the opportunity to achieve their full potential free from stigma and prejudice.

Mental Health America Mission

Mental Health America is dedicated to promoting mental health, preventing mental disorders and achieving victory over mental illnesses through advocacy, education, research and service.

2008 Summary of Activities

Advocacy

Mental Health Parity Legislation
In October, Mental Health America hailed the passage of mental health parity legislation that broadly outlawed discrimination against Americans with mental health and substance-use conditions in employer-sponsored health plans. The legislation, which recognized the importance of mental health to overall health, banned employers and insurers from imposing stricter limits on coverage for mental health and substance-use conditions than those set for other health problems. The advocacy of Mental Health America staff, Mental Health America affiliates and thousands of individuals throughout the country helped fuel the success of this and many recent mental health-related issues in Congress.

Healthcare Reform Advocacy Training
Mental Health America continued a proud tradition of advocacy training. MHA and its affiliates worked with coalitions of consumer, family and advocacy groups across the country to assist them in their policy efforts and train them to become more effective voices for change in the public and private mental health systems. Training emphasized coalition building, issue knowledge, strategy development and issue-specific advocacy events. Mental Health America also provided technical assistance through its advocacy resource center. Examples included analysis of legislation, issue fact sheets and talking points, best practices and strategy guidance documents and model legislation.

Fall Policy Conference
The Healthcare Reform department holds an annual policy conference every fall, and 2008's conference, *Cultivating Change: Turning Policy Into Action,* was held October 15-17. The foundation for the 2008 conference was MHA's Policy 13: Integration of Mental and General Health Care. Building on the integration presentations at the 2007 Fall Policy Conference, this year's plenaries and workshops focused on specific tools affiliates could use in their states and communities to remove the financial, attitudinal and policy barriers to integration. Forty policy leaders from the affiliate field attended, talking with national and affiliate policy experts. They discussed emerging policy trends, shared advocacy strategies and explored new web technologies as an advocacy tool.

Legislative Updates
Over the summer, Mental Health America successfully promoted legislation to delay implementation of several recently issued Medicaid regulations that would have dramatically limited reimbursement for rehabilitative, case management and school-based administrative services. MHA worked with a small coalition of mental health, disability and child welfare organizations to educate congressional staff about the risks posed by these regulations and push for this provision. The assistance of many affiliates was also critical to this success in providing technical expertise on the impact of these regulations, responding to our alerts to urge members of Congress to block these regulations and in raising these issues during visits to congressional offices during Capitol Hill Day of our annual conference.

MHA led a coalition effort to highlight and address the overwhelming mental health concerns in the juvenile justice context and worked with Sen. Kennedy's staff in developing and reviewing legislative proposals to strengthen the mental health components of a proposed reauthorization bill.

At a Judiciary Committee markup on July 31st, Sen. Dianne Feinstein (D-CA) offered Sen. Kennedy's amendment to strengthen requirements in a bill relating to the treatment of juveniles with mental health or substance abuse disorders by authorizing grant funds to be used for treatment, diversion and increased training.

On June 25, the House of Representatives passed the "Stop Child Abuse in Residential Programs for Teens Act," which would establish and enforce protective standards governing programs such as boot camps and therapeutic boarding schools serving youth with emotional, behavioral, mental health, or substance-abuse problems. MHA worked with staff from the House Committee on Education and Labor Chairman, Rep. George Miller (D-CA), providing assistance in connection with the oversight hearing, reviewing drafts of the proposed legislation and providing support for the bill's passage.

In 2008, Mental Health America also achieved a long-time advocacy goal in Medicare when Congress approved a bill that included a provision to phase out the higher, 50% co-insurance rate for outpatient mental health care. This provision that phased out the higher co-insurance over six years was included in a larger Medicare bill entitled the "Medicare Improvements for Patients and Providers Act of 2008" (MIPPA) (H.R. 6331, Pub. L. 110-275), which was enacted on July 15th.

State Advocacy

Mental Health America staff attended and facilitated the participation of affiliate representatives from Arizona, Florida, Kansas, Kentucky, Louisiana, Mississippi, Nebraska and Rhode Island in the 2008 National Conference of State Legislators (NCSL) Legislative Summit in New Orleans. Some highlights of the activities at the Summit included corresponding with over 1,700 legislators and their staff prior to the Summit to tell them about our Mental Health Caucus materials, advertising the MHA exhibit booth. MHA strategized and worked with the affiliate participants on educating state legislators on mental health and MHA policy priorities, including state mental health caucuses. MHA also met with state legislators, legislative staff and workshop presenters on priority healthcare reform issues and joined NCSL's Science to Policy Advisory Group, which will advise NCSL members on utilizing the latest research and scientific evidence to inform their policymaking.

MHA successfully led the effort to include a specific parity requirement in the State Children's Health Insurance Program (SCHIP), stating that if a state provides mental health or substance use services through CHIP, the financial requirements and treatment limitations may not be more restrictive than those for medical or surgical benefits.

Veterans' Mental Health

Mental Health America continued to pursue avenues to advocate for the mental health needs of returning veterans. Among them, MHA wrote a commentary for MIWatch (an online news publication about mental illness) entitled "Peer to Peer: Returning Vets Mental Health Care," January 7th. At the request of Senate Veterans Affairs Committee staff, MHA wrote a letter to the Chairman amplifying on concerns we had earlier voiced about the approximately 500 thousand veterans of service in Iraq and Afghanistan who have not availed themselves of any VA health care services.

Council on Science and Research

On December 16, Mental Health America held its bi-annual meeting of MHA's Council on Science and Research, *Beyond Clinical Trials: Comparative Effectiveness Research.* MHA gave members an overview of proposed federal comparative effectiveness legislation. Attendees heard from two speakers and then engaged in discussion on comparative effectiveness as it relates specifically to mental health.

Public Education

Mental Health America Resource Center
Mental Health America's Resource Center is central to the public education and service mission of Mental Health America. The Resource Center touches the lives of hundreds of thousands of people each year by providing accurate, timely and free mental health information and referral assistance. Operated by experienced, professionally trained staff, the Resource Center responds to requests from the public in English and Spanish through Mental Health America's toll-free line, e-mail and online resources.

In 2008, the Mental Health America Resource Center responded to over 1,365,878 inquiries from 50 states, the District of Columbia, Puerto Rico, and 31 countries received through:

- Direct calls to 1-800-969-6642
- Phone message library of mental health topics
- Email and mail correspondence
- Online FAQs and Fact Sheets

Campaign for America's Mental Health
Mental Health America continued its Campaign for America's Mental Health, a comprehensive effort to improve Americans' awareness, attitudes and behaviors regarding mental health and mental illness. Mental Health America worked closely with 41 Campaign sites to organize and conduct educational, screening and media activities. Sponsorships supported these ongoing activities by enabling Mental Health America to provide local outreach grants, free publications and ongoing technical assistance. From January to October 2008, MHA educated more than 3.7 million people at over 3,000 events, screened more than 12,000 people locally, and referred more than 12,000 people to treatment and services.

FundaMENTAL Health
Mental Health America undertook a significant initiative aimed at addressing the impact of mental health conditions on the U.S. workforce. The centerpiece of this initiative is a dynamic, multi-media slide presentation that examines the prevalence and disability of mental health conditions and demonstrates that an investment in behavioral health services and mental health promotion is critical to employee health and productivity, as well as cost containment. After the first FundaMENTAL Health presentation at the annual meeting in June, MHA kicked off the tour on October 22 with a successful event in Chicago, with over 30 people in attendance from a variety of industries.

Dialogue for Recovery
Through the Dialogue for Recovery educational initiative, Mental Health America seeks to enhance recovery, health and quality-of-life for individuals with severe mental illness. The program works to improve communication between mental health consumers, their healthcare providers, family members and others to support an individual's empowerment and recovery. Between August and October 2008, Mental Health America built and strengthened its capacity to reach consumers. MHA began developing six brochures covering topics in recovery, including an overview, medications, supporting loved ones, treatment options, working with your healthcare provider and wellness. Mental Health America began redesigning the Dialogue for Recovery website, with expected completion in the 1st quarter of 2009. Mental Health America, in partnership with the National Endowment for Financial Education (NEFE), created *Your Personal Financial Growth Instructor's Guide*. The manual provides information on conducting a one-hour workshop to teach concrete

skills, like developing a spending plan, handling credit wisely and reducing medicine costs. Mental Health America sent copies of the manual to each affiliate and continues to receive requests from affiliates for assistance in planning programs/seminars on this topic.

Maternal Depression
Between August and October 2008, Mental Health America completed the content of *Maternal Depression—Making a Difference Through Community Action: A Planning Guide*. The *Guide* aims to build awareness and acceptance of the need for a family-focused, community-driven approach, strengthen the capacity of communities to mobilize around a significant public health issue, promote the use of state, local and even neighborhood partners, and spur strategic thinking that leads to effective community action and change. The *Guide* offers community organizations and other stakeholder groups an easy-to-use, practical framework to create a well-thought-out plan of action that is customized to their communities. It provides an in-depth look at the issue of maternal depression, examples of outreach programs and practices, n easy-to-follow roadmap for action, and tools and resources to use in all stages of the planning process.

Mental Health Month
Mental Health America celebrated May as Mental Health month by launching a "Get Connected" initiative. The theme in 2008, "Get Connected," focused on the important role social connectedness plays in maintaining and protecting mental health and wellness. Mental Health America challenged all Americans to the ***Mental Health Connection Challenge*** by making five positive and life-fulfilling connections this month. Research shows that social networks can reduce stress and promote overall health by providing a sense of belonging, self-worth and security.

Outreach

Jammin' Away The Blues
In August, Mental Health America teamed with The Blues Foundation to launch "Jammin' Away The Blues," a program to raise the awareness level of the importance of mental health as well as funds for mental health advocacy, public education and research. Two concerts were held in the fall of 2008, one in San Diego and one in Kansas City, with more planned for upcoming years.

Annual Conference and Promotion and Prevention Summit
Mental Health America held its Inaugural Promotion and Prevention Summit in June during its Annual Conference. The events brought together advocates, mental health consumers, policy makers, community leaders, and executives and staff from Mental Health America state and local affiliates to learn about critical issues in the behavioral health field and map strategies for collective action. The summit featured experts who articulated the current science in mental health promotion and prevention, shared successes and challenges in the implementation of research-based programs and interventions, and connected researchers and advocates to build a movement for the advancement of promotion and prevention in public awareness, practice and policy. Additionally, conference attendees participated in Capitol Hill day to meet with legislators to discuss mental health issues.

Research

Online Schizophrenia Survey

In January, Mental Health America released results of the first national online survey to examine overall healthcare in mental health settings from the perspective of both people with schizophrenia and psychiatrists. Results showed that although both groups are aware of actions to improve overall health and quality of life, they are not discussing such actions to the extent possible. Mental Health America conducted the survey in response to recent data showing that people with serious mental illnesses - including schizophrenia - die at least 25 years earlier than the general population, largely due to preventable medical conditions such as diabetes, cardiovascular disease and respiratory and infectious diseases. Nationwide, rates of chronic illnesses such as heart disease and diabetes are at epidemic levels. Nowhere is this public health dilemma more evident than in people with serious mental illnesses such as schizophrenia, who die at nearly twice the rate of the rest of the population from heart disease and diabetes.

Disparities among minorities

In March, Mental Health America began an initiative to help stakeholders in rural areas reduce barriers to mental health treatment as part of its disparities partnership with the U.S. Department of Health and Human Services' Office of Minority Health (OMH). Minorities in America are significantly less likely than non-Hispanic whites to seek or receive mental health treatment for a variety of reasons, including stigma, cost of care and our nation's fragmented mental health system. The gap is particularly wide in rural and geographically remote areas, where minorities face numerous geographic and cultural challenges, including a shortage of culturally competent providers and fear of breaches to confidentiality. The two-day, multi-state meeting, held in Albuquerque, New Mexico, brought together teams of affiliates, consumers, rural service providers and tribal and state health leaders from six states (Colorado, Montana, New Mexico, Nevada, North Dakota and Utah). The goals were twofold: to highlight concerns about barriers to mental health treatment in rural areas and provide stakeholders with tools and strategies to build innovative models for improving access to appropriate services in their home states. The meeting helped build a new platform that provides delegations with the ability to build innovative models and create action plans for services in their home states.

Leadership

National Staff Institute

The National Staff Institute brings together affiliate leaders for the purposes of strengthening relationships between affiliate offices, shared learning and developing strong management practices. At regional meetings which take place at affiliate host sites, leaders of state and local offices focus on issues around management as well as critical concerns of unmet needs throughout the affiliate field to determine how as a network, they can become more effective in service delivery and fortify organizational sustainability. Since its inception in 2007, meetings have concentrated on issues such as eliminating disparities in mental health among regional and frontier communities, and addressing the needs of America's service members/veterans and their families.

The National Working Group on Evidence Based Health Care

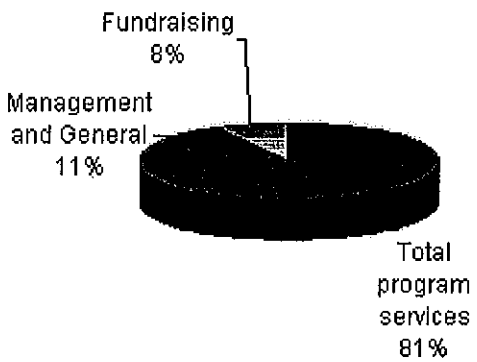
Mental Health America (MHA) continued its work with the National Working Group on Evidence-based Health Care (The Working Group) to help ensure greater patient-focused, consumer

knowledge, and involvement in national and state-focused initiatives seeking to promote a better quality of care. MHA convened The National Working Group on Evidence Based Health Care, which represents consumers, caregivers, practitioners and researchers committed to promoting accurate and appropriate evidence-based policies and practices that improve the quality of health care services in the United States. In addition to Mental Health America, Working Group members include more than 40 patient and disease advocacy groups including The Epilepsy Foundation, Breast Cancer Network of Strength, American Psychiatric Association, and the Asthma and Allergy Foundation of America.

The group released a report that found the person who has the most at stake when it comes to healthcare decisions-the patient-should be involved in research, advocacy and all segments of the health care system. *The Role of the Patient/Consumer in Establishing a Dynamic Clinical Research Continuum: Models of Patient/Consumer Inclusion* described successful examples of groundbreaking patient/consumer engagement in evidence-based healthcare. Designed for patients/consumers, providers and decision-makers, this report identified best practices for meaningfully involving patients/consumers, especially given discussions about increasing the U.S. capacity for comparative effectiveness research and the potential for a new centralized entity to conduct the research. The report built off a March 2008 Working Group forum that promoted the inclusion of patients and consumers throughout the research process.

2008 Financials

REVENUE AND SUPPORT	
Grants, contracts and contributions	$5,689,609
Bequests	$1,167,014
Affiliate support	$473,488
In-kind contributions	$63,524
Combined federal campaign	$53,563
Sales	$31,656
Rental income	$30,158
Interest and dividend income	$210,981
Realized (losses) gains on investments	($199,087)
TOTAL	**$7,520,906**
EXPENSES	
Education	$2,195,580
Advocacy	$1,420,214
Constituency services	$1,646,969
Research	$434,762
Total program services	**$5,697,525**
Management and General	**$758,707**
Fundraising	**$562,629**
TOTAL	**$7,018,861**



CHANGE IN NET ASSETS	**$502,045**
(before unrealized losses on investments)	
UNREALIZED LOSSES ON INVESTMENTS	**-$1,362,791**
CHANGE IN NET ASSETS	**($860,746)**
NET ASSETS, BEGINNING OF YEAR	**$8,209,520**
NET ASSETS, END OF YEAR	**$7,348,774**

2008 Board Members

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Chair of the Board

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Community Health Charities of N.J.
Czarnowski
Community Health Charities of Georgia
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Gertrude H. Niehans
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Rena D. Wrenn
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Stephen B. Shepherd
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Section 8. Conflicts of Interest. A "conflict of interest" exists when the Corporation is contemplating entering into a transaction or arrangement that would benefit the private interest of an officer or Director of the Corporation or might result in an "excess benefit transaction."

(a) Excess Benefit Transaction. An "excess benefit transaction" means a transaction in which an economic benefit is provided, directly or indirectly, to or for the use of an "interested person," and the value of the economic benefit provided by the Corporation exceeds the value of the consideration received by the Corporation.

(b) Interested Person. An "interested person" means any Director or officer of the Corporation, and any member of a committee with Board-delegated powers, who has a direct or indirect "financial interest" in an "excess benefit transaction."

(c) Financial Interest. A person has a "financial interest" if the person has, directly or indirectly, an ownership or investment interest in any entity with which the Corporation has negotiated or is negotiating a transaction or arrangement or if the person has a compensation arrangement with the Corporation or with any entity or individual with which the Corporation has negotiated or is negotiating a transaction or arrangement.

(d) Disclosure Responsibility. Immediately upon determining that a conflict of interest exists, the interested person shall disclose the existence and nature of the financial interest and all material facts to the Board. When such conflict of interest is relevant to a matter requiring action by the Board, or a committee with Board-delegated powers, the interested person shall call it to the attention of the Board (or its committee), and such person shall not vote on the matter.

(e) Recusal Responsibility. Moreover, a person having a conflict of interest shall retire from the room in which the Board (or its committee) is meeting on a matter on which the person has a conflict of interest and shall not participate in any deliberation or decision regarding the matter .The minutes of the meeting of the Board or committee shall reflect that the conflict of interest was disclosed and that the interested person was not present during the final discussion and vote and did not vote.

(f) Board Responsibility. When there is doubt as to whether a conflict of interest exists, the matter shall be resolved by a vote of the Board (or its committee).

(g) Annual Disclosure by Directors. Every year, members of the Board shall submit to the Chair of the Board a letter disclosing any direct or indirect benefits received by a Director as a result of the Corporation's agreements with any outside party and any financial interest within the meaning of paragraph (c) above.

Section 9. Honorary Members of the Board. From time to time, the Board may designate one or more persons as an honorary member of the Board. Persons who have distinguished themselves through their efforts to promote and protect the rights and dignity of all people, who have worked to promote mental health and prevent mental disorders and who have made significant contributions to the mission of the Corporation shall be eligible for selection as honorary members of the Board. Honorary members of the Board shall serve in an advisory and consultant status to the Board and may attend meetings of the Board. Honorary members of the Board shall serve at the pleasure of the Board and shall not have the right to vote at meetings of the Board.

CONFLICT OF INTEREST

A conflict of interest may exist when the interests or concerns of any director, officer or staff member, or said person's immediate family, or any party, group or organization to which said person has allegiance, may be seen as competing with the interests or concerns of the Association.

Any possible conflict of interest shall be disclosed to the board of directors by the person concerned.

When such conflict of interest is relevant to a matter requiring action by the board of directors, the interested person shall call it to the attention of the board of directors (or its committee) and such person shall not vote on the matter.

Moreover, the person having a conflict shall retire from the room in which the board (or its committee) is meeting and shall not participate in the deliberation or decision regarding the matter under consideration.

The minutes of the meeting of the board or committee shall reflect that the conflict of interest was disclosed and that the interested person was not present during the final discussion or vote and did not vote.

When there is doubt as to whether a conflict of interest exists, the matter shall be resolved by a vote of the board of directors (or its committee), excluding the person concerning whose situation the doubt has arisen.

Members of the board of directors will annually submit to the Chair of the Board a letter disclosing any direct or indirect benefits received as a result of the Association's agreements with any outside party.

*** Excerpt from the Mental Health America Bylaws as amended by the Board of Directors on March 3, 2007.**

Mental Health America

PLEASE RETURN

To: Jessica Kennedy
2000 North Beauregard Street, 6th Floor
Alexandria, VA 22311
Fax: 703-739-5917

CONFLICT OF INTEREST DISCLOSURE FORM

With the exception of those items listed below, I have not received in 2008-2009, nor intend to receive in 2009-2010, any direct or indirect benefits as a result of the Association's agreement with any outside party, nor has any member of my immediate family, or any party, group or organization to which I have allegiance, which may be as competing with the interests or concerns of the Association.

Signing below indicates all information on this page is true to the best of your knowledge, and that you have read and understood the conflict of interest policy.

Exceptions **(If none, so state)**

Please list any family or business relationships you have with other board members or employees of Mental Health America **(If none, so state)**

_____
Signature

_____
Printed Name

_____
Date